A Child Psychotherapy Primer

Parents

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PARENTS

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PARENTS

WHAT IS THE NATURE OF THE RELATIONSHIP BETWEEN THE CHILD'S THERAPIST AND THE CHILD'S PARENTS??

Parents are important in child psychotherapy. In therapy sessions with the therapist, the child should be changing: learning about self, developing more mature ways of dealing with stress, acquiring new competencies, improving self-image, and achieving greater independence. However, the child does not live only in the therapy room (weekly therapy sessions occupy about six-tenths of 1 percent of the child's time), and the parents play an active part in this change process. Their influence on the change may be positive, negative, or mixed. The ideal relationship between parent and therapist will be described; then some realities will be discussed.

Ideally, the parents, the therapist, and the child all work together to alleviate whatever is presenting a problem for the child and the family. This means arriving at a common view of the problem and its causes plus coming to agreement about the best strategies to be used by each to help resolve the problem. To achieve this close working relationship requires frequent and clear communication between parents, therapist, and child. In a clinic that uses the team approach the parents may be regularly seeing a mental health worker other than the child's therapist. In that case the parents' worker must also establish clear communication with all parties. Yet the privacy of each member of the family would be preserved.

There are many factors both in the family, in the clinicians, and in the nature of the therapeutic enterprise that work against such an ideal relationship. The parents may not be in agreement with each other about the nature of the problem in their family or the decision to seek outside help. A common, though by no means universal, attitude in families is the father's belief that there is no problem or, if there is, that the mother should take care of it since she has primary responsibility for raising the children. The mother may feel that the father is uninvolved with the children and insensitive to both their and her needs. Even if the parents are in agreement about the problem, they may disagree with the clinician's view of the problem and his/her suggestions as to what might be done about it. Often the

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parents bring the child to the mental health clinic with the same expectation with which they bring the child to a medical clinic, namely, that the doctor should diagnose and treat their child directly, with pills if possible. If the parents are to be involved at all, it is simply to carry out the doctor's instructions at home. This mental set seems counter to the message they usually receive from the mental health clinic personnel, who believe that the parents are an integral part of the problem and that the solutions to the problem lie within the family, individually and collectively. The parents with this attitude would be particularly impatient with play techniques, which they might see as slow in bringing about change. They wonder how "just playing" can help, since the child can play at home and at a much cheaper price!

Sometimes parents bring their child to a mental health clinic as an entree to seeking treatment for themselves, either individually or for their marriage relationship. The clinician should be alert to this possibility and realize that although the parents may be seeking help for themselves, this does not necessarily mean that they do not also want help for their child.

Sometimes parents feel much guilt about "causing" their child's problems. They may react to suggestions from the mental health worker about what they might try in order to alter an impasse with their child as if they were being blamed for that impasse. I have found that a good approach to helping the parents deal with their guilt about causing their child's problem is as follows. If, after a discussion with the parents about the staff s assessment of the problem, usually in the interpretive session, the parents indicate some guilt, the therapist says, "Of course you played an important part in your child's development; he did not grow up in a vacuum. But it is not as if you *deliberately* set out to produce this problem. As your child was growing, you did what you thought was best for him. There was no way for you to anticipate what would happen. Different children react in different ways, and he could have developed quite differently even if you behaved in much the same way. In other words, while you are intimately involved in your child's development, he brings his own characteristics and temperament. No one can blame you for consciously producing problems for your child; certainly you shouldn't blame yourself." (In those rare cases where parents *have* deliberately sabotaged their child's healthy development, they usually do not have *enough* guilt.)

Parents may come to the clinic with much anger at their child for causing stress in the family and for causing the inconvenience and expense of psychotherapy. If this anger is suppressed or repressed, it

could make a barrier to open communication between mental health worker and parent.

At least one family therapist, Raymond Pittmen, is convinced that people who seek help at a mental health clinic *do not want to change.* They want to stop hurting, but they want *others* to change. Such an attitude would clearly interfere with communication of suggestions from the mental health worker about steps the parent might try to break the impasse in their family. For many parents the change process in their child might cause them to become frustrated and angry at the clinic. The change is usually slower than the parents would hope for, and sometimes the child's behavior at home becomes even worse! This is particularly true of overly inhibited children who, as therapy progresses, are helped to become more openly expressive. The parents come to the clinic with the half serious plea, “Please put him back the way he was!” In any case the parents might perceive that the child’s therapist is allied with the child against them, which would arouse resentment and anger in their struggle to resist change in themselves.

Jealousy of the therapist is experienced by many parents and can certainly interfere with a close, cooperative working relationship between parents and clinic staff. The jealousy of any one parent has several potential sources. The parent with high dependency needs might be jealous of the exclusive attention the child receives in the close therapeutic relationship. The parent who feels inadequate as a parent (probably this feeling is true of the majority of parents who seek mental health help) might believe that the child's therapist makes a better parent than he/she does and therefore becomes jealous of the therapist.

Before we condemn parents too readily or too severely, let us remind ourselves that not all of the factors disruptive to good communication and working relationships between mental health workers and parents lie on the parents’ side; the child’s therapist is also liable to have some destructive attitudes and feelings. Most child therapists, as they begin to form an attachment to the child, have rescue fantasies something like “If only I could take this child home with me, I could save him/her from the psychological pits.” The unspoken part of this fantasy is, “The parents did such a bad job of raising the child, I certainly could do better.” As the therapist becomes fond of the child he/she might become angry at the parents for “causing” such past and current pain in the child.

Just as the parents might become jealous of the therapist, so might the therapist become jealous of

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the parents, who have so much time with the child. In the face of these feelings toward the parents, the therapist might want to adopt an isolationist position; "Just leave us alone in our therapy room where we can do our private thing. We can work out the problem alone. Let the rest of the world, particularly the parents, go by." Such an attitude would certainly disrupt communication with the parents.

Finally, the desirability of preserving confidentiality of both the child's revelations to the therapist and the parents' revelations to either therapist or a separate therapist works against open communication.

So what do you do? Foremost, the parents must be kept an active part of the treatment for both theoretical and practical reasons so, in spite of all the barriers enumerated above, the clinic staff must make every effort to establish and maintain a good working relationship with the parents. The theoretical reason why parents must be included in treatment is discussed above, namely, the child does not live in isolation and therefore cannot be most efficiently treated in isolation. The practical reason is that the parents are the legal guardians of the child (except in rare cases where that right is removed by the court), and *they* decide if and when the child receives treatment. If they do not consent to treatment, all of our good, professional, and reasonable ideas are so much wind.

Even if the parents are seen by a mental health worker other than the child's therapist, the therapist should work closely with the parents from the very beginning of treatment or, if possible, from evaluation. The therapist should have sessions with the parents to explore their perception of the problem, their ideas about possible solutions, and the therapist's ideas about problems and possible solutions. The outcome of these sessions is an agreement as to what will be tried and what each party's role in the treatment will be. It is often helpful if the therapist and parents together set a fairly short time, 4 to 6 weeks of treatment, after which time all will take another look at the problem and how the intervention is going. This helps parents in the beginning to avoid an often serious barrier to making a commitment to treatment, namely, the feeling that they are committing themselves to an endless and prohibitively expensive enterprise. It is especially important to involve the traditional father in this decision-making process, since he is often more removed psychologically from the problem but very involved financially if he is the one who makes the family's financial decisions.

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The therapist needs to be aware of all the potential feelings he/she may have toward the parents and the parents toward him/her, not that the therapist reveals to the parents or expects the parents to reveal to him/her each little feeling, as such a practice would be burdensome, impractical, unproductive, and endless. Rather, the therapist needs to know the possibilities so as to be aware of when any of these feelings on his/her part or the parents' part becomes a serious barrier to communication in the therapeutic effort. In that case the therapist and/or the mental health worker seeing the parents could deal directly with the attitude or feeling.

As a side note, the beginning therapist should become aware of the potentially valuable therapeutic use of his/her own feelings toward the parents. It is possible that the therapist's emotional reactions to the parents are in some ways parallel to the child's reactions to them. The therapist can use the feelings to understand better what the child is experiencing in the parent-child relationship. From that understanding could evolve some work with the child around learning more adaptive ways of dealing with his/her emotional reactions to the parents and of interacting with them.

I usually follow a procedure that is useful in promoting close cooperation without threatening confidentiality too greatly. I try to conduct all feedback and planning meetings with everyone present—i.e., child's therapist, parents, child, and if involved, the parents' mental health worker. This creates some problems in that the meeting is sometimes cumbersome and the participants may not feel comfortable saving what is on their minds with everyone present. However, the practice has advantages. Each participant knows what is said to whom and does not have to speculate about what might be said at a meeting at which he/she was not present. In addition, the message is clear from the format that everyone has a share in the problem and its solution.

WHAT ARE SOME OF THE POTENTIAL PROBLEMS BETWEEN THE CHILD'S THERAPIST AND THE CHILD'S PARENTS?

By being aware of potential problems in relating to parents, the therapist perhaps can prevent some difficult situations from developing. Some parents have a great need to talk with someone about their personal concerns. If the parent also has high need for nurture and is jealous of the child's relationship with the therapist, he/she may attempt to get some of the therapist's time and attention. A

frequent parent maneuver is to ask to see you for a few minutes at the beginning of the child's session. Those few minutes, even with the child present, can often stretch into a significant amount of the child's time. The parent may use the child's problems as an entree but then swing into his/her own issues. You can become frustrated because you want to get on with your child session, the parent feels pressure to keep you engaged in listening to him/her, and the child grows angry at being pushed off the stage. One tactic to avoid getting into this situation is to offer the parent a few minutes at the end of the child's session if the parent approaches you at the beginning. This would give you the opportunity to speculate with the child about what is on the parent's mind. If the parent attempted to prolong the contact at the end of the child's session, then at least the child's time is not being taken away. You will also be able to use other commitments as a reality factor in terminating the time with the parent. If the parent persists in taking your time, some decisions need to be made. Primarily, you need to understand why the parent is behaving this way. Are the issues the parent brings up parent-child related and do you need to set up some conferences with the parent? Is the parent deliberately or unconsciously wanting to hurt the child by stealing time and attention from him/her? Does the parent need and/or want therapy for him/herself? If you can answer these questions, you will have a better chance of helping the parent and the child.

If the parent needs and desires therapy for him/herself, you might be tempted to become the parent's therapist, particularly if you are in private practice instead of on a clinic team. Being both the parent's and the child's therapist has some advantages in that you can gain a more complete understanding of what goes on in the family and you can coordinate the child's and parent's treatment goals as well as the means of achieving these goals. There are, however, some danger spots. Preserving confidentiality with material from both parent and child may be difficult if for no other reason than just keeping track of what you heard from whom. Parents and children inevitably have conflict. As your emotional involvement with both parent and child can never be exactly equal, you will tend to side more with one than the other, to the detriment of your working relationship with the other. If these conflicts come to court, such as in a custody hearing, and you have to get on the stand, you are in a no-win position. You might save yourself some personal stress and avoid potential damage to your clients if you make arrangements for another therapist to work with the parent.

Child custody battles can sometimes put the therapist in a difficult position. Each parent attempts to

enlist the therapist on his/her side, to convince the therapist that he/she is correct and that the other parent is the evil one. If the child has complained bitterly about one parent, the therapist may be tempted to advocate for the child in the courtroom. Obviously, if the therapist testifies against the parent who is bringing the child to therapy, the therapy is likely to terminate. The therapist may not have any choice if the parent gives permission and the therapist receives a subpoena to testify in court. It might be helpful if the therapist realizes that unless he/she has been part of a complete custody evaluation, he/she does not have the full picture. Information about the parents obtained primarily through the child can be quite skewed; certainly information from only one parent will be. In general, I favor an open approach to the problem, that is, to tell the parent, with the child present, what I think about the information I have but point out that I have only a very limited view. Of course, openness does not go so far as to violate the child’s confidence. If, for example, the child had told you but not the custodial parent that he/she did not want to stay with that parent and you told the parent, you would not only violate the child's confidence but would almost certainly bring about abrupt termination of therapy. Dealing with parents in the midst of a custody dispute requires utmost delicacy. Once you give testimony in court, you simply have to reassess the new situation to see if you can play any useful role in the child's treatment. Because of all these difficulties, many child therapists try to avoid court involvement in custody disputes unless they are specifically engaged in custody evaluations.

What if in your sessions with the parents they tell you what you want to hear about how they deal with their child around rules, discipline, and positive interactions, but then you gather from the child or other sources that family matters are not as presented by the parents? To compound the situation, suppose that you believe that the parents are interacting with the child in ways you feel are clearly detrimental to the child (but not to the extent of child abuse)? You might be trying, for example, to help build the child’s self-confidence, and you discover that the parents are directly or indirectly telling the child that he/she is a worthless, rotten kid. Certainly, you would feel angry with the parents and frustrated that you could not control the child’s environment. What can you do? Confronting the parent directly is probably what you would feel like doing, but this would likely accomplish only one thing: termination of therapy. Except in the few instances where child therapy is court-ordered, the parents control whether their child continues in therapy or not, so maintaining a working relationship with the parents is essential. Berating them is not a way to maintain a good relationship. The first move I would

recommend in this situation is to set up some family therapy sessions. When your goal is to change interaction patterns between parents and child, successful family therapy is a good way to accomplish the goal. In family sessions the tone of parent-child interactions is likely to emerge, and all will begin seeing how the parents ignore or put down the child. You will probably also see what the child does to elicit and perpetuate this behavior from the parents and what role the siblings play in the interaction patterns.

In my experience it is often difficult to involve in family therapy the kinds of families described above. Reasons for resistance to family therapy could be feelings of threat from outsiders who will find fault with their parenting, anger at the child, just not caring enough to put the energy into family sessions, involvement of a parent in his/her own problems (e.g., alcoholism), or any combination of these reasons. So, failing to engage the family in family therapy, you can only continue your efforts to present clearly to the parents your view of their child's problem and what he/ she needs. You will probably make better progress by applauding and expanding on what positive things the parents tell you they do with their child than by challenging them. That is, if you believe they are not giving enough attention to the child but they say they are, you could say something like, "It's great that you are giving Billy that time because that is exactly what he needs. In fact, he could be helped with even more of that kind of help from you." You might then explore other ways the parents could give time and attention to the child. Still, you will probably find that it is an uphill struggle, that it is extremely difficult for the child therapist to change parent behavior without direct intervention such as through family therapy. One of the things most difficult for the beginning child psychotherapist to learn is to live with the frustration of not being able to effect changes in major areas of the child's life. Not that one gives up trying, but sometimes one can get professional satisfaction only from the limited amount of help one is able to give the child in sessions with him/her.

Many children in psychotherapy have divorced parents. Perhaps they are both interested in being involved in the child's therapy yet are not communicating with each other. They may attempt to engage you as a liaison or messenger between them. It is often tempting to go along with this role because it is in the child's interest that the parents do indeed communicate about the child, particularly, from your point of view, around psychotherapy issues. To fall into the liaison role, however, ultimately abets the parents in avoiding talking to each other when they really need to work through this communication problem

themselves.

WHAT CAN YOU SAY TO A PARENT ABOUT A CHILD AND STILL PRESERVE THE CHILD'S CONFIDENTIALITY?

The therapist really must, I am convinced, have sessions with the parents, even if the parents have their own mental health worker at the clinic. The parents want to learn of the child's progress as seen by the therapist, and the therapist wants to learn of the child's progress as seen by the parents at home, in school, and in the neighborhood. Usually the child will be concerned with privacy at a different level from that of the parents. The child may, for example, not want the parent to hear about some secret he/she has told the therapist, such as a misdeed, some violation of a family rule, anger at one of the parents, a fight with a sibling, or a secret wish; whereas the parent is more interested in global assessment of the child's progress, such as controlling impulses, becoming more independent, becoming less fearful, or growing in self-confidence.

If you believe that your meeting with the parents must take place, then you should not ask the child for permission to talk with his/her parents lest the child say no. Here is a suggestion as to how the session with the child prior to the therapist-parent meeting might go. You say, "Your parents want to know how you are getting along in the sessions here. When I meet with them, I will not tell them any of your secrets or specifically what we do, but I plan to tell them in general terms how I think you are getting along. I'll tell them we play and talk and have gotten to know each other pretty well. I plan to say to them, '[child's name] seems to be growing up well and getting better control over his anger. He still has a bit of trouble and will continue working on it. I think he gets down on himself too much, which is too bad, because I think he has many reasons to feel really good about himself.' Is it OK if I say something like that?" If the child says no, then say, "Well, I have to tell them *something.* What do you want me to say?" If the child says OK to what you plan to say, ask if there is anything else he/she would like you to add.

At this point you might invite the child to sit in on the session and hear for him/herself what is said. In my experience many children do not want to sit in on the parent conference. Perhaps the offer is enough to reassure them of your intention to preserve their privacy, or perhaps they know they will be too uncomfortable sitting and listening to significant people talk about them. If the child does sit in on your session with the parent, then you and the child might have a profitable rehash of the meeting

during your next therapy session. Discussion could be about the content of what you and the parents said, about the emotional tone of the meeting, and about the child's feelings during the meeting.

At the start of the parent-therapist meeting, you would explain that in order to preserve the child's confidentiality you will not be giving any private details from the therapy sessions but that the child has agreed to some general statements about your view of his/her progress. I have never worked with parents who did not accept this structure.

WHAT CAN YOU DO WITH INFORMATION ABOUT THE CHILD THAT YOU RECEIVE DIRECTLY, OR THROUGH A THIRD PARTY, FROM THE PARENTS?

If in a spirit of openness, you tell the child at once what you have heard, then you will avoid the trap of waiting, waiting for the child to bring up the material, while the child is perhaps waiting, waiting for you to bring it up. Once the material is on the table between you, then you and the child may or may not decide to deal further with it at that time.

HOW DO YOU DEAL WITH REQUESTS FROM PARENTS TO WATCH OR VIEW TAPES OF A SESSION WITH A CHILD?

The issues here are complex because of a conflict of rights. The parents have a right to know what is going on with their child; the child is theirs, after all, and they are legally responsible for the child's health and welfare. The child, on the other hand, has a right to privacy, particularly in therapy sessions where he/she may be talking about or playing out family scenes that he/she does not want the parents to know about. One solution is to obtain the child's permission to have the parents watch. However, the child's play could be significantly altered by such knowledge and, more important, it would disturb the special and private, my-time, my-therapist context of the therapy relationship.

I have tried several approaches to this problem and have found that it works best not to allow the parent to watch—ever. It might make it easier on the therapist to invoke a rule: "Parents do not watch their children's therapy sessions in this clinic." If the parents have difficulty accepting this rule, it could provide an entree into understanding the parent-child relationship, the parents' feelings about the child, the clinic, and the child's therapist, and the parents' trust in the whole process. With this stance

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about observation, the clinician must be willing to accept the possibility that the parent will not live with this rule and will withdraw the child from treatment.

WHAT ARE SOME BENEFITS AND POTENTIAL PROBLEMS IN MAKING HOME VISITS?

Benefits

1. The therapist sees the child in his/her natural setting; the therapist learns how the child interacts with family members at home.

2. The child takes pride in showing the therapist “my toys, my bed, my pet, my family."

3. Many contextual cues and meanings are acquired by the therapist. That is, after the home visit, when the child talks in therapy session about the events at home, the therapist can visualize and obtain a better feel for what happened.

4. The therapist gets to meet the child's siblings.

5. The child is proud to show off his/her therapist. It makes the child feel special to receive a visit from an important adult in his/her life.

Potential Problems

1. The setting is not really natural with the therapist present. The child and the family might put on their “best behavior.

2. The therapist is likely to be treated as a guest in the home, since the parents know the role of host best and may feel uncomfortable or unable to allow the therapist to be a silent observer.

3. The child may not like to share his/her therapist with others.

4. If the home is of a different SES (socio-economic status) or if the family is of a different racial or ethnic group than the therapist, the therapist may react with nonverbal communication to elements in the house and home life that are different or new to the therapist. These may be negative reactions, or the family might perceive them to be negative reactions, which would then put strains on the therapist-family relationship.

WHAT CONTACT DO YOU HAVE WITH RELATIVES OTHER THAN THE PARENTS?

Clearly if the child's grandparents(s), aunt, uncle, or other relative is the child's primary caretaker, then everything written about parents in this section will apply to them. Otherwise, the answer to the question depends on the immediacy of the relative in the child's life. Grandparents who live across the country and who visit the child's family once a year would probably not be involved in the child's psychotherapy. In fact, their involvement might unnecessarily complicate matters, especially if the child's parents and grandparents have major unresolved issues between them. The child's problem, for example, might be used by a grandparent to put the blame on their child or child-in-law for the problem. The child's parents certainly do not need that. The less the grandparents know about the details of the child's treatment the better. These same comments about cross-country grandparents would apply to other cross-country relatives such as aunts, uncles, and emancipated siblings.

If, on the other hand, the grandparents live in the same house with the child, then they will probably need to become involved in the child's treatment. Certainly, if family therapy were the mode of treatment, they will be included in the family sessions along with siblings and anyone else living under the same roof. If the child is being seen in individual psychotherapy sessions, the therapist might consider occasionally including other household adult relatives in interpretive sessions so they can understand and facilitate the treatment goals. Some therapists also include siblings in such sessions. If all of the household members, including the child client, are included in sessions with the child's therapist, then the therapist should be well armed with family therapy skills, since he/she will have to deal with family dynamics. The line between family feedback sessions and family therapy becomes blurred. Probably the reason the child therapist in the traditional child guidance clinic of the 1940s through 1960s did not meet with the entire family, and sometimes not even with the parents, is that most child therapists of that era did not have family therapy training and skills.

Relatives who live somewhere between cross-country and under the same roof can be included in the treatment process in proportion to how involved and influential they are in the child's life. Relatives can be a good source of information about a child and his/her family. A grandparent or an aunt who lives in the same town, for example, might have new knowledge and a different perspective on the child's life from those in the immediate household. The process of obtaining this information from a relative is

sometimes complicated. First, the parents would have to know about and approve of the interview between clinician and relative; next, the interview needs to be arranged and held; then the parents will want to know what the relative said; finally, the child needs to be informed of all this. Quite possibly the relative will want feedback from the clinician about what the clinician thinks is wrong with the child and what is being done in therapy, but the clinician cannot ethically give that information without consent from the parent and, optimally, also from the child. If the relative's involvement continues into the treatment phase, the clinician must carry on the same juggling act. It is no wonder that most child clinicians do not generally make good use of relatives in the treatment process.

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