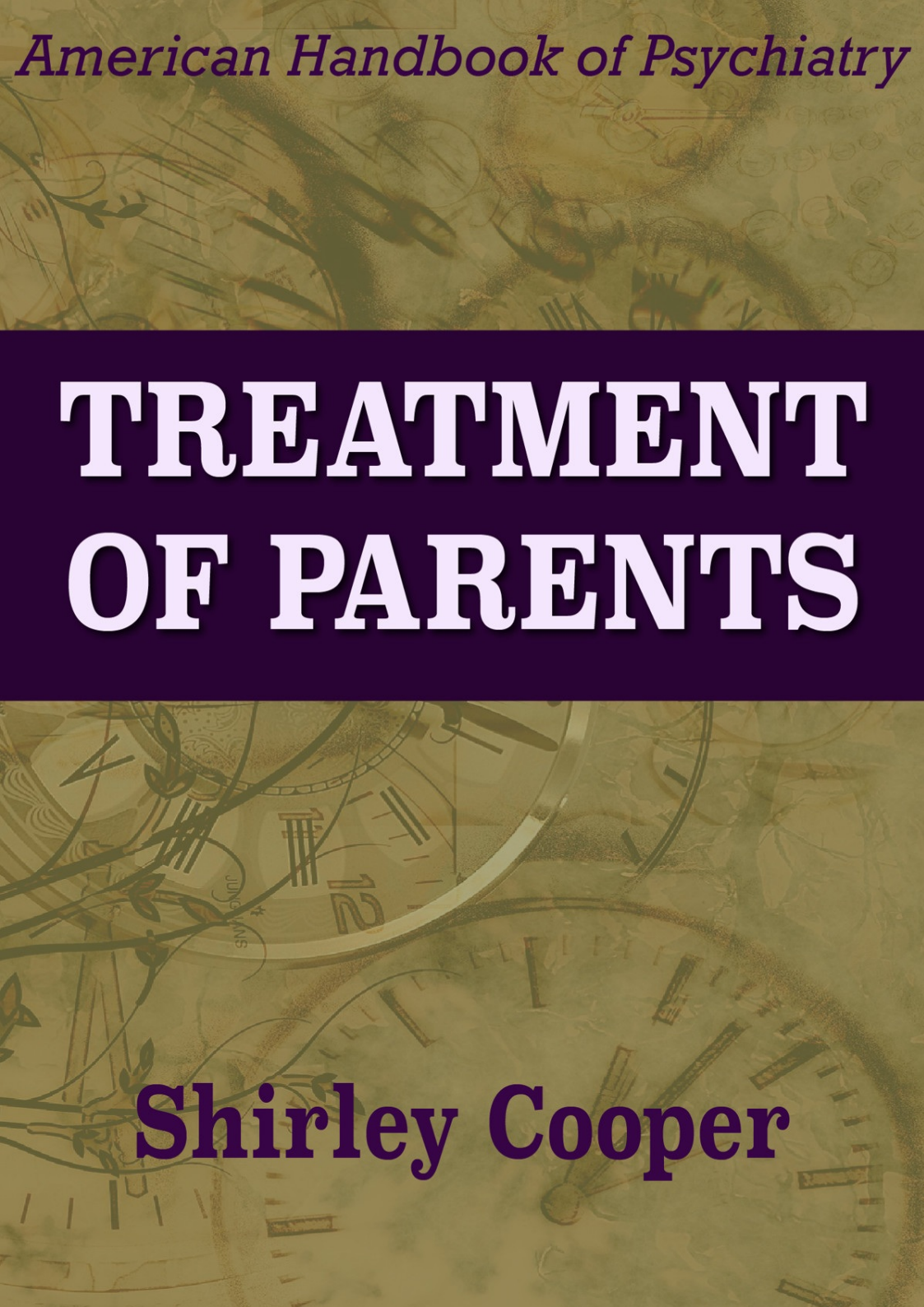
American Handbook of Psychiatry

TREATMENT OF PARENTS



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Introduction

The Changing Family

Work with parents in behalf of the psychotherapy of children is influenced by changes within our culture and the consequent pressures these place on the family. Within a short period historically, the American family has been forced to redefine its role and function to a degree almost unknown in history.

Along the path of its development, the American family shed in-laws, grandparents, cousins, aunts and retainers: It handed over production to the factory and the office, religion to the churches, the administration of justice to the courts, formal education to the schools, medical attention to the hospitals, and it has even begun to hand over some of the basic life decisions to the psychotherapist. It has been stripped down to the bare frame of being marriage centered and child fulfilled.

No longer is the family a productive unit economically, gathered together in one place close to its kin, providing continuity and stability. Fathers no longer unquestionably rule the roost, and more and more women perform dual roles as homemakers and breadwinners.[1] For stability we have

substituted mobility; for authority the possibility of greater mutuality. Confronted with rapid and constant change, parents are plagued by intense anxiety about their children. Older bonds of tradition, religious and moral cohesion, economic necessity, and occupational certainty no longer support today's family. Opportunities for varied models provided by the extended family are less available to children, while parents must purchase help formerly offered by family members. Simultaneously, we have learned that what occurs within the family is of central importance to the health and psychological wellbeing of its members.

Children have moved from a position without rights to one with many claims. Such change creates its own tensions. Benign neglect in child rearing has become unacceptable in middle-class families. The parent who observes a child doing nothing often experiences a vague sense of guilt and rushes to occupy him. This can diminish the child's opportunities for privacy and lead to the parent's compensating reactions of over-care. The boundaries of safety become confused for the child, while his demands may become tyrannical. The parent risks succumbing to living in the shadow of his child, feeling cheated and uneasy, unable to define the limits of his own giving and his child's demanding.

The role of women is also shifting. Until recently women were a particularly handy group for scapegoating. Seen as powerful, tender,

magically strong, they are at the same time capricious, vain, a bit foolish, scheming, and irrational. Women have been made to feel they must be completely selfless and devoted to their children. It is as though the child remains always the infant needing his parent's attention exclusively. The more emancipated role of women provides opportunities for greater mutuality in marriage as well as opportunities for self-fulfillment apart from child-rearing. We are only now coming to recognize that women who feel unfulfilled are unlikely to provide good mothering.

The Role of the Expert

Unable to rely upon past tradition as a guide, troubled and confused parents invited the experts to move into the vacuum. The experts rarely demurred. Instead, they offered advice that was at times conflicting, slimly supported by evidence, and partially contaminated by cultural bias. Usually the advice was given predominantly from the standpoint of the child and his development. "How to's" and "not to's" were offered in plenty as experts became ever more interested and skillful in observing the child. Threaded throughout the diverse and often conflicting views of the experts one finds an attitude that the child is an artless innocent, always potentially the victim, while the adult is always "the guilty fumbler, bumbler, meddler and destroyer." *The Rights of Infants,* a challenging publication of the 1940s, contributed understanding of the needs of the very young. Nevertheless, it

seemed permeated by attitudes about good and evil. Infancy was good, precious, and needed immediate "in-tune" response; otherwise the fragile infant was in mortal danger. For example, "breast feeding is the very essence of 'mothering' and the most important means of immunizing a baby against anxiety;" "any curbing of the child's natural ways at an early age may very well endanger the smooth functioning of delicate mechanisms that make it possible for the human body to live and breathe and have its being;" "babies of mothers who are emotionally detached or absorbed in social, professional or artistic pursuits suffer retardation in speech or locomotion."

Popular literature, further distorting professional insights, exhorted parents to adhere to demand schedules, to consider themselves as both responsible for and blameworthy about all that went awry in child development. It was not until the 1950s that a more reciprocal view of parent-child interaction was presented. We moved from Ribble and in-tune mothering in 1943 to Winnicott, who offered the concept of good enough mothering in 1956.

Winnicott and others recognized that it was impossible to talk about adequate or inadequate mothering in the light of highly complicated parent-child interactions. Nor was it possible to prescribe the amount and kind of parenting for all children: "the child's needs vary according to his state of development, his individuality, and his previous experiences. These

variations do not allow us to talk about a specific amount of care as being adequate or inadequate for all children. What is adequate for one child may not be nearly adequate for another. An experience that imposes a task which one child masters successfully and that strengthens him may be traumatic for another."

Anna Freud noted the temptation to apply psychoanalytic insights about adults to the upbringing of children.

> The therapeutic analysis of adult neurotics left no doubt about the detrimental influence of many environmental attitudes and actions such as dishonesty in sexual matters, unrealistically high moral standards, over-strictness or over-indulgence, frustrations, punishments or seductive behavior. It seemed a feasible task to remove some of these threats from the next generation of children by enlightening parents and altering the conditions of upbringing and to devise thereby "a psychoanalytic education" serving the prevention of neurosis.

This hope has never been fulfilled. Freud noted that some of the advice was contradictory and generated unwanted, unpredicted side effects. For example, the advice to parents to reduce a child's fear of them partially provoked the child's increasing fears of his own conscience, and "produced the deepest of all anxieties, i.e. the fear of human beings who feel unprotected against the pressure of their drives."

The study of individual differences in neonates since the 1940s countered the view that all pathology originates with the parents. There are

children who for reasons not yet completely understood seem incapable of accepting comfort, and others who seem so quixotic even in the earliest stages as to make reading their signals almost impossible, as well as chance events that create their own momentum of trauma, dissonance between maturational spurts and developmental readiness, and the impact of wider cultural influences on the child and his parents. Moreover, recent work with different socioeconomic and ethnic populations supports the view that there is considerable variety in styles of parenting, each providing benefits and potential hazards. Most recently, understanding about parents has been enriched by the recognition that parenthood is itself a developmental process, influenced significantly by the marital configuration. Until now grossly neglected, the psychology of parenthood is coming into its own. Related to its central socializing function, parenthood in its own right is beginning to stir scientific interest. Observations suggest that the child may initiate and stimulate reactions in the parent drawn from his own history, these reactions in turn further influencing the child and parent.

The child's absolute need lays claim on a mother whose need for her child is relative. This unequal partnership between mother and child (influenced importantly by the father's differentiated participation with each) is a complicated affair. If the mother's need is absolute, the possibility for growth and individuation for child and mother is seriously impaired. In such instances one is likely to see the mother behaving toward the child as she

experienced or fantasized her parents' behavior toward herself. A three-generational condensation forces the mother to vacillate between being the child herself as well as her own parent in dealing with her child.

Mrs. Jones illustrates this well. In her treatment hour, she reports observing her thirteen-year-old son Frank being picked up by the school bus. No one welcomed him or made a place for him to sit. Suffering for her son, Mrs. Jones vigorously berated the other youngsters for the lack of consideration. Frank, embarrassed, experienced his mother's outburst not as protection but as interference. Later in the same hour, Mrs. Jones reports hearing sounds from her son's bedroom. Without knocking she entered his room to observe him struggle into his pajamas. Clearly she had caught Frank in the act of masturbating. In her account she speaks of this with guilt apparently related to Frank's masturbation as well as her intrusion. Almost without pause, she shows her therapist a letter from her mother who had recently visited. The letter berates Mrs. Jones for seeing and hearing too much about her children. Mrs. Jones experiences her mother's letter not only as critical intrusion but also as demonstrable evidence that her mother has never permitted her to gain the status of an adult. Mrs. Jones seems to experience herself as child, parent, and grandparent simultaneously. She is the guilty victim as well as the judging intruder.

Though we have become increasingly sophisticated in our

understanding of relevant components in the interactional spiral of child-rearing and parenthood, the picture is neither complete nor thoroughly synthesized. Fatherhood remains an uncharted psychological territory. And in spite of heightened sophistication, the temptation to require saintliness of parents continues.

Direct Work with Parents

Goals

Work with parents involves three basic aims: (1) to develop an alliance that will support the child's growth in treatment; (2) to secure necessary information about the child and his experiences; and (3) to help bring about changes in the environment to further the child's growth and development. At minimum, the parent will need to help by getting the child to his interviews regularly, paying fees, and providing information about the child's daily life and important events. When a parent is allied with the goals of treatment for his child and is not now contributing to the child's problems, parental participation may be limited to these contributions. On the other hand, the work with parents may set as its goal the modification of a parent's personality in significant ways. This may involve intensive treatment for the parent. Between these extremes work with parents may have other goals. Some parents will benefit by advice and suggestions in the handling of a child.

These may include environmental suggestions as well as proposals for parental handling of particular child behavior. Other times the work will involve helping the parent loosen his neurotic tie to the child by offering a new object (the therapist) toward whom he can direct some of his energy. On occasion, the parent will be required to alter specific pathological interactions which may yield thorough identification with the therapist. At other times the parent who is incapable of changing significantly may be asked to temporarily yield the major role of parenting to surrogates.

To put it another way: An early effort must be made to sort out where the interventions and therapeutic strategies can best take place in order to (1) create optimum conditions for protecting the child's treatment; (2) release forces to help the child develop; (3) reduce or alter contributing parental pathological interactions; and/or (4) significantly alter personality difficulties within the parent that impinge on the child's development.

Parents change and their needs differ from time to time. No initial diagnosis and disposition, no matter how skillful, is immutable. A parent with whom we have established a good working tie, who arranges for his child's regular attendance, provides useful and relevant information, and pays his bills, may suddenly become a bit distant and develop car trouble or babysitting difficulties that disrupt the child's treatment. In these ways he may be announcing that his child's change, so very much wanted at an earlier

time when symptoms were rampant, is now a threat. The parent may find himself in internal conflict, deeply though unconsciously ambivalent about his wish to permit the child's progress. The therapist must now intervene to chart a new course of action if the child's opportunity for continued growth is to be safeguarded.

Conversely, a parent driven by guilt in the initial phase of the work may experience considerable relief as he discovers that his therapist does not judge him and hold him responsible for his child's difficulty. Confusion and uncertainty may be replaced by tenderness, affection, and firmness. The altered parent-child interaction may dictate a change in the direction of reduced interviews. At other times, shifts in emphasis occur within the same framework, requiring no change in frequency but a highly flexible approach and style.

Mrs. Thomas, the sole support of her family, considers returning to work. Her child has been subject to a variety of separations that are central to his pathology. The mother, seen by the child's therapist weekly, discusses her concerns about preparing her child for her going to work. In several interviews, the mother ruminates about how to correctly prepare her child, discarding one suggestion after the other. It is not until several hours later that the therapist catches on to the idea that this obsessive concern with the proper way of preparing the child is in fact a reflection of the mother's own

ambivalence about going to work. The mother has been using the child's difficulties, when in fact these are her own worries. Until now, work with Mrs. Thomas centered on the child's behavior and the ways in which the mother could be helped to deal more appropriately with him. At this point the focus must shift to the mother's own concerns, with the recognition that preparing the child is in fact a piece of resistance.

The ability to alter prior ways of working consonant with the changing needs of parent and child deepens support for the child's treatment, while simultaneously helping the adult function with greater choice over life decisions. The purposes for which we involve a parent in collaborative work do not automatically dictate the treatment method, its frequency, or its timing. Some parents will profit most from regular individual sessions, others from intermittent meetings; some make gains through groups, while others may benefit most from family therapy. If a parent's difficulty is of such an order that it is crippling the child's growth at this developmental stage and in the near future, collateral work is in order. However, a parental neurosis is not necessarily expressed through a child even when the child may at one time have lent himself to this expression. Neither does the parent's neurosis inevitably have relevance to the child's development. Whatever the goals of work with the parent, this treatment requires all the diagnostic and treatment skill necessary to any psychotherapeutic endeavor.

The Request for Help

Rarely does the child himself initiate the request for help. The parent is often directed to seek help from an institution such as school or court, institutions that represent authority. His own reactions to authority are quickly mobilized. How he defends in such situations will partially dictate whether he can engage as an ally in the treatment partnership.

Asking for help is stressful for almost every family except the rare few who feel no home is complete without a psychological advisor. Almost all parents experience bewilderment, inadequacy, helplessness, shame, anxiety, guilt, and anger during the normal process of child rearing. When a parent acknowledges that he is no longer able to cope with the care of his child, these feelings become sharply aggravated, shaking his self-esteem. In a sense, the child's behavior serves as the parent's report card. Parents ask themselves the questions put poignantly by Deborah's parents in *I Never Promised You a Rose Garden:* "How did we share in this thing? What awful wrongs did we do?" "Do I know," he answered. "If I knew would I have done them? It seemed like a good life. Now they say it wasn't." Deborah's mother wonders: "Sometimes it even seemed that with Deborah's illness coming to a head, the whole thrust and purpose of their lives was forced under scrutiny."

Parents worry about being judged by and exposed to people to whom they must turn for help. Usually the request for help comes after other

painfully unsuccessful efforts have been made. On occasion, their request for help with a child may disguise a request for help for themselves.

As with all patients, the parent's experience dictates how he will approach the helping process. It is important to elicit the parent's theories about the meaning of help. From what do these theories derive? Do they come from prior experience, propaganda, extensions of how the referral agent is understood, or from his own intrapsychic and interpersonal problems? It matters a very great deal how the parent perceives the cause of his child's problem, and whether he seeks to fix blame or recognizes complex contributing factors. These attitudes can be observed as the parent reports his experience with the referral agent, his view of the child's problems, the efforts he has made to cope with these, and his expectations of the therapist. Is he fearful that an important relationship with the child will be split up? Does he hope the therapist will side with him against the child? Is he asking the therapist to assume all parental responsibility, wishing the therapist to take over for him? Is the parent ambivalent, yet passively expecting immediate and miraculous change? Does he competitively invite the therapist to fail to assuage his sense that the child, not he, is totally responsible? Is he overly ready to accept all responsibility? Is he hostile and threatened, again aware of some complicity in the child's pathology, resistant to the change that the therapist by his presence represents? As with all patients, attitudes about dependency and authority are mobilized by the very act of seeking help.

Unrecognized, these can create difficulties in the treatment of child and parent.

Moreover, the parent is not simply dealing with attitudes toward taking help; he is here about another, his child. The very feelings that color his relationship to the child may affect his attitudes toward the therapist. If he is angered or humiliated, made vulnerable to exposure by his child's behavior, these feelings may be displaced on the therapist. Unless the child is already grown, able to finance his own treatment, and no longer so dependent on parental approval, the parent can decide whether the child will be treated or not. Yet too often the work with the parent develops as a wrestling with the enemy to exorcise the noxious power of parent over child. It is difficult indeed to make an ally of an enemy. The parent who comes as captive and is not helped to become participant endangers the treatment of both child and parent.

There are hazards the therapist may bring to his work. He may over-identify with the child and seek to rescue him to prove that he can provide better parenting. Or he may side with the parent to behave suppressively with his child patient. The overzealous therapist may require commitments parents are unwilling to make and which are unnecessary for the work with the child. After all, the ideal patient is one who is clearly motivated, does not injure therapeutic narcissism by rejecting therapeutic offerings, wants change

for himself rather than for someone else, and invests heavily in this process. This is rarely true of anyone; it is perhaps even less true for the parent. Unless these hazards are recognized, they can impede the treatment of child and parent.

In the first sessions an emotional climate is established out of which parent and therapist engage in serious work to determine how to best help the child. There are no magical ways to overcome resistance with parents any more than with any other patient. The tact, skill, and benign but committed neutrality central to the treatment of all patients is paradigmatic for work with parents. Good treatment is never simply a discussion; it is an experience. From the experience of these early hours the parent forms his decision about whether to choose treatment for his child and how he will participate in it. The importance of utilizing the first hours to decrease resistance, to enhance motivation, and to set in motion a partnership aimed at problem-solving cannot be overstressed.

On Exchanging Information

A child cannot be treated without knowledge of his environment. Anthony observed that though the child's world may encompass "not much more than a half dozen houses, a handful of people, a school, a church, and a playground . . . we need to know it well and be familiar with every corner of it,

if we aim to talk to him smoothly and easily." Much can be supplied by the child; more is usually needed from the parent. The child cannot always draw an accurate representation of his environment. It may be altered and distorted by his defenses. Though this holds for all patients, the child's immaturity makes it mandatory that we understand his world both as he conveys it and as it exists more objectively.

For example, Sara, age seven, is an active, bright, and precocious child. Bossy with peers and resistant to following directions, she is underachieving at school. Mrs. Johnson, the mother, concerned that her placement of Sara with the grandparents after her divorce is responsible for the child's difficulties, rapidly accepts the teacher's suggestion for psychiatric help. Placed at age four, Sara remained with her grandparents for almost two years while her mother moved to a new city, found employment, and recovered from her depression. The grandmother's death precipitated Sara's return to her mother, who remarried shortly before Sara came home. Sara is very fond of her stepfather.

Sara's initial hours are filled with activity. Masterfully and cheerfully, she orders her therapist to help with the many games and projects she devises. Shortly before Sara arrives for this particular hour, the mother informs the therapist that Mr. Johnson's job required that he be away from home for two or three weeks. Sara starts the hour typically by ordering the

therapist to get her the family of dolls. Then, in atypical desultory fashion, she sets up housekeeping under the desk, shielding her play from the therapist. The therapist's efforts to discover what is going on are met with stubborn silence, angry comments to be quiet, assaults on the mother doll who is called stupid, and an alternating cuddling and pummeling of the girl doll. The therapist's comment that it is sometimes hard to feel alone leads to a play disruption. The dolls are swooped up, followed by angry comments about the poor quality of the toys and a period of aimless rummaging in the toy cabinet. Sara discovers the jacks, setting several of them twirling just outside the interview room. Firmly closing the door on them, Sara announces almost tearfully that they are lost, will have to take care of themselves, or "maybe they are dead."

Without the information provided by the mother that her husband was away temporarily, this atypical play would be incomprehensible; even more, the therapist's ability later in the hour to help Sara express her concern that when people leave she fears they will die would be sharply diminished.

Gathering data about the child is an important part of the work between parent and therapist, yet such facts may at times be gotten at the expense of the working alliance. The ability to shift with the parents' interests and needs and to hear out what they consider most critical cannot be deflected by the therapist's need for information. The child and his family are not only the

victims of their problems but the participants in their creation who will now participate in their solution. Evaluation and diagnosis cannot simply be a fact-gathering process. Rather it must be the beginning of an active working toward a commitment to change. To be sure, important milestones and traumas, developmental progressions and regressions, skills, interfamilial and peer relationships, medical history, current experiences, and so on must be understood in order to institute remedial help. But parents are not computer storers of developmental statistics who spew forth at the push of a button. Unless memory is jogged by tactful inquiry, it may not be possible to distinguish between resistance, uncertainty, or repression of information. For example, to ask whether a child was planned may provide clues about the child's conception; it may offer slim information about the child's reception. The latter may be better understood by such inquiry as: Did you want a boy or girl? How did you choose the child's name? Who helped with that? What baby equipment did you have? Did you have help when you came home with the baby? Where was his crib placed? In addition, the gathering of history cannot be a onetime event. As with all patients, parents will correct and elaborate historical and other information as situations arise that trigger memory and as their trust in the therapist develops.

In short, the gathering of information is a skillful process that enlists the active participation of the parent, takes cognizance of human defensive operations, and proceeds at a pace and in the style that will make it a graphic

sample of what help is about.

No diagnostic evaluation is complete without reporting to the parent judgments made by the therapist about the child and the proposed treatment design. Again, this is not simply a rendering of one-sided judgments; it is as with all aspects of treatment a process actively involving all the participants. Parents often base their expectations of treatment on past experiences. A parent who has taken his child to a physician expects him to report his findings, including those involving tests, and to get advice about remedial procedures. If the diagnostic process has been well done, the parents' expectation for finite statements and judgments will have yielded some such statements, but they will still need to hear what is known and understood and what must still be left for future discovery. When diagnostic findings are offered in perfunctory ways, parents are left with great uncertainty about the nature and degree of their child's problems and the uncomfortable feeling that their questions are intrusions. It is in just such soil that suspicion and rivalry flourish. The permission to inquire, to exchange useful information, and to clarify confusion enlists cooperation and alliance, a process that can be promoted during the post-diagnostic sessions, to be continued throughout the work.

As indicated, bringing a child for treatment often reflects on one's parenting. Worries about what goes on during the treatment hours may not

only reflect concern about what the child may be revealing but touch off concerns about turning one's child over to someone else. Helping parents to know what goes on in the treatment room, to give them some understanding of the very paraphernalia used in work with children, can sometimes resolve or mitigate some of these concerns. As the parent senses the therapist's willingness to share his knowledge about the child, his own participation is enlisted. There is a great difference between maintaining the confidentiality of patients and reporting so little or in such constrained ways as to give the impression that vast secrets are being guarded. Sometimes confidentiality is invoked when the therapist is himself unsure about what and how to present information usefully.

The mother of a congenitally impaired youngster applies on behalf of her son, aged twelve. Among other factors, the mother's guilt about producing a "damaged" child is central to her overprotectiveness. In addition to the expected curiosity about what is going on during the early hours in her son's treatment, the mother is worried about the therapist's appraisal of her. She informs the therapist about her curiosity, directly and indirectly. The therapist, concerned for guarding the child's confidential experience with him, responds to these messages by a short lecture announcing that he cannot tell the mother specifically what the child does and says, but that he will hold himself responsible for reporting on the child's general progress in treatment. He has done his duty. He has acknowledged the mother's rights by agreeing to

keep her informed of the child's progress. The therapist is puzzled and irritated when the mother continues to question her son about what goes on during the sessions. The therapist, hewing close to the letter of psychological law, has obscured his vision about its spirit. The mother's guilt cannot so easily recede nor can her symbiotic tie diminish because she has been told that she can know some things and not others. There is no reason to withhold from her the fact that the boy is beginning to work on his worries about being curious, which contribute to his learning problems. The mother's help can be enlisted by advising her to encourage the boy's curiosity and demonstrating to the mother that curiosity is valued, both hers and her child's. Moreover, failing to address himself to the mother's guilt, to her worry that her child perceives her as bad, a reflection in part of her own self-image, the therapist leaves her to find alternative routes for her concern, routes further away from him and thus not so easily available to handle.

Dispositional Issues

Dispositional judgments with parents in a child's case rest on many factors, among which are the age of the child, the purpose for which one engages the parent or parents, the timing of assignments, the frequency of meetings with each of the "members" in the case, the mode of treatment (individual, conjoint, family, group, or combinations of these) and whether one or several therapists will work on the case.

Whether a family is treated by one therapist or collaboratively by several clinicians is dictated both by conviction and style. Advocates for the thesis that all cases must be separated are matched by equally strong advocates for the view that cases are best handled by one therapist alone. Each has its own set of advantages and problems. Collaborative work built on the model of the team has its difficulties. Many therapists report difficulty in finding time to meet. Jealousies and rivalry often develop between collaborators. Dissonance in viewpoints about goals develops. Unless collaborating colleagues are relatively evenly matched, each respecting the other's skills, one member of the collaborating team is likely to assume leadership over the others. In some settings where social workers only treat parents while other disciplines treat the child, interdisciplinary rivalries may develop. How to use the data provided by a collaborator in one's own case may pose thorny problems. It is not a rare occurrence that the case begins to falter at precisely such moments when one or another of the collaborating team finds himself unsure about how to use the information secured from a colleague. If the parent is being treated in his own right, the information about the child's life that the child therapist requires may not be forthcoming. Here, too, the collaboration may falter. The parent's therapist may see it as an imposition to interrupt his work with his adult patient to get information about the child. The simple practice of having the child therapist see the parent for such information is often overlooked.

On the other hand, a case carried by one therapist has its own potential hazards. Remaining equidistant from each patient is not always an easy task. As indicated, the child therapist is often drawn toward his smaller child patient. Covert rivalries with the parent, who is often a factor in the child's pathology, occur. While the family's being treated by one therapist may save time, since collaboration if practiced carefully requires time, it is with some cases clearly contraindicated. More typically, adolescents struggling to achieve independence from their parents may be unable to trust their therapists if they know the parent is also being seen. However, age alone may not be the only factor in dictating the separation of a case. Therapeutic style may weigh as heavily as any other variable.

No matter what the style or the level of skill of treatment, there are cases that do not succeed. There are parents who must for reasons of their own unyielding pathology have a sick child. There are parents who dare not yield their child to another. The child and parent may collude to maintain this tie, allowing no helper to intrude on such unity. The parent who needs his child for his own completeness may never be able to develop an alliance with a therapist, who represents a threat to his balance.

Special problems occur with those who seek to turn over the parenting role entirely to the therapist. Treatment cannot substitute for daily care. Concrete services to help the parent feel less burdened may be necessary.

However, when the parent can no longer assume any parental responsibility, the treatment of choice may be placement of the child away from home, either briefly until the parent regains the strength to do his job or for a longer time to permit the child to develop in an atmosphere of greater safety and care. When the aims of the treatment are significantly opposed to those the parent holds for his child, the child may by the very act of continuing treatment be placed in the completely untenable position of trying to be loyal to two opposing pulls. Unless the child is willing to renounce the parental object, as is sometimes the case with adolescents whose development permits such options, the child will not be able to choose. In such instances we do the child no favor by continuing his treatment.

Ongoing Work

How we expect to help the parent function more effectively with his child will dictate the treatment plan. As suggested where parents are in harmony with the treatment goals for the child and do not contribute to the child's pathology, some regular plan for sharing information may be all that is necessary.

Where other issues are at stake, an understanding of the parent's needs, strivings, and problems must be taken into account to work effectively and flexibly. For example, giving advice is predicated not alone on what the child

requires but on whether the parent can use the advice. This is in turn dependent on whether the advice is consonant with the parent's hope for his child, his style of parenting, his capacity to try new ways of functioning or on sufficient identification with the therapist so that the parent will trust and try a new way.

For example, a seven-year-old, deeply disturbed youngster is brought to treatment because of inability to function in a normal school setting. His sudden verbal outbursts and strange hand gestures are frightening to peers. In the beginning it becomes clear that the mother, pressed by outside institutions, wished that the child would become less noticeably bizarre yet she maintained an intense investment in some of his pathology. Although the hand gestures had bothered her, she rationalized and denied some of her concern. After a period of treatment, the gestures disappear and the youngster begins to cut out the first letters of his name, taking these with him everywhere, to school, and to his treatment sessions. The therapist clearly understands from the child that these letters represent a progressive step forward in development. The strange hand gestures have yielded away from his own body to an external representation, which he makes "to help keep me safe."

The mother, disturbed and puzzled by this new behavior, begins to institute repressive disciplinary tactics. Unconsciously she is trying to hold

onto her child's difficulty in its most primitive form. The tricky business of attempting to help a mother at such a moment, when unconscious fears operate and when the reality is for her both noxious and incomprehensible, becomes a central factor in the work with her. The therapist must help the mother permit the emergence of new transitional behavior before more acceptable behavior can be evolved.

The interest and concern demonstrated by the therapist for this woman's barren life has helped to build a trusting relationship, decisive now in helping this mother support the treatment. The mother's identification with the therapist makes it possible for her to act on the advice not to repress the child's new progressive efforts.

Work with families invariably involves divergences in therapeutic goals held by different family members. At times these may be in sharp conflict, disrupting the treatment completely. More often there will be out of phase periods, when the child's advances may for a time confront the parent with unwanted insults or doubts. What helps to sustain the parent through these periods is his general confidence in the therapeutic endeavor.

Other goals focus on specific pathological interactions without aiming to alter the parent's basic character structure. Family therapy may be particularly useful in these instances, since the therapist can observe such

interactions as they occur and intervene to modify them.[2]

Another level of parental work involves marital counseling where marital conflicts intrude on the child's development. It is in such instances that conjoint interviewing techniques that require the careful equidistant stance of the therapist are often most useful.

The parents of a six-year-old child are seen separately and together during the diagnostic process. The father thinks the child will outgrow his difficulties, whereas the mother maintains that the father's laissez-faire attitude reflects his wish to turn over all parenting responsibilities to her. Beneath this complaint is the mother's view that her husband is indifferent to her, considering her only as a useful and necessary homemaker. The mother's application for treatment for her son in part involves the hope that the therapist will support her in her complaints and accusations. The father, sensing this, defends himself by greater withdrawal, but does acknowledge that his son seems troubled. Clearly this six-year-old son represents the battleground upon which marital struggles are being fought. Unless the existing relationships within this family can be altered, the child's anxiety, based in part on his confused and constantly shifting sense of loyalty to each of his parents, cannot be modified.

Whatever the goals, we must directly engage the parent with the aim of

helping him as an adult to function more effectively as a parent. Whenever a parent is seen in behalf of his child, there is the danger that the child enters as a ghost into the interview room. The therapist may be tempted to become the advocate for the ghost child. The effort to reach one human being through the needs of another almost invariably ensures that the person in the room will see himself as less valued and less important to the therapist than the ghost hovering between them. To illustrate: Mrs. Ferrari, age forty-six, deserted by her husband fourteen years ago, had raised her sixteen-year-old daughter, Maria, alone and by dint of much hard work and sacrifice. For the last three years Maria had refused to attend school. Mrs. Ferrari went from one doctor to another seeking the necessary medical recommendation for home teachers. Now with the doctors' refusal, and upon the school's insistence, Mrs. Ferrari and Maria arrived at the psychiatric clinic. Both were accepted for treatment and each assigned a therapist. It soon became evident that the mother's terror of losing Maria, the only pleasure in her life, was a major factor in the girl's school avoidance. During her treatment hours, Mrs. Ferrari spoke of her daughter's virtues, her confusion about Maria's symptoms, and her detailed and lengthy accounts of the many efforts she had made to give Maria all the things a young girl should have. The therapist found few places to intervene to help change the course of events. However, during one session, although Mrs. Ferrari began as usual, gradually more and more irritation with Maria began to show. She was annoyed with Maria's tentative

steps into the world of dating and her insistence on getting a new dress for a dance. Recognizing that Mrs. Ferrari was at last talking pointedly to the problems at hand, the therapist reported, “Gently I spoke to Mrs. Ferrari of adolescence and tried to educate and prepare her for Maria’s need to make some separation from her.”

This comment was unfortunate, for what the therapist was trying to do was understandable. Certainly Maria and her mother were doomed to a life of symbiosis if neither could let the other go. However, Mrs. Ferrari was clearly describing her desperate fear of loneliness and desertion, and unless the therapist could help the mother with such feelings, her freeing Maria would be impossible. No amount of education about Maria’s evolving adolescence could serve to break these unhealthy ties. By reaching for the ghost child through the mother, without stopping to attend to the mother herself, the therapist lost both. Mrs. Ferrari felt misunderstood and threatened. Her next move was out of the clinic with Maria close behind.

In all instances, short of work with the parent in his own right, which does not differ from work with any adult, work with parents can be viewed as collateral to the work with the child, with the aim of helping each to live one with the other in more self-respecting and satisfying ways.

Work with Fathers

Fathers are truly the forgotten men in treatment. If the psychology of parenthood has been grossly neglected, fatherhood remains even less well understood. Earlier endowed, at least in the idealized version, with the greatest clarity, the father's position is now one of considerable ambiguity. The compelling biological position of the mother, coupled with its cultural imperatives of child-rearing does not hold for the father. While fathers are expected to function as protectors and providers, they no longer keep a stern but distant watch over the child's discipline and work habits. Although not invariably, the father is now far more engaged in the daily care of his children, sharing in their rearing with his wife. The father's greater intimacy can offer wider opportunities for satisfaction and pride in his child's development. If, instead, he feels displaced by his children, he may turn away from the family in search of gratifications other than those inherent in fatherhood. This in turn can leave the mother and child without important sources of support while the child and mother deepen their dependence on one another.

For example: Mr. Thornton, Tom's father, was uncertain that his son needed treatment. He felt that the mother exaggerated five-and-a-half-year-old Tom's aggressive behavior, which deeply worried his wife. The mother was also troubled by Tom's rubbing up against her and masturbating in front of her, yet she seemed incapable of stopping him. In a joint meeting with both parents, the mother complains that Mr. Thornton spends too little time with Tom. She appeals to the therapist: "Don't boys need their fathers?" The father

listens uncomfortably to these and other complaints, then asserts that the mother seems unable to recognize when Tom is overly demanding, exhausting herself during the nighttime rituals instead of putting a stop to Tom's endless requests before he finally goes to sleep. With mounting anger he announces that Tom always turns to her for help. For example, Tom will always ask his mother to help him tie his shoelaces though his father often offers assistance. Mr. Thornton states that when this happens his wife seems unaware that he has offered help, and he feels "elbowed out during these scenes."

Clearly both parents contribute to Tom's difficulty. The mother's ambivalent wish for her son and husband to become close leads her to demand more of her husband for Tom while at other times she elbows him out of the relationship. The father, who feels left out by son and wife, cannot offer a firm hand in parenting, thus leaving Tom to retain an over-closeness with his mother, which should now be receding. This engenders Mr. Thornton's anger with his wife and his son, which further reduces his ability to act as father and husband. Mr. Thornton's assistance will be needed in helping Tom develop; even more his participation can alter the balance in this basically good marriage so that he and his wife can return to a more satisfactory and adult relationship.

In his own right, a father's overbalanced need for pride in his offspring

may turn into driving or perfectionistic ambition creating the potential for pathology in the child and other members of the family.

Fathers rarely initiate a request for help. This is logically so, since they are typically less involved in the child's care than the mother, and perhaps also because men even more so than women are imbued with the view that to ask for help is an admission of weakness, to experience tenderness is less than manly. It is more common to hear fathers assert that their child's troubles will pass with time, that too much is being made of the trouble. Yet many fathers have much to contribute to an understanding of the child. Out of their own needs, they may become strong allies in therapy when they feel their wives' over-interest in the children leaves them unattended and uncertain of their place in their families.

Experience suggests that when mothers proclaim with certainty that their husbands are too busy or unable to participate because of other commitments this may not always be the case. It is wise to attempt to meet directly with the father to determine how he views the child's problem and his part in its solution. When both parents disagree sharply about whether help is needed, additional strains are added to the family and to the treatment. Unless these are resolved, the child will be pulled in opposing ways.

If we are persuaded that fathers are important for the health and well-being of their family and are themselves altered by its health or disturbance, we are bound to reach out for the fathers' help.

Work with Poor or Minority Families

Wealth does not invariably immunize against pathology nor does poverty inevitably breed it. Yet as the old adage would have it, if you are going to be unhappy, you might as well also be rich. The maladaptive effects of poverty or oppression, and often these go together, are difficult to withstand. It is, however, important to distinguish between stable, low-income families and families who have experienced intense and chronic social and economic deprivation, which often leads to family disorganization. Families almost exclusively involved in a struggle to survive and subsist rarely have energy to spare for participation in remedial work for their children. However, even within this latter group there is a wide range of disorganization and pathology, which heightens and recedes at different times. Generally, however, the poor have a greater tendency to view themselves as alienated from the rest of society. A sense of distrust for professional authority is not uncommon. The professional himself, usually drawn from social strata other than the poor, is often uneasy when treating people not of his own group. Hence psychological barriers are maintained from both directions, and the mutual process of exploring and understanding can be more difficult. One

consequence of such barriers has been the tendency to stereotype poor and ethnic families and to see them as far more homogeneous in their parenting practices than recent inquiry suggests.

The recent rise of ethnic interest, a byproduct of more active struggles by minority people for equality, has begun to provide important insights about differences within these groups, the effects of oppression on personality formation and child-rearing practices. We are only now beginning to accumulate some experience with poor and minority families. As a consequence, our knowledge about effective treatment strategies with these groups, where and in what ways the more traditional styles of treatment require modification, is not fully developed.

Chilman observed that "many of the very poor suffer from a chronic, deep depression, linked to a hopeless anxiety springing out of a lifetime of frustration, failure and rejection. Often this depression is dealt with in an impulsive, dramatic expressive style, rather than in the more compulsive, intellectualized, instrumentalist style generally employed by the middle class in dealing with their hopeful, goal-oriented anxiety."

In a study of a small group of severe multi-problem families, Bandler delineated five basic pathogenic characteristics: (1) a sense of psychological, educational, social, and cultural deprivation; (2) the constant and intense

sense of danger from inner impulses and from violent and unexpected behaviors from the outer world; (3) the excesses derived from extremes of disorganized stimuli; (4) the absence of patterned, predictable behavior which contributes to a sense of uncertainty and inconsistency; and (5) the lethargy and hopelessness that become organized into pervasive passivity.

Despite such overwhelming difficulties, Bandler observed that mothers in such families were often capable, with help, of developing sufficient parental altruism to offer their children love, competence, and a sense of value derived from their own enjoyment of the children when these mothers were "no longer faced with near starvation" themselves.

Certainly parents cannot give to their children what they do not themselves possess. Parents who were themselves impoverished will need considerable help and support before they can make themselves available to their children. In such instances, clearly programmatic help in sharing the burdens of parenting may be needed to supplement direct work with the family. One may need to help the family by reducing the pathogenic pressures from the environment in order to enable the parents to function more effectively. In such instances, interventions traditionally associated with casework and social work, including direct services with concrete assistance, may be required. These may include assistance with income, jobs, housing, child care, and transportation to the agencies providing help to the child and

his parent. However, such help cannot be forthcoming from social work alone. The problems of poverty, racism, health, education, welfare, and work will not be solved by professional groups. They confront our society as a whole. However, when such problems create personality distortion and human suffering, we cannot wait until society acts. Nevertheless, we must recognize that there are some children and parents who are so impaired that psychological and social work rehabilitation with today's tools is no longer possible. While such cases are more likely to be found among the poor, it is important to exercise special caution to ensure that our decisions and dispositions spring from understanding rather than bias.

Conclusion

The family, a changing institution, retains its importance as the most significant shaping influence on its members and more particularly its children. Parenthood in its own right offers opportunities for the further evolution of adult personality. Work with parents in behalf of children requires careful assessment and differentiated treatment and disposition strategies. Efforts to assist the child without engaging the parent through involvement with his [the parent's] needs and psychology are likely to fail.

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Notes

1 In 1965 4 million mothers with children under the age of six were employed full time.

2 See Chapter 2.