Critical Issues

Working with the child's external world

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When individuals come into therapy, they come with a retinue of family. Some family is internal (early family dynamics) and some family is external (present day events). With adults, the therapist works indirectly with both these families. With children, the therapist similarly works indirectly with the internal family, but the work with the external family must be direct. This work inevitably brings a new set of challenges for the therapist.

As trauma therapists, we are well aware of the need to address the multiple and unstable representations of the internal mother (persecutor/victim/care-taker) (Liotti, 1999) but, all too often, we mistakenly assume that the present parent – be it birth, step, adoptive, or foster – bringing the child to our office is a stable figure. This parent has recognized the child's distress, the child's need for therapy; this parent wants the child's world to be more stable. This recognition and wish may indicate the parent is stable or it may come from the parent's own sense of instability.

Therapy for a child with dissociation is unlikely to be successful on a long-term basis (that is, maintained beyond the time of therapy) if the child returns from therapy into a setting where the parent is responding from his or her own unresolved trauma. If the parent responds to the child with multiple presentations (frightening other, frightened other, care-taking other), the child, of necessity, needs to maintain multiple internal self-models (victim, persecutor, cared for) (Liotti, 1999). As child therapists, we must address a parent's need for therapy.

Two major blocks occur: funding and willingness by the parent. Coverage for therapy can usually be procured for the child who has been victimized; funding for the parent is far less accessible. Therapy may require (1) splitting the child's fee with a colleague who is willing to see the parent at half fee or (2) providing therapeutic processing for the parent within the child's time. The first alternative is the ideal, but it assumes not only generous colleagues but also a parent who is willing to look at his or her own experiences and internalizations. With the second alternative, the child unfortunately loses some of his or her time as well as the therapist being dependent on the parent's openness to working on personal issues.

For the parent who is unwilling to engage in therapy (and these are the parents least able to see the child separate from themselves and their own childhood issues), the child therapist is left with the challenge of creating a new relationship experience for an individual still caught in the past.

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As the parent talks about the child and his or her experiences with the child, the therapist can listen and validate. This listening and validating casts the therapist into the role of 'supportive other' to the parent. To give the parent an experience of a consistent single positive model of other, as opposed to the early disorganized (multiple-model) attachment we can assume this parent had, we have to be very careful. If we start to point out parenting errors, we may become the 'critical/persecutor other'. Educating about trauma and dissociation, an important part of the first stage of therapy for a child with dissociation, can help the therapist stay in a supportive role. Educating provides corrective ideas as to what the child needs while allowing the therapist to maintain a distance from the parent's actual behaviors. But many parents, because of their past experiences, are either not able to understand the ideas presented or not able to make personal use of the ideas.

Questions such as: *"When did you, as a child, feel like this?" "Perhaps you as an adult have felt that way – what was it like?" "What do you think it would be like to feel that way?" "What do you wish your parent/your partner had done then?" "Yes, you should have had that,"* can enable the therapist to stay as a supportive figure while encouraging some internal identification with the child. *"What do you think your child was reacting to when s/he did that?" "Where do you think your child's feeling, sensation, thinking came from?" "What might help your child with that experience?"* The questions suggested above are best asked when the therapist is meeting alone with the parent and when there is time for the therapist to follow whatever content the parent raises. The therapist will want to avoid questions such as *"How did you get through such experiences?" "How do you want your child to be different?"* because the ideas generated by these questions may re-enforce negative or dissociative behaviors.

When working with the child and parent together, the therapist can have both the child and the parent identify the emotional feelings and body sensations that come with particular situations or topics. This method provides both the child and the parent with increased self-awareness and enables those parents who can to attend more closely to their children. These sensations can be attended to, slowly shifted (see Levine & Kline, 2007), and then redescribed by both the child and the parent. This technique provides some processing for old fears or anxieties at the same time as giving the parent a tool to use with the child (and with themselves) at home.

Meeting with parents separately to clarify their behavioral expectations of the child and their system of correcting and teaching

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the child is important. Parents who have been experiencing chaos within the home are usually appreciative of the structure these sessions can provide. Therapists can often learn a great deal about the way the parent was raised from these sessions. How parents want their child's life to be the same or different from their own can be highlighted. Ideas to make this happen can be worked on together. Consistency and follow-through is always emphasized both by the therapist's explanation and by the therapist's own behavior (i.e., the therapist must be consistent and follow-through with the parent just as she wants the parent to be with the child).

Helping parents identify the triggers that cause shifts within the child and providing them with phrases for grounding the child reinforces the therapist as the 'supportive other.' Therapists can help parents modify or eliminate triggers at the beginning of therapy. Later the therapist and parent can work as a team to slowly reintroduce the triggers. The parent, as part of the team, learns to talk about the present safety and the difference between the past and now. As parents talk to the child about these positive changes, parents are also talking to themselves and building a new sense of safety for themselves. As parents become more aware of what triggers their child, they may also become more aware of what triggers them. The therapist can play an observer role in this process *("I wonder if that might be a trigger for you too?" "I noticed you becoming quiet then. Perhaps my comment triggered something for you?").*

Therapists can teach parents integrative-type language to use with their child. *"I am aware that seeing your brothers can make you really angry but I need the thinking part of you to be there as well the angry part so no one gets hurt on the visit. Then after the visit, the angry you can tell me all the feelings and thoughts, and sensations that came up." "The you that has been safe here for the last six months can let the scared you know that this house is safe." "This hug is for all of you—the you that breaks things and the you that takes care of things."* Because these comments help a child settle down, parents have a sense of progress and of being able to help their child. Our noticing and commenting on any small positive changes by the parent (even if only momentary) is important.

Advocating for parents with protective services, the school system, and the health system also reinforces a supportive role for the therapist.

Additional issues come up when the child is in a foster home or residential setting and is having visits (supervised or unsupervised) with the original parent. It is important for the therapist to meet with this parent. Recognizing the hurt, and perhaps shame, this parent is experiencing from having his or her child removed is an important place to start. The therapist here plays a dual role: the therapist wants to support and help the parent and, at the same time, is assessing whether continued contact and what type of contact is beneficial for the child. From a child's comments, the therapist can usually tell what sorts of messages the parent is giving to the child. Of course a parent wants to tell a child that s/he wants the child home and is working to make this happen. And the child wants to hear it. But this message stops the child from building an attachment to the new 'parent figure'. Helping a parent recognize what may or may not be possible and how to talk to the child about these possibilities will be important for the child's stability and for a stable base on which integration can occur. When this discussion is not a possibility, then the therapist must work with the child to help the child recognize the parent's limitations.

When the therapist, in her work with the parent, does shift into a corrective role (and inevitably this does happen either with words or attitude), it is important for the therapist to name what she has done and ask about the parent's experience of the shift. The parent may minimize what has happened but it is the therapist's job to correct herself and take responsibility (it is our job to support, to educate, to explore, to develop ideas, but not to correct). It is then our job to re-establish the supportive relationship. Maintenance of a consistent supportive relationship with the parent is essential if the parent is to have an experience (albeit a small experience within the parent's whole world) of a steady, secure attachment. It is this steady, secure attachment that can provide a base for a single positive self or an integrated multiple self. With the single or integrated self, the parent can provide greater stability for the child.

All of this discussion may occur while the parent is in the room with the therapist and child at the beginning or end of the session or when the parent is seeing the therapist alone at the beginning of the session or in a separate session. Yes, this is time taken from the child's therapy. But it is time that enables the child's therapy to be successful.

Maintaining a supportive stance can be extremely difficult when the parent's behavior toward the child and, indeed, the parent's attitude toward the child is destructive. We are, after all, first and foremost the child's therapist. Consultation where the therapist can express her frustration and even anger with the parent is essential. This processing enables the therapist to come back to the importance of her relationship experience with the parent. It helps the therapist remember that the parent does not choose what Siegel and Hartzell (2003) refer to as the 'low road' of parenting; it occurs from past experiences the parent has not been able to process. For the child to benefit from long-term therapy, the parent needs a new relationship experience. Consultation - with colleagues and within one's own mind - can help us come back to the next therapy session without critical judgment.

However hard we as therapists work, we cannot always prevent destructive situations: a parent's distress keeps the child in a state of anxiety; the child's anxiety behaviors trigger the parent's fears and multiple negative responding by the parent occurs. We need to be alert to these interactions and to when they reach a level at which neither the parent nor the child is going to be able to de-escalate. It is at this point, whether the home is a foster home, an adoptive home, or a birth or step-family home, that a move needs to be considered for the child. Safety and stability for the child is our primary objective. No therapy can occur without it.

References

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