

Child and adolescent psychotherapy with parents and carers

Introduction

A child is by definition a dependent being, and child and adolescent psychotherapists are aware of the need to pay full attention to the context in which a young person lives. The influential people in his or her life will be grouped around them in widening concentric circles. First, the parent or parents with siblings and other family members and connections, then school, then others who are involved - possibly social workers, doctors, key workers or the police - all of whom have to be taken into account.

These people, and more, may need to be in touch with the treatment of a child or young person in child and adolescent mental health services (CAMHS) or in related outreach and community services. However, nearest to the centre are the parents or foster carers. Whether children are offered individual sessions or family ones, it is essential to support those upon whom they depend if the professional intervention is to be successful.

The need for support

Parents, whether single parents, intact couples, step-parents or foster parents, present at CAMHS in a complex state of mind. They arrive with a mixture of hope and dread, and they certainly come under some degree of duress, whether the pressure comes from within themselves or from an external agency. What child psychotherapists are able to offer is some understanding of this situation where matters have become so difficult at home that help has had to be sought. Parents and carers will be hoping that the help will be effective, but they will also bring their doubts about the help, and indeed about the helpers. They will bring their fears that damage may be irremediable; and their dread - rational or not - of being exposed as failing in their task. The job of the child psychotherapist is to begin a process of thinking about the troubles that bring the family to the service, and to do it in such a way that the clients are not put off. Children can never be treated in isolation, because they always go back home, where their dependence on adults is entire. So parents need to be supported in their wish to change things for the better, which can only be fulfilled if some difficult thoughts and feelings can be entertained by them.

The nature of the support

The support involves the attempt to establish a co-operative working partnership with parents where it is taken for granted that the role of adults is to join together to begin to deal with problems that children are too young to sort out alone. However, the main problem in families who consult child psychotherapists is that ordinary adult thinking has already broken down. What child psychotherapists hope to do is to offer a reliable setting - the same worker, the same room, regular appointments which are not cancelled or interrupted - within which some trust in the service's resources can be engendered. Given serious attention, parents or carers may be able to address questions which have remained largely unspoken, perhaps even

totally suppressed. Engagement in the task includes thinking about the child or young person, about the experience of coming to the service, about relationships within the family, about parenting issues and all the many anxieties which will be permeating the family mind.

Ordinary observation tells us that having children awakens in us all thoughts and feelings about our own childhoods and the ways in which we were parented. Thus parents may feel impelled to tell the worker about their own early life as well as their current one.

But the focus of the attention remains on the child. The parents have come as adults whose adult capacity is for the time being impaired and who need tolerant, non-judgmental but clear-sighted support to think about what is going wrong and what needs to be done.

What is going wrong?

Case example: Tyler

Tyler was a little boy in Reception class who was already at risk of exclusion. His wild and unmanageable behaviour caused his school much trouble and concern. He was said by his mother and step-father to be beyond their control. He had been referred to the CAMHS psychiatrist who referred him on to the child psychotherapy discipline.

The child psychiatrist felt pessimistic. Tyler's father had been violently abusive to Tyler's mother and Tyler had lived in an atmosphere of alcohol, drugs and out-of-control adults. Now his mother was expecting a new baby by her new partner. The chorus of desperation rose ever louder from the parents, who were now being seen by a child psychotherapist. It became clear that all difficulties were being ascribed to him, and all they could imagine was to be freed from their problems by medicating Tyler increasingly heavily and by seeking respite care from him.

At the same time another worker saw Tyler at the child psychiatrist's request and found a child who certainly had the potential for violence but who also was suffering from extreme fear and anxiety.

This is an example of a painful and anxiety-provoking case which needed time to unravel. But given the chance to voice their dread - particularly Tyler's mother's - that damage had been caused which was irreversible, there was a chance of liberating Tyler from the burden of fear and destructiveness which had been put upon him.

In the case of Tyler, it was obvious that he needed help and so did his parents. The long-term aim was to help the parents distinguish their own thoughts and emotions from those of the child, and for him to have therapy for those problems which really were his own, not someone else's.

Down the generations

The task of any worker in CAMHS is to make an attempt to stop disturbance and damage passing unmodified from one generation to the next. A key factor in tackling this is the extent to which a parent can reflect upon a child's experience.

It is obvious that Tyler's mother was unable to bear to think about what her son's life had felt like to him without the help of her new partner and the regular support that was given to the couple over time.

What are the main aims of work with parents and carers?

- To help them concentrate on what has happened and what has been happening despite the distress this may bring
- To create circumstances which enable the child or young person to engage in and continue treatment
- To observe and manage the parents' and carers' states of mind
- To be available to make informed links with the external network

Discussion of a case example: Emma (15 months)

This is an example of brief work with a toddler and her parents, K and S. Emma's mother, S, telephoned the clinic in tears on the suggestion of the health visitor. The parents were young; the father was in work, the mother at home with her child.

- In the first meeting the agitated parents told the child psychotherapist that Emma refused to be weaned. She slept in their bed and had never been parted from her mother for longer than a few minutes. The parents had, much to their fright, begun a series of quarrels starting in disagreement about how to handle Emma. The mother said she had believed she had found a man different from her angry father, but the quiet placid K had begun to show quite another side. Emma demanded the breast several times in the session and anxiously refused to look at the toys offered.
- Two weeks later it was clear that all kinds of sensible suggestions for managing the separation between Emma and S had already been rejected as impossible by the parents many times. The parents spoke with increasing indignation about the uselessness of all the professionals (health visitor, GP) and also of the advice their families were proffering. S declared defiantly that Emma would wean herself when she was ready. K looked dubious and said he wouldn't mind having his partner back. Emma continued to behave in a clinging and unhappy way.
- After three weeks the parents were starting to agree that change might be desirable. All sorts of strategies were discussed yet again and still regarded with doubt. Emma did not ask for the breast at all. She listened to the conversation. Suddenly the placid K fired up. He challenged the child psychotherapist - what on earth did she think she was doing? She hadn't given them any help at all. Just pathetic and useless, that's it. He leant back, looking horrified, relieved and even a little triumphant. In the silence S turned to him and said she thought he was quite right. What they needed was to see someone different.
- Despite this, they came back in another three weeks. To the child psychotherapist's surprise, progress had been made. Some of the plans previously despised had been put into action and Emma had been amazingly acquiescent. It looked as though change was in motion - something different was happening.
- At their last visit the couple said that things really were much better. They had been out together while S's sister babysat Emma and the child was sleeping in her own cot.

Their mood had lifted, and not only theirs, because Emma was toddling around vigorously, playing with the toys and obviously beginning to talk a lot. It was possible to look back and think about the fact that the word “no” doesn’t have to be rough and brutal, and that Emma had needed some help in saying “no” to herself. It seemed as though a crucial factor in the change of mind had been the child psychotherapist’s capacity to withstand the discouragement and difficulty involved in feeling useless, and then to be able to tolerate a real blast of anger.

This is a case where change came quickly, as it can do especially in young families at the start of a baby’s life.

Sustaining therapy

This is an account of beginning work with Sula, the mother of a depressed young adolescent, Sam, which shows the need for parent work to sustain the therapy of the young person.

Case example: Sula and Sam

It had already been decided that Sam should start a time-limited piece of work with another child psychotherapist. Sula recapitulated their story: she is the sole carer - Black African with a background of trauma and loss, a refugee from conflict in her country of origin. Sam’s father is white British but only has occasional contact with Sam; Sula is sole provider. She communicated strong distress and was unsure how to help Sam and scared by his low mood. Sula didn’t attend the following session.

The child psychotherapist wrote a brief letter saying that she was expecting Sula next week. Later in the week Sam came for his session. Sula came, but instead of being voluble and asking for help, she was hesitant and silent. The child psychotherapist spoke about Sula’s uncertainty about taking on this new venture with the CAMHS service. Sula warmed up and became less tense as she gradually acknowledged the strains of being a single mother with little contact with people in the city who shared her cultural origins.

The child psychotherapist acknowledged the differences between herself and Sula. This meeting was taken up with Sula talking about Sam’s father, about his aggressiveness and hostile behaviour. She said she was no longer frightened of him, but she was very much afraid of Sam growing up to be like his dad. The whole question of Sam’s development was discussed. Might it be a good idea for Sam’s dad to come to meet the child psychotherapist on his own sometime?

As is plain, Sula had a great deal to think over against the background of the loss of her country, her culture and her settled family life. No wonder she had found Sam’s despair too much to bear.

As the work went on, she became more able to sort out her own struggles from her son’s and to find much more connection with her local community and with people from her own country of origin.

The practical world and the world of the mind

In cases where it is appropriate a child psychotherapist can liaise with outside agencies both on behalf of the child and also on behalf of the parent who may need direction and help in accessing all sorts of services. Attention to events in the outside world goes along with the attention to events in the inner world of thought and emotion, memory and imagination.

The training of the child psychotherapist enables him or her to confront problematical and extreme states of mind with the wish not to deny them but to understand them.

Fostering and adoption

Many parents and carers are under the strain of having to deal with complicated networks of agencies and appointments as well as the stress of living with a child who is disturbed and disturbing. This is clearly evident in cases of fostering and adoption which have run into serious difficulty.

The parents or carers in this type of case are very vulnerable to the despair which can lead to the breakdown of a placement and are in particular need of careful steady support.

A frequent example of this is the kind of case where a child has been removed from the family of origin and adopted late - at eight or nine years old. Perhaps for five or six years things go fairly well, but with the upsurge of puberty and adolescence the child's whole identity is then called into question.

Often we find the young person in a violently confused state, running away, behaving unmanageably at school, taking to the extremes of rebellious behaviour.

Consequently, before long the family may find itself caught up with school exclusions, adoption or fostering support social workers, even youth offending teams and the police.



In addition, they are living with a young person who is in a state of mind calculated to communicate itself to all and to result in all kinds of scenes and anxieties at home.

The child psychotherapist is well placed to realise the need for liaison with the other agencies whose input is vital but also to understand the turbulence of mind conveyed to the carers which comes from the past but has to be managed in the present. In all these cases the goal is to re-establish proper adult thinking and benign adult authority. Work with parents seeks

always to remember that the child is the responsibility of the parent and that the parent is a grown up, but simultaneously to work with the disturbances which are preventing that responsibility being properly discharged.

Key publications

Green, V. (2000) Chapter on **“Work with Parents. Therapeutic Space for Recreating the Child in the Mind of the Parents”** (eds Dr Tsiantis, J. et al) Work with Parents - Psychoanalytic Psychotherapy with Children and Adolescents, E.F.P.P Clinical Monograph Series, Karnac Books (p.25 - 46).

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Harris, M. (1968) **“The child psychotherapist and the patient’s family”**, Journal of Child Psychotherapy, Vol 2, No 2.

Hopkins, J. (2009) in Lanyado, M. and Horne, A. (eds) **“The Handbook of Child and Adolescent Psychotherapy: Psychoanalytic Approaches”**, Routledge, London.

Jarvis, C. (2005) **“Parenting problems: research and clinical perspectives on parenting adolescents,”** Journal of Child Psychotherapy, Vol 31, No 2.

Klauber, Trudy (1998) **“The significance of trauma in the work with parents of severely disturbed children and its implications for parent work in general”**, Journal of Child Psychotherapy, Vol 24, No 1, 85-107.

Rustin M. (1998) **“Dialogues with parents”**, Journal of Child Psychotherapy, Vol 24 No2;

Rustin M. (2009) in **Lanyado and Horne** [as above]. This is an updated version of the “Dialogues with parents” paper.

Trevatt, David (2005) **“Adolescents in mind”**, Journal of Child Psychotherapy, Vol 31 No 2.

Commissioning child and adolescent psychotherapy

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