The Eternal Triangle: Child, Parents, Therapists: How Do We Cope with Parents When Working with the Child?

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Introduction

There is no way to avoid parents when working with small children. Even if they are not in the room with the child and the therapist, their presence is felt. It is only a question if we admit this or see the therapy room as a cocoon of therapist and child, with a strong barrier around it. Of course there is a dyadic relationship between child and therapist, just as there are dyadic relationships between mother and child, and father and child. But the triad also exists, and in fact it is a developmental necessity for the child to move from dyadic to triadic relationships.

Many things can confuse the simple fact that we are dealing with a triad. We insist on confidentiality; we see intimacy and our dyadic intimacy with the child as the basis for therapy; we develop sympathy or often anger at the parents; and of course have our own parental relationships somewhere in our psychic background.

So how do we cope with the constant existence of the parents? How we do see them as a significant third, and especially - how do we accept that the child belongs to his parents, and the aim of therapy is to help that relationship, not compete with it.

I will address these questions through the concept of “letting go”.

Letting go is a developmental task, perhaps one of the most difficult ones for many parents. It is not just the child who takes on developmental tasks that were previously done for him by his parents; the parents must also let him take over these tasks. Mahler’s separation-individuation includes two parallel processes achieved by two people, who must both participate in this complex movement towards independence. Loewald describes the achievement of independence as patricide - in the sense that any function the child takes over from the parent is an aggressive act against the parent, sensed as a murderous act.

Separation-Individuation is at the basis of any growing process, and certainly the core of independent growth or growth into independence. It is a process best achieved when the child and the parent(s) can facilitate it. It is both a physical and emotional process - letting the child go quite literally (cross the street himself, do her own homework, try to walk - or ride a bicycle - or any other activity that the child has to master). One of the aims of therapy in children is to encourage normal development, to put the child back on the normal pathway, whether he has normal capacities and has “strayed” from normal development because of external, reactive factors, or because he has inborn difficulties that make development along the usual pathways an impossibility.

The therapist, whether working with children or adults, has the same task as the parent in terms of growth and independence: he is meant to help the patient achieve things that will enable the patient to leave him. There are problems with any letting go (and adult patients are often very aware of the therapist’s feelings about this and “use” the countertransference to avoid termination). But working with children makes this doubly difficult and much more complex. The two main factors which affect this, to my mind, are the parents - who are an integral but nonintegral part of the therapy; and our own primitive reactions to protect children.

In psychotherapy, the parents are already established as parents, and the first “letting go” is their function. They have to turn over their child to an intimate relationship with a stranger, and a stranger whom they are afraid will judge them and criticize them. They have already experienced some “letting go” to other people: grandparents, nursemaid, kindergarten,
school etc. And often these previous experiences dictate, unconsciously, how they will hand the child over to the therapist. Again - this is a triangular situation, and the three parts have to deal with it, together and separately: the parents, the therapist and the child. But the therapist has the major responsibility here: it is his job to recognize if there is a problem, to facilitate the “letting go” and to leave his own emotions out of the equation. He must also assess when the parents are not really able to let the child into therapy, as I will show in one of the cases.

Clinical Vignettes

Case 1

This case is from a therapeutic setting: a special kindergarten for children suffering from autism. The children are there 8 hours a day, and aside from the usual didactic functions, they receive speech therapy, occupational therapy and psychotherapy.

R. was 5 when she was admitted to the therapeutic kindergarten. She was an adopted child from a single parent, and I had assessed her in her former kindergarten. I had been impressed by the great difficulties she had forming any kind of self-identity, aside from a great deal of learning problems. This seemed to tie in with her past history - of an orphanage - but also, in my assessment, was connected with her mother, who seemed to have almost no ability to understand her, serve as her container, digest and return to her the complex things R. was feeling. The program for R. consisted of a lot of special education, occupational therapy and speech therapy - but there was a main focus on intensive psychodynamic psychotherapy for her and dyadic work with her and her mother.

R. progressed well. She began forming ties with other children, defining her boundaries and in essence developing a sense of self. She moved back and forth from dreamy, aimless wanderings to being able to sit at a table and work, even relating to what the other children round the table were doing. Seeing R. wandering around the courtyard, relating to no one, including herself - it was hard to believe she was the same child who talked, related, and progressed to normal scholastic level. But both pictures were parts of R. The staff were “divided” according to these two pictures, some seeing the progress and some seeing the regression. It took a while to see the two pictures as one, and to integrate them into one child, who had a variety of needs. There was much more progress in psychotherapy when it was accepted that both states were part of R., and the wandering was a present necessity, not a regression to earlier stages. For R. the staff served as a cohesive envelope, achieving containment for R., who could then gradually integrate all the different parts of herself.

But around the mother there was great controversy. The staff stood in great admiration of the mother. They felt she invested an enormous amount of time and energy in R., and was doing a great job. I couldn’t recognize the woman I had seen in the description of the staff. I hypothesized that she had been in depression and despair when I met her, and now the progress of R. had given her new hope; perhaps I had simply had a bad day myself and made a mistaken assessment. We all assumed that the present picture, presented by the staff, was the “correct” one. In retrospect, this was because it was a “good” picture, and served to cover up any doubts the staff had about the mother and the child.

Things came to a head when termination of treatment became imminent. Suddenly, everyone felt that R. had to stay on. This was voiced in terms of the mother. The staff said she wanted this. It was very hard to pinpoint where the problem was - there was only a feeling of animosity towards me, as if I was ruining something by saying she had to move on to school.

At this point we assumed something countertransferential or projective was going on. Usually discussions in the staff are very open, trying out new ideas, trying to understand what is happening. When things become angry and rigid - it is clear to us that we are covering up something. When we realized that the anger seemed to be addressed towards me, without any overt reason for it, we remembered the difference of assessment of the mother, thinking that perhaps we had been concentrating on the child - but actually we were avoiding “seeing things” about the mother. This opened up the fears of the staff of abandoning R. to her mother, whom they felt could not continue with all the things R. needed. The main fear was that she couldn’t understand and contain R. The mother indeed invested her whole life in R., but hadn’t really ever understood her. In fact, when we allowed ourselves to reassess her, she was seen as a person who had to have rules and dictates; who had her own ideas about bringing up children - which were good ideas in themselves, but simply unsuited to R. It gradually became clear that the staff had attributed all R.’s identity problems to the orphanage, denying that the mother may have contributed to them, or at least had not been a help in solving them. They then became afraid that the mother would not be able to continue the good work they had been doing, and that without Mother-Kindergraten, R. could not continue to progress.

There was a great sense of freedom when all this had been worked out. Clearly, the need “not to see” had put a severe burden on the staff, especially on their ability to think. Once we had worked things out, and identified the roots of the problem, we could make a better decision as to termination - for the correct reasons, rather than through our projections and denials.
Case 2

This is a 5-year-old boy, B., suffering from extremely severe allergies - to the extent that he is constantly under the threat of death. He reacts to dust, milk products, smoke and many other things. But the 3 mentioned were the ones that caused the most problems in kindergarten, as there were shaggy rugs, milk products were the most common food, and two of the staff smoked.

The physical solutions seemed easy: change the rugs, keep his food totally separate, and smoke outside!! But none of these solutions was used. The kindergarten claimed it was too expensive to change the rugs, someone managed to give him milk (and he almost died on the way to hospital) and the smokers simply didn’t go outside.

The mental health staff was invited to intervene on two levels: guidance to the family, and guidance to the kindergarten. It turned out that the father was a paranoid, militant demander of justice, who had totally antagonized everyone working in the kindergarten. The mother was a dependent, frightened person who needed to be told what to do and was afraid of her own opinions. As a couple this worked well. The father was the one who dealt with the outside world, and the mother kept out of any conflict or even contact. She didn’t go to the kindergarten - just the father did. The staff there couldn’t identify with the very real problems or stress as they were so busy being angry at him.

When we assessed the child and family (no one had asked us to assess the child - we just felt we couldn’t do an assessment without seeing him…) we felt that his whole existence had been defined by the illness, and he had great difficulty developing any real sense of self. He did not portray fear - this seemed to be the parent’s job; he just did what he was told, had come to accept only parental authority, and certainly had no peer relations or even relations with kindergarten staff. This was seen as natural, given the father’s nature, but no one had paid attention to the damage to the child. The “cover story”, of course, was his life-threatening illness but this was indeed a cover story. In effect, the parents had no sense of their child. He was their connection with the world, their main theme in life. They took extremely good care of him physically; the He was their connection with the world, their main theme in life.

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Finally, the parents brought up some new problems: B. developed enencopresis, and was aggressive towards his little sister. They agreed to send B. to psychotherapy, so he would stop having temper tantrums and hitting his sister.

B. wanted therapy very much, became attached to his therapist and came willingly. It was mainly the father who brought him, and for many sessions he insisted on being in the room with B. Whenever B. started developing symbolic play the father would listen to his lungs, to see if he was getting an attack. The therapist had great difficulty with this, as she felt the father was using this to block therapy - but how can you argue with a potentially life-threatening situation? As time went on, the father waited outside, and B. began expressing his fears of poisoning, his aggression to the world and his sense of being constantly attacked. He became much more open and less aggressive.

Suddenly the father demanded a letter to the authorities demanding counseling for the kindergarten. When the therapist refused to give him such a letter he announced that therapy would stop there and then, and didn’t even allow B. a parting session.

The therapist spent weeks wondering what she could have done differently, and finally asked for a consultation. She sent me a very detailed case report, writing in great detail about the father and much less about B. (in effect, mirroring what the rest of the world had been doing and she had so strongly objected to). When we went over the material, it became clear that the parents pulled their child out of therapy as soon as he began to change; and there was also denial of the very destructive role the kindergarten had played. She had put all the blame on the father - who supplied ample material for being blamed - and had completely denied that the kindergarten, in its own way, had been just as rigid, stubborn, resistant and blaming. It was no chance that a letter to the authorities about the kindergarten was the cause of the break; but it would have occurred anyway. She felt she had abandoned the child, aroused hope in him for a different type of object relations and then pulled the rug out from under him. She had great difficulty accepting that there was really nothing she could do. Therapy would indeed be helpful for this boy, and had begun to bear fruits. But the parents couldn’t allow for change. They needed this particular interaction with their son, as part of their family dynamic and their way of communicating with the world. Her identification with the boy in itself was no help to him.

We discussed the feelings of helplessness and despair she underwent at this abrupt termination, and whether they mirrored the little boy’s feelings or rather her own difficulty in accepting there was nothing she could do. She had previously created a therapeutic cocoon around herself and the boy. This is a normal therapeutic position, but one the parents could never accept.

To my mind, this case is a clear but difficult example of a therapy that should never have started. It should have been obvious from the start that they parents could not allow the child to change, and that beginning therapy would become a broken promise to the child. But such decisions take great courage, and arouse much doubt.
Case 3

We usually present “problem” cases to make our point. In this case I would like to present a “successful” interaction and termination, with a divorced couple - just to show that the dynamics can be the same.

I had been called in to A’s family when they were going through a divorce, and wanted someone to advise them on visitation rights. For 2 years I saw the parents regularly, seeing A about once every 6 months, from age 3 to 5. The parents began by agreeing on nothing, and using me as a buffer, but gradually we could space out their visits with me. We developed a system of writing everything down: not only the days of visits, or changes, but also who would bring her ballet clothes, who would take her to swimming lessons, etc. We printed this out in 4 copies: one for each parent, one for me and one to hang in A’s room, even though she couldn’t read yet. She wanted this as a kind of transitional object, which signified law and order in her world. They would all refer to this page, and it became a presence in their lives, a concretisation of my being.

As time went on, they had less and less fights, and could work things out themselves. But when I suggested termination they begged me to continue. They needed both the actual vis-work things out themselves. But when I suggested termination a presence in their lives, a concretisation of my being. They were “paying” for it and correcting it by having her in therapy, and at the same time not losing me as their safe place. Occasionally, they would ask advice about their own. They admitted this might even be an unconscious way of their expressing their dependency, but felt that I had become the family mascot, and didn’t want to do without it. After seeing A for her regular visit, I suggested she come in for psychotherapy. I felt that the outside situation was stable enough to allow this, and she was mature enough to begin dealing with the family issues on her own. It would serve a side-benefit of weaning the parents from me.

Play therapy was a natural for A., and she used the doll house to recreate family situations, work through her difficulties, and define herself. Again, I won’t go into details of the therapy, but deal with the termination. The parents felt she could go on forever - they felt it was a burden off their shoulders. They had created problems for her by divorcing, remarrying, having more children. They were “paying” for it and correcting it by having her in therapy, and at the same time not losing me as their safe place. Occasionally, they would ask advice about summer vacations etc. for A., assuming that I understood her better through play therapy than they did. And A. indeed used me as a means to develop her own desires, and not be caught up between the parents, or trying to satisfy both of them.

Everyone seemed happy with this situation, and for me it was a relaxing therapy that I felt was helpful. It was pleasant not to be dealing with severe pathology, and I convinced myself that basically healthy children and healthy families also had a right to therapy… Still, I occasionally brought up the question of termination with the parents, who regularly resisted it.

After a year and a half, A. came in one day and said: “Why do I have to play with you? Can’t I just tell you what I want? I want to go to summer camp and then go on holiday with my father. And then when we get back I want to be at home and visit him like I usually do. Anything else?”

We all took our cue from A., and agreed that she now could really tell us what she wanted. The only thing lacking was that she tells her parents directly, not through me. This time I accepted the role of limit-setting and letting go - in fact, forcing them to let go - and declared that not only A. but they themselves were grown up enough and independent enough to do things on their own. They accepted this, secure in the knowledge that I was there if they needed me.

My own associations were to a personal experience: when my older son was 3, my husband went on sabbatical and my son and I joined him for part of the time. When we came back, just my son and myself, I asked for extra time off from work in order to help him through readjustment, especially as his father wasn’t here. But the next morning he got up, fetched his bag for kindergarten, and said: “I’m going to kindergarten and mommy is going to work. She will pick me up”. And that took care of all the readjustment… I went back to work the next day and realized that it was me who wanted to stay home with him a bit longer, and felt a bit sad that he didn’t need me more.

Discussion

Therapy with small children is a world of its own. There are so many changes due to natural growth that it is often difficult to tease out the specific changes due to therapy. The addition of the therapist to the child-parent world can of itself create change - either easing the tension and making things better almost without doing any therapy - just by being there - or make things almost impossible, because of the competition or the parents’ fear of exposure or intrusion. We make the therapeutic contract with the parents (not only the technicalities of time and money but also the aims of treatment etc.) but work with the child, with or without the parents. But we are never without the parents, even when they are not an active part of the therapy. And we are not only transferential objects for the child - we are also real objects, who influence their growth and development. Thus we are constantly dealing with a system, not just a dyad.

To my mind, we cannot deal with projections and transference in a system as if they are a series of dyadic relationships. True, every contact with another person forms a dyad, and families are not only triads and quadrads etc., but also a collec-
tion of dyads. A great deal of the literature and training dealing with psychotherapy and psychoanalysis deals with dyads, and the concepts of transference-countertransference, projection-counterprojection are used mainly in dyadic contexts. So our way of thinking, our internal reference, is basically to a dyadic system, and we tend to enlarge this to intrusions and inclusions of added people into the dyad.

This parallels the theories of development we were brought up on. The original idea was of the mother-baby dyad, with the father entering much later, and serving a different role than the mother. Now it is accepted that the baby forms dyadic relationships with a number of caretakers from the beginning. The baby is capable of multiple dyads, and does not have one basic dyad that all other relationships are based on.

If we take this into therapy, then we must accept that any patient is part of a system, and the particular dyad he forms with the therapist is one particular aspect of his being.

With children, if we centralize the therapist-child dyad, we can end up seeing the parents as intruders - just as they see us as the intruders (which, in fact, we are - even if we are wonderfully helpful intruders). It is not always easy to remember that for the child the parents are his main objects, and we are there to facilitate that relationship. Sometimes we feel that they should be facilitating our relationship with the child. It is much easier to see them as competing with us than as competing with them…

Once therapy is underway, a lot of these issues are put on hold. But they come up in great intensity as we begin to think of terminating therapy, or if the parents initiate it. We feel we are “giving back” the child to the parents. We have to let go of the child, just as they had to let go of him when they let him enter therapy. There are a lot of parallel situations between what the parents have to do when they put the child in therapy and what the therapist has to do at termination. Trust is a major one: we expect the parents to trust us (even though we deeply understand this to intrusions and inclusions of added people into the dyad).

At the same time, all the adults must be aware that transitions, especially final transitions such as termination, arouse fear and aggression. The child is taking on independent functions - and the parent may feel either depressed or even attacked, because something is being taken from him: when therapy is terminated the parents are taking on independent functions, and we may feel depressed or attacked - that something is being taken from us.

The more intense the therapy, the longer it goes on - the greater role we have played in the child’s real life, not only in his fantasy world of transference. The letting go, then, is very real, and not just a projection of our own difficulties, or the parents or the child. Terminating therapy, when therapy is successful, has great positive significance, just as any growth. But this does not deny the fear of independence.

The most extreme example of the fear of letting go I am familiar with is the Premature Baby Unit. There, one is not giving the baby back to his parents - one is letting them become parents. For months the nurses and doctors are indeed the parents: they feed, wash, and maintain the survival of the baby. They are around all the time - the parents come for visits, and can do very little for their baby. They cannot breastfeed or feed (tubes are doing that); they cannot hold the child: at best they can stroke him in the incubator through plastic covering; they get no response showing the baby is content or discontent, as the prematures don’t cry or smile yet, and anyway the monitors “know” if the baby is well or not. Often, the staffs have literally saved the baby’s life a number of times.

When these babies go home, there is a major crisis. The parents are already afraid to have the child without all the machines; they feel very alone, after dozens of people were constantly involved in caring for their child; and they have bonded with a fantasy of the child, but hardly know the child himself. The staffs usually feel they are abandoning the child they have raised and parented to two incompetent strangers. This reaction is common even when there were good ties between the staff and the parents, with mutual liking and respect. It is even worse when the parents were going through a crisis due to the premature birth, or felt depressed and unworthy anyway. Or if they had been demanding and aggressive, as their way of dealing with the situation.

In essence, the basic problem is still letting go, and knowing when and how to let go. Letting go can be a satisfying, fulfilling experience for parent and child or therapist-child-parent. It can give them the sense of growth and leave the therapist with a sense of satisfaction. But letting go can also range from an aggressive, destructive act of abandonment to a declaration of letting go while physically or symbolically clinging to the child. In order to deal with this complex issue, one must first admit that letting go is not easy for the adults, even when they are proud of the child, are glad he can achieve independence, are happy he has successfully graduated from therapy.

How much more difficult is it when there is no success story! This is true of children with developmental difficulties, who still must be given a sense of independence: and it is true for children who have progressed only a little, or not at all, in therapy.

At this point, there is always doubt. How do we know we
can or should stop therapy, and whether we are giving up too soon? Shouldn’t we continue? Are we continuing just to calm our conscience, or to delay admitting that there is no chance of progress? Are we making a real assessment, or colluding with the parents’ needs? Aren’t the parents’ needs also part of therapy? Are we continuing because we are angry at the parents, and afraid to admit it? Are we afraid to admit that therapy is useless in some cases, because it arouses doubts in our profession?

Summary

This is not really a topic than can be summarized. Terminations are as variable as therapy itself. It forces one to review the therapy, assess it and expose it to the outside world, just as parents feel exposed when their children go off to kindergarten. It also means making a decision in real life, something psychotherapists are not always happy to do. Occasionally the decision will be made for us by some external reality, and it is amazing how much easier it is then. But if we can adjust to a wide range of external realities, we should be able to function when we can terminate therapy without any external dictates! Surprising how difficult this decision is, because there are not always clear markers when we have “finished” therapy.

I think we should admit this and face up to it, as we are expected to do with any other multiply determined, unclear or undefined situation. What we should not do is project onto the parents our uncertainties, or our difficulty in making concrete, real decisions, and them be able to blame them or put the weight of the decision on them. Or go to the other extreme, and see the parents as completely out of the picture in making these decisions. The third possibility is subconscious messages via the child, who then gets caught up in the hidden communications between therapist and parents.

In the end, these issues emphasize a general problem in intense psychotherapy/psychoanalysis: we are involved with our patients! This is a good thing, but like all good things, there is a price. When therapy is successful, we have a natural desire to be the successful one. When it is unsuccessful, we want to blame someone else - and with children the “natural” people to blame are the parents.

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Conflicts of Interest

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