

# **Some Observations from Work with Parents in a Child Therapy Program**

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#### **Introduction**

This paper represents the first step in an examination of experience with parents of children brought to the Counseling Center and seen by members of the Child Therapy Group. These experiences are considered in relation to client-centered theory and to experiences with other adult clients. Special emphasis is placed upon the establishment of the conditions necessary for therapy and the implications of our experience in this area for work with difficult ("failure zone") clients.

The over-all theoretical framework within which the experiences will be examined is given in Carl Roger's paper, "A Theory of Therapy, Personality and Interpersonal Relations, as Developed in the Client-Centered Framework" (1956, see also 1959). The sections in Rogers' paper, on therapy and personality change, interpersonal relationships, and implications for family life are particularly relevant. The consideration of the manner in which clients approach therapy (or the point at which they enter therapy on a scale of therapy process) is based particularly on the concepts and descriptions of behavior presented by Rogers (1958) and Kirtner and Cartwright (1958).

There are two distinct but closely related aspects of a child therapy program: the direct experiences with the child and those with one or both of his parents (or other significant persons in his environment, such as siblings grandparents, teachers, etc.). In this paper we shall be concerned only with our experiences with the parents.

#### **Learning at the Counseling Center**

As indicated by Pollak (1952), Ackerman (1958) and many others in the literature on child therapy, most child guidance clinics endeavor to establish a close relationship with one or more of the child's parents (or persons with whom he is living). They regard knowledge of the basic factors in the child's present environment and his developmental history essential for a preliminary diagnosis and determination of a treatment plan and for evaluation during the process of psychotherapy. In addition, they have found that the child's therapeutic progress is usually most satisfactory if the parents are also in therapy. Over the years, in the Child Therapy Program at the Counseling Center, we have evolved a position with regard to working with parents which seems similar to that found in most child guidance clinics, yet has some clear differences. In early years at the Center, in the context of our belief that diagnosis and the formation of a specific treatment plan were not necessary, we often swung to the extreme of considering contact with the parents unnecessary—except for the purpose of arranging for the child's therapy. As a result, we

focused our attention upon the child, keeping interaction with the parents or others at a minimum and often seeing it as an unwelcome intrusion into the therapeutic relationship with the child. Thus, the parents (except those who had requested therapy for themselves) had no consistent contact with the Center. They were seen only if they requested a conference or the therapist felt a need for information.

Upon examining our experiences, however, we began to notice that the parents seemed to fall into two groups: those who withdrew their children from therapy before either the child or the therapist felt ready to stop and those who allowed them to continue until they reached a termination point satisfactory to both child and therapist. Upon further examination, we found that, for the most part, the parents in the first group were those who had only minimal contact with the Center and those in the second group were the ones who were in therapy themselves or had some kind of relationship with the Center.

We wondered about this apparent connection between the parents' contact with the Center and the length of stay in therapy for the children and began searching for explanations. The parents who withdrew their children usually stated that they were doing so because of external circumstances, such as difficulty in scheduling appointments, taking a long trip to the Center, obtaining baby-sitters for the other children in the family, etc. Or sometimes they simply reported that they felt, on the basis of changes in the child's behavior at home or school—either for the better or for the worse—that therapy either was no longer necessary or was not doing any good. We felt, however, that there were other, underlying, reasons for their action. For example, it seemed as if the parents might be feeling a lack of involvement in the child's therapy and possibly resentment at being "left out," relegated to the waiting room. Or, on a deeper level, they might be experiencing a real discomfort, uneasiness and perhaps fear when changes in the children's interaction with them forced upon them an awareness of their own usual modes of interaction and hence created the necessity for some change in, or at least examination of their previous behavior. If such feelings arose, the parents usually had no alternative but to withdraw their children and leave the Center; for we had made no provision for them to discuss their feelings and concerns as they developed. (Sometimes, when we saw what was happening, arrangements were made for the parents to see someone. Frequently, however, it was then too late to reach them.)

We began to realize, then, that we were devoting all of our attention to the children and overlooking the basic fact that it was the parents who were feeling concerned and brought their concern to us. We were actually ignoring the persons who had come to the Center seeking help and were turning our attention entirely to the persons they had come about. Thus, it became clear that the differences between the two groups of parents—those who withdrew their children and those who allowed them to remain in therapy—might be attributed, in large part, to the differences in the way we related to them. When the parents were being responded to (either in their own therapy or some other relationship with the Center), we were more likely to be able to maintain satisfactory relationships with the children. When they were being ignored, they were more likely to remove the children from any relationship with us.

On the basis of this realization, we decided to work with the parents as well as the children. As a result of this decision, and our belief that a therapeutic experience would provide the help they were seeking, we then swung to the other extreme and required (or

at least strongly recommended) that the parents enter therapy for themselves before we would see the children. For the parents who were seeking therapy for themselves, this created no problem. Once again, however, we were ignoring a basic fact about the other parents—those who were not seeking therapy for themselves. We were recognizing that they were the persons who felt a concern and were seeking help, but we were assuming this meant that they wished to use therapy as we saw it—a process of deep self-exploration and experiencing of one's feelings. Actually, as will be developed more fully later on in this paper, these parents had no thought of such an experience for themselves. What they wanted, first of all, was to have something done to or for the children in trouble. Then, with regard to themselves, they wanted to know what specific kinds of behavior they should adopt in relation to the children in order to help them change. Thus, insisting that these parents meet with therapists who, because of their general experience and point of view with regard to the process of therapy, expected them to begin to explore and examine their own feelings and attitudes, frequently resulted in utter confusion and frustration for both the parents and the therapists.

Out of these experiences, then, we have arrived at our present position with regard to working with parents. In accordance with our earlier decision, we continue to work closely with the parents and no longer consider the children the only clients. However, we no longer assume that the parents want therapy for themselves and thus no longer insist they enter such a relationship. All that we now require is that we see the parents before seeing the children and that we maintain some kind of regular contact with them during the course of therapy for the children. It is our goal, however, to establish a therapeutic relationship with the parents; for we still believe—as will be explained more fully later—that, in the long run, therapy for the parents as well as the children will help them meet their particular problems, within themselves and in relation to their children, in the most effective and permanent way. In fact, sometimes, after the parents have had therapy, it is not necessary to see the children at all.

As stated earlier, our present position seems similar to that found in many child guidance clinics, yet there is a clear difference in emphasis at one point. Our main purpose in the first meetings with the parents is not to obtain information and impressions upon which to form a diagnosis and treatment plan for the child or the family, but rather to begin immediately to establish a therapeutic relationship with the person who has come to us for help.

We have reached a point, then, at which our goal is quite clear: we want to provide therapy for the parents. We have found, however, that many of the parents who do permit their children to complete therapy do not seem to have a therapeutic experience themselves. These parents come regularly for their own sessions throughout the period of their children's therapy, but they do not use their relationship with us in the way we consider most valuable. For example, they usually devote their sessions to either anecdotal reports concerning the children or cathartic releases of pent-up feelings about the children, their families, the school, etc. Often they report that they really enjoy coming to the Center, having a chance to talk to someone about their problems and to get out of the house for a while. They seldom dip below the surface, however, and thus their experiences with us are usually on a superficial level, lacking the deeper self-exploration and self-experiencing we consider characteristic of therapy. In addition, the fact that they automatically end their own sessions when the children terminate therapy, seems to

indicate that they consider their relationships with us extensions of the children's therapy rather than separate experiences for themselves. If acceptable changes have occurred in the children's behavior, the parents are satisfied with the total experience; if not, they are dissatisfied. However, when the parents have not had a therapeutic experience, we are dissatisfied. In such cases, we feel that the total experience for the family has been a minimal one; it has been incomplete and has not provided what we consider the most permanent and effective help for meeting their present and future problems.

One explanation for the fact that these parents do not have a therapeutic experience could be, of course, that they have decided they do not want such an experience. If this is the case, we cannot and do not want to force them into therapy. They will use the relationship with us therapeutically only if they choose to do so. As I work with these parents, however, I have begun to wonder if they are really being given a chance to make such a choice. Rather, it seems to me, there is something lacking in the experience we are providing them so that they really do not know what a therapeutic experience would be like and hence do not have the knowledge upon which to base a choice.

### Theoretical Basis

In order to determine what it is that seems to be lacking in our experiences with these parents, I believe it would help to step back from it for a moment and examine it in terms of our theoretical framework. According to client-centered theory, as outlined by Rogers (1956, p. 45), the process of therapy has certain characteristic directions which are described in terms of increasing awareness of feelings, fuller and more accurate experiencing of self and environment and consequent reorganization of concept of self. Other descriptions of the process—e.g., Rogers' stages of process (1958); Roth (1959); Rice, Wagstaff, and Butler (1959); Gendlin (1959) and Zimring (1958)—differ slightly, but they all consider movement in the direction of fuller experiencing as movement in the direction of therapy. According to Rogers' statement of theory, there are certain conditions which are both necessary and sufficient for therapy (i.e., the process of therapy will not occur if they do not exist and *will* occur if they do exist). Thus, if therapy does not occur, it can be assumed that all of the conditions do not exist. As stated above, although it has been our intent to provide therapy for the parents we see, we have felt that many of them have not been moving in the directions described above as characteristic of the process of therapy; an observation from which we conclude that therapy has not been occurring in our relationships with them. On the basis of the theory, then, it would seem that some of the conditions necessary for therapy must be lacking. This thought has led me to a further examination of our experiences with the parents. In the following sections of this paper, these experiences will be examined in terms of the necessary and sufficient conditions of therapy, with the aim of determining, if possible, which conditions do and which do not exist. The examination is based entirely upon general observation and recall of our experiences, not a study of data systematically collected.

The conditions necessary for therapy are stated as follows by Rogers (1956):

For therapy to occur it is necessary that these conditions exist.

1. That two persons are in *contact*.

2. That the first person, whom we shall term the client, is in a state of *incongruence*, being *vulnerable*, or *anxious*.
3. That the second person, whom we shall term the therapist, is *congruent* in the *relationship*.
4. That the therapist is *experiencing unconditional positive regard* toward the client.
5. That the therapist is *experiencing* an *empathic* understanding of the client's *internal frame of reference*.
6. That the client *perceives*, to a minimal degree, conditions 4 and 5, the unconditional positive regard of the therapist for him and the empathic understanding of the therapist. (1956, p. 40, [see also 1959, p. 213])

The specific definitions of the underlined terms or phrases are given on pages 17 to 39b of Rogers' paper [1956, see also 1959].

Do these conditions exist in our relationships with parents? In my experience the existence of the first two conditions is quite clear. As with almost all clients, there is at least a minimal contact between therapist and parent from the moment they meet and the parent is either anxious or vulnerable to at least a minimum degree. It seems to me, however, that it is more difficult with most parents than with most other clients to provide an experience in which the remaining four conditions exist. It can be assumed that the client-centered therapist, because of his theoretical orientation, is trying to provide these conditions. Why then is it more difficult with parents? Does the source of the difficulty lie with the therapist, the client, or the particular relationship between them? An examination of each person at the moment they enter the relationship and of their subsequent interaction during the first interview may give us some clues to the difficulties involved.<sup>1</sup>

### ***The Therapist***

First, what is characteristic of the therapist in the relationship? What does he bring to it? On the basis of his experience and theoretical orientation, the therapist enters the relationship with certain assumptions regarding the parent (usually the mother),<sup>2</sup> the relationship between the parent and the child, and the effectiveness of psychotherapy. These assumptions determine, to a large extent, his behavior and attitudes during the relationship. He assumes:

1. That the parent is concerned about the child she has come to discuss and feels at least minimally anxious or vulnerable.
2. That the relationship between the parent and the child has deteriorated or is tending in that direction.
3. That psychotherapy for the parent and the child (and as many other members of the family as possible) will be the most effective means of improving the relationship and thereby helping them meet whatever particular problems they face now and will face in the future.

The therapist is supported in his first two assumptions by the fact that they have been found to hold true, except in rare instances, in all of his clinical experiences with parents. Even when it seems that there is no problem in interpersonal relations (such as a preliminary interview in which a parent requests information about I. Q. tests), it frequently turns out, as in other adult therapy, that the presenting problem is not the "real" concern of the individual.

The support for the third assumption is found in Rogers' theory of therapy (1956, p. 40, [1959, p. 213]) and his theory of interpersonal relationships (1956, p. 76, [1959, pp. 235-244]):

1) an individual can become more congruent through therapy and 2) if one of two individuals in a relationship becomes more congruent, both persons will be more able to communicate with each other and to relate in a more mutually satisfying way. Thus, therapy for either the child or the parent will improve the relationship between them. (In Appendix these assumptions are spelled out more specifically in terms of Rogers' theoretical presentation.) We have found, however, that it is harder for the improvement to take place when the child is the more congruent individual, the one who, by virtue of his greater congruence, theoretically is considered more able to carry the weight of shifting the relationships from a deteriorating one to an improving one. He is more dependent upon the parents—emotionally, socially, physically—than they are upon him and hence less able to effect a radical change in the relationship. Although it is more difficult, this does happen, however. Often the child is more open or ready for therapy than the parent, more free to use the experience once he is immersed in it. Then changes which occur in him seem to free the parent from some of her anxiety and thus enable her to become more open and able to use the experience. The assumption is that whoever is most able to use the therapeutic experience starts the process of improving the relationship. If the opportunity is available for both, then each can proceed at his own pace.

Thus, acting on the basis of the assumptions outlined above, the therapist brings to his relationship with the parent the intent of providing therapy for her, one member of the deteriorating parent-child relationship. He hopes, in this way, to start the process of improving that relationship. In addition, he will be planning to arrange for a similar opportunity for the child and other members of the family.

### ***The Client***

What are the characteristics of the clients in the relationship? What do they bring to it? When we look at the clients, it immediately becomes apparent that they vary considerably in the ways in which they approach the relationship. Each parent has certain assumptions regarding the source of her particular problems and certain expectations regarding the way in which the therapist will help solve them. The assumptions and expectations are not the same for all parents, however. At the moment of entering the relationship, they are alike in that they all feel concerned in some way about a child, are experiencing some degree of threat, are seeking help, and see the Counseling Center as a source of help in some form—expert guidance, information or treatment. Otherwise, however, they are quite different from each other.

In an attempt to specify the ways in which the parents differ, the following descriptive categories were devised. These categories need refinement, but they can serve,

at least for the present, to delineate the major types of assumptions and expectations implicit in the attitudes and behavior which the parents display in their sessions at the Counseling Center. The categories are:

1. The parent views the problem as entirely in the child, unrelated to any feelings or attitudes she may have and creating no anxiety in her other than the relatively external concern about the child. The expectations held by this parent are, then, that the Counseling Center will provide specific information concerning the child's problem (a diagnosis) and ways in which the parent can help the child, plus some kind of treatment which will change the child.

2. The problem lies entirely in the child, but its existence has created a problem for the parent—has aroused anxiety over her inability to help the child and the resultant disruption in the relationship between herself and the child. The parent expects and seeks treatment of the child, information concerning the problem and advice on how to behave toward the child.

3. The problem lies in the relationship between the child and the parent—something has gone amiss and has resulted in unacceptable behavior on the part of the child. This parent is seeking help for herself in relation to the child.

4. The problem lies entirely in the parent, the parent's inner turmoil is causing a difficult relationship for the child and resulting in behavioral signs of disturbance. Usually this parent has already sought therapy for herself and is simply seeking a similar opportunity for a child whom she feels must be affected by her own turmoil.

Upon closer examination of the behaviors from which these categories were derived, it becomes apparent that the differences among the parents are similar to the differences among clients as described by Rogers (1958) and Kirtner and Cartwright (1958). It is not surprising, then, that the parents with whom we have the most difficulty (those in categories 1 and 2 and occasionally 3) are similar to the clients considered difficult ("failure zone" clients) by Kirtner and Cartwright (types Y and Z) and Rogers (those in stages 1 and 2).<sup>3</sup> These are individuals who, as Rogers (1958) says of clients in stage 1, "are not likely to come voluntarily for therapy" (p. 9). These parents, for example, probably would not come to the Center at all if their children were not in trouble.

Rogers (1958) further describes the individuals in these stages of therapy as follows:

Stage 1. The individual has little or no recognition of the ebb and flow of the feeling life within him. The ways in which he construes experience have been set by his past, and are rigidly unaffected by the actualities of the present. He is (to use the terms of Gendlin and Zimring) structure-bound in his manner of experiencing. That is, "he reacts to the situation of now by finding it to be like a past experience and then reacting to that past, feeling *it*?" Differentiation of personal meanings in experience is crude or global, experience being seen largely in black and white terms. He does not communicate himself, but only communicates about externals. He tends to see himself as having no problems, or the problems he recognizes are perceived as entirely external to himself. There is much blockage of internal communication between self and experience. The individual at this

stage is represented by such terms as stasis, fixity, the opposite of flow or change. (1958, pp. 10-11).

Stage 2. ... a slight loosening and flowing of symbolic expression occurs ... (1958, pp. 10-11).

The description of initial in-therapy behavior of clients of types Y and Z by Kirtner and Cartwright (1958), indicate similar characteristics. It is rather disconcerting, then, to discover, when classifying the parents we see according to the four categories above that most of them fall into categories 1 and 2. Thus, we are faced with the fact that most of the time we are working with clients who are at the lower ends of any scale of therapy process. These are the clients with whom, therefore, we might expect to have little success and with whom in our general experience, we find we do, in fact, have the least success.

### ***The Relationship***

Thus we have two persons entering a relationship, a therapist who is intent upon providing a therapeutic experience for the client and a client who, usually, is approaching the relationship in a manner characteristic of individuals with whom we have found it very difficult to form a therapeutic relationship. If we assume (as we shall for this paper) that therapy can and will take place if the "necessary sufficient conditions" exist, then, it seems to me, our problem in working with most parents is to determine how to establish these conditions for individuals who behave (and think and feel) as described above and thus enable them to take the first step in the process of therapy. Anything we can learn from working with these clients should have implications for work with difficult ("failure zone") clients in an adult therapy program.

At this point, then, it seems appropriate to examine carefully the difficulties which seem to arise in relation to the conditions of therapy in the particular situation with which we are concerned—work with parents in a child therapy program. I would like to emphasize, however, that from now on when I refer to parents, I mean those with whom we have difficulty—feel dissatisfied—not all parents who come to the Counseling Center.

As we indicated earlier, the *first* condition necessary for psychotherapy is that the two persons be in contact, and it seems safe to assume that this condition exists, at least to a minimum degree. The parent has voluntarily come to the therapist ready to talk about the problem she sees or feels and so presumably is in contact.

The *second* condition, that the parent is in a state of incongruence, being vulnerable, or anxious, also seems clearly to exist in a parent who has come to the Center regarding a child. The most frequent and obvious state of incongruence is that found in the mother who sees herself as a reasonably "good," "proper" mother who loves her child and is doing her best to bring him up "properly," i.e., to be socially acceptable and reasonably happy and self-sufficient. Then she has the experience of having a child who is in difficulty in school or society or shows signs of unhappiness or stress. He becomes an indicator, in her eyes and the eyes of society, that she must not be a good mother. Then she finds herself feeling anger, resentment, disgust and even hate toward the child. Thus, she is faced with the discrepancy between her view of herself as a "good" mother who loves her child and her experience of herself as a "bad" mother who hates her child. In addition, by the time she comes to the Counseling Center for help, she usually feels very



frustrated and blocked in her attempts to communicate with the child and hence unable to satisfy her desire to love him and be loved by him as well as to be a good mother. Frequently the anxiety touched off by these discrepancies and frustrations she experiences dips into other areas of her self-concept and exposes other discrepancies of which she was heretofore unaware. As a result, she is easily threatened by much of her own behavior and the child's behavior.

It seems to me that difficulties in relation to this condition arise not in terms of its existence, but rather in relation to the degree to which the parent is aware of the discrepancy within herself. Thus, she may see herself as unthreatened and not anxious while the therapist is receiving cues which indicate a discrepancy between herself and experience, i.e., a state of incongruence. From the external point of view, then, we see her as vulnerable. From the internal point of view, then, she sees herself as unthreatened. Frequently the therapist begins to respond to the indicators of anxiety rather than the verbal expression of lack of anxiety, i.e., in terms of an external rather than an internal frame of reference. Sensing, or assuming, that the parent is anxious or threatened, the therapist responds by some recognition of this feeling. Sometimes the anxiety is close enough to awareness so that recognition of or response to it does not surprise the parent. Other times, however, it is deeper and the parent reacts even more defensively to a recognition of it.

For example, sometimes, recognizing the parent's anxiety, the therapist suggests the possibility of psychotherapy for her as well as the child. This action creates a new degree of threat and raises new or stronger defenses on the part of the parent. Often it results in a greater insistence upon treatment of the child and advice and information from the therapist. It may drive the parent out of the relationship completely—remove even a minimal desire for contact with the therapist or the Center.

In the light of this difficulty, then, it seems particularly important that the therapist be sensitive to the degree to which the client is aware of her anxiety—of the discrepancy between her view of her self and her experience. This is a problem we seldom face initially with other clients because they usually come to the Center as the result of some degree of inner turmoil of which they are aware. The parent is coming about someone else and, though usually anxious, can be truly unaware of the fact that her anxiety has anything to do with feelings about herself—she is anxious for or about the child.<sup>4</sup>

What about the *third* condition, the congruence of the therapist? Rogers emphasizes over and over again that the congruence, or genuineness, of the therapist is of utmost importance in the therapeutic relationship. This is a problem area in any therapy program. It seems to me to be a particularly difficult area, in a child therapy program, in relations with both the child and the parents. For the purposes of this paper, we'll examine the experiences with parents only.

It seems to me that the relationship with parents can easily create a number of conflicts within the therapist and hence make it difficult to be congruent (i.e., open to and aware of his experience and his perception of himself, lacking discrepancies between them). For example:

1. One factor which I think creates much difficulty is the fact that the manner in which the parent approaches the relationship and the solution of the problem

is usually quite opposed to the therapist's approach and aims—one sees it as an external problem and the other as an internal one. The irritation caused by this difference in approach is often unrecognized by the therapist who is valiantly trying to "catch the feelings" of the parent who isn't really offering any. This difference in approach may be the result of differences of professional background and training or of personality characteristics, or it may be very deeply rooted in cultural or ethnic background. The therapist, who spends much of his time in "soul-searching," may find it truly difficult to understand a person who never does this and does not consider it an acceptable kind of behavior.

2. Another cause of lack of congruence in the therapist can be a lack of clarity of purpose on his part. If the therapist is not sure just what he considers important in his relationship with the parent and what his goals are in this relationship, it is very easy to get caught up in the external approach—to devote his attention to noting what's wrong in the family, how the different members relate to each other, etc. This gathering of information and impressions can add to the therapist's total understanding of the situation, but it is not likely to provide a therapeutic atmosphere for the parent. The therapist then feels confused as to his goals and is likely to shift back and forth in his approach. Does he want to know more about the parent and the child and the family, or does he want to understand her better? When faced with a parent seeking "expert guidance," it is difficult to admit this confusion to one's awareness.

3. There seems to be a tendency to identify with the child, especially if the parent's behavior is similar to negative behavior on the part of the therapist's parents. Then if feelings of hurt, anger, resentment, rejection are aroused, they come into conflict with the desire, as a therapist, to provide a therapeutic climate for the parent—i.e., to understand, to empathize, to have unconditional positive regard for the person. Under these circumstances, especially when the parent is asking for advice, it is easy to slip into the position of trying to tell the parent how to change her behavior in order to meet the needs of the child. It is also easy, although not as typical, to become identified with the parent against the child.

4. Finally, it seems to me that it is most difficult for a therapist to be congruent in a relationship with any client when his ability as a therapist is frequently threatened. Often, when working with parents, we feel all of the conflicts mentioned above plus the feeling that no therapeutic progress is taking place, we have no sense of movement, of personality or behavioral change in the parent. Under these circumstances I believe it is very easy for the therapist to have a number of feelings to which he is not completely open or of which he is not completely aware—such as anger at the parent, a sense of inadequacy, a feeling of failure as a therapist, a loss of professional identity.

The difficulties met in establishing the *fourth* condition, experiencing unconditional positive regard toward the client, seem closely related to the difficulties of being congruent.

In addition to the effect upon the therapist's congruence, I believe it is difficult to accept fully, without conditions, all of the self-experiences of a person who has an approach to life, to problem-solving, to therapy, to interpersonal relations, which is quite the opposite of my own. For example, I believe it is hard for me to accept fully a mother who assumes absolutely no responsibility for any difficulties in her relations with her

child. However, I also believe that this mother cannot begin to explore the possibility of self-responsibility if I cannot accept her unless she does so, i.e., if such self-exploration is a condition of worth, a condition of my positive regard for her.

A similar difficulty arises in relation to the aims of therapy. If the parent's goal is to obtain information about the child and suggestions as to how to behave in a way which will make the child behave differently and my goal is to facilitate self-exploration and self-experiencing in both the child and the parent, so they can relate better, more openly, to each other, then we are likely to clash in our aims. And, it seems to me, it will be difficult for me to feel unconditional positive regard for the mother. I will want the mother to change her goal or approach. Thus, my positive regard will tend to have certain conditions attached to it.

In addition, just as certain attitudes and kinds of behavior of some parents are likely to touch an area of incongruence in the therapist, so might they also make it difficult to experience unconditional positive regard for that person (e.g., toward a parent who is berating a child or completely intent upon manipulating him).

Another difficulty lies in the fact that often we don't have a constant relationship—it may be fragmentary, frequently interrupted, and entered into reluctantly by the parent. As a result we don't get a chance to know the person and gradually develop a real feeling of unconditional positive regard. I believe we need to know the parent in order to know whether or not we like her and we cannot know her if we seldom see her.

With respect to the *ffth* condition, it seems to me it is particularly difficult to experience empathic understanding of the parent's internal frame of reference when she is focusing on something outside of herself, e.g., the child's behavior. Under these circumstances, we receive minimal cues as to her own feelings, usually accompanied by the attitude that these feelings, although present, are unimportant—it's the child's feelings and behavior that must be considered. Hence any attempt on our part to focus on the parent is distracting, disrupting to the purpose and focus she has and hence can be threatening to her. As a result, it is difficult to know the internal frame of reference, beyond the feeling of concern about the child.

If all the above difficulties have been overcome and conditions *one* through *five* do exist, the *sixth* condition—that the client perceive, at least to a minimal degree, the unconditional positive regard and empathic understanding of the therapist—still may not exist. If such is the case, the difficulty may lie in a lack of expressivity (ability to communicate) on the part of the therapist or a lack of receptivity (ability to draw the proper inferences from the communication) on the part of the parent. Standal (1954) develops this idea more fully in terms of limited ranges of "evocable responses," "expressive signs" and "inferential signs" in both the therapist and the client. Whatever the reasons for our difficulties with this condition, it is clear from our experience, as Rogers states about clients in Stage 2 (1956) that "We seem to know too little about the ways in which a person at this stage may come to experience himself as 'received'" (p.13).

### Overcoming Difficulties

These, then, are the difficulties we experience and some of the possible causes. How can we overcome these difficulties? What changes in attitude and behavior might help us improve our attempts to establish the conditions and hence provide the therapy

for the parent which will in turn improve the total family relationships and thus help provide the individuals involved the most effective means of solving their particular problems?

We have found that the therapist seems to encounter the most difficulty at these points:

1. his own congruence
2. empathic understanding of the parent
3. unconditional positive regard for the parent
4. communication of the latter two qualities to the parent

The fact that we seem to have special difficulty being congruent, suggests that it is particularly important that the therapist be alert to his own feelings and attitudes and examine them carefully and frequently during the relationship. Our usual methods of refining our sensitivity to ourselves and our clients (e.g., self-exploration, discussions with other staff members, listening to recordings) would certainly be helpful in attempting to overcome this particular difficulty, and all the others. However, there are two other methods of overcoming the difficulties which seem especially relevant to me under these particular circumstances:

1. a clear recognition, by the therapist, of his own beliefs and goals with respect to the relationship, and
2. more active participation than usual on the part of the therapist.

I'd like to spell out these ideas a bit more in the following paragraphs.

If the therapist is aware of his own beliefs and goals, it seems to me that he is less likely to be thrown into conflict and threatened by the attitudes of the parent and hence more likely to be more congruent, to experience more unconditional positive regard for and more empathic understanding of the parent. Thus, he can be free to meet the parent fully and openly, not becoming confused by differences between his own point of view and hers. He is able to enter the relationship wherever the parent happens to be, providing a real encounter with a person who is as genuine as possible in the relationship and, being free of his own confusions, is able to listen to the other person.<sup>5</sup> I believe that a consideration of basic assumptions within a theoretical framework, such as I have tried to do in this paper, can help clarify the therapist's point of view and thus enable him to be more sensitive to and aware of himself and the parent.

Once the therapist has clearly recognized his own beliefs and goals, then he can devote his efforts to participating in ways which make it possible for the parent to feel "received" (understood, liked). I believe this participation needs to be more active than usual. One way for it to be more active is for the therapist to concentrate upon increasing his expressivity, upon activities which stimulate expressive behavior in the client. (This kind of participation is being considered more fully by Rice, Wagstaff and Butler, and by Zimring.) Another way, which will be developed in this paper, is for the therapist to act, to do something with the parent, in terms of his view of her particular frame of reference, rather than simply to respond verbally to her feelings.

We are trying to understand and then to communicate our understanding in a way which will penetrate. With persons at the early stages in the process of therapy, it seems to me that, in addition to the problems involved in the establishment of conditions 3, 4, and 5, it is necessary to apply extra effort to the communication of these conditions to the client. It's as if we have to say it more loudly, more frequently and in many different ways. (In line with this thought, I think it holds that actions speak louder than words.)

When working with a child, we often demonstrate our understanding by participating, by acting or talking in terms of the child's manner of communication (usually in acting out, symbolic, fantasy-laden type of behavior). The appropriateness or lack of appropriateness of our interaction or participation conveys our understanding or acceptance, or lack of it, not our words. The child is living, experiencing, a relationship, not examining it. Perhaps adults at Stages 1 and 2 are more like the children in this way and what is needed in order to enable them to move toward more freedom to experience their feelings is doing something with them.<sup>6</sup> I think this idea needs further development and thought. We need to consider more fully what we mean or what we are doing when we say we are "acting with" rather than "talking to" the child. We don't become children, we don't completely enter their world, but we do try to enter, to experience something with them while keeping one foot in our own world. We seem to move in and out with a child. In addition, we "stay with" him while he experiences his own feelings.

Similarly, when working with parents, especially parents who have indicated they do not wish to examine their own feelings or attitudes or their relationship with the child, it seems to me we can try to enter their world in some way, to see things the way they are seeing them, to "meet them where they are." For example, in order to experience empathic understanding of the parent, the therapist must understand all of the parent's feelings, not just her feelings toward herself. The parent's main feeling, usually, is concern about the child and a sense of need for some kind of advice, help, information. Under these circumstances, a willingness to look at the problem with her from her point of view, to enter her frame of reference, is, I believe, a better demonstration of our understanding than any attempt to focus on her feelings—usually unexpressed or at least unintentionally or only incidentally revealed. The therapist might, for example, discuss with the parent the child and his particular problem areas, or general aspects of child development, or child rearing practices in general. He would enter the discussion as a participant, expressing his own ideas, giving information if it seemed relevant, etc. However, he would also be focusing upon understanding the way the parent sees and understands the child or the situation and upon leaving the parent free to bring in more of her own feelings and attitudes. His aim would be to demonstrate more clearly his understanding of and positive regard for her, while maintaining his own belief in the value of self-exploration and self-experiencing. In fact, the therapist would be encouraging self-exploration and experiencing of feelings, but not insisting upon this activity on the part of the parent and not ignoring other aspects of the interaction.

Actually, what we would be doing, I believe, is demonstrating our understanding by acting in terms of it, rather than relying upon verbal communication of it. The two practices which are fairly well-established policies in our present work with parents are, I believe, attempts to carry out this idea—we see the parent first, and we maintain some kind of contact with the parent (or parents) while the child is in therapy. The kind of contact depends upon the therapist's understanding of the parent's approach to the

relationship. It is the therapist's belief that some contact is necessary and therefore this is insisted upon. It need not be therapy, however. One kind of contact which we have not used much, but believe would be useful, is parent groups. Parents could enter these groups at any level they wished—to consider their own feelings and attitudes, to seek information about stages of development in a child, to find out what other parents experience, etc.

The arrangement of therapy for the child is also an example of participation in terms of the parent's frame of reference. The parent comes in focusing upon the child as the problem. The therapist sees or senses the parent's involvement and concern about the child and acts in terms of an understanding of it by arranging therapy for the child. The degree to which the parent is aware of her feelings determines the degree to which the therapist immediately responds to them while acting in terms of the stated focus—help for the child.

All of this participation, as stated before, requires that the therapist be very sure of his own goals and purposes, willing to discuss and participate in the parent's way of doing things, the external approach, but not completely bound by it. The assumption is that the process of therapy will emerge naturally, self-exploration will start, if the parent really feels understood and accepted—i.e., if the conditions of therapy are really established.

### **Conclusion**

Thus, we have explored the way in which the therapist and the parent approach therapy (the initial interview), the difficulties which arise and some suggested ways of overcoming these difficulties. I have further intimated that all of these considerations have triplications for therapy with the so-called difficult ("failure zone") clients (Types Y and Z, Stages 1 and 2) and might be explored further in relation to them.

In order to take these comments out of the realm of conjecture, we need to test these impressions by a systematic examination of preliminary interviews and other sessions with parents. For example, I would like to know, with reference to specific interviews or series of sessions:

1. Do the actual statements of both client and therapist in the preliminary interviews provide concrete evidence for the statements I have made concerning their approach to the first interview—their assumptions and goals? Do the descriptive categories of parent behavior derived from my over-all impressions and found to be similar to the descriptions of the behavior of other adult clients (by Rogers, Roth, Kirtner, and Cartwright) fit the actual behavior of specific parents in specific interviews?

2. Is therapy occurring? Is the parent moving in certain directions characteristic of the process of therapy? The process scales and descriptive categories being developed by several researchers in the area of client-centered therapy should be useful in considering this question.

3. If therapy is not occurring, is there evidence that certain of the necessary conditions are lacking? If so, which? What is the evidence?

4. Does the experience of therapy, if it occurs, for child and parent, or either one, result in an improved relationship between them *and* solution of the particular presenting problem or problems?

5. Is more "participativeness" on the part of the therapist (as described in this paper) actually related to the establishment of the conditions of therapy?

In other words, can the assumptions, hunches [and] hypotheses, presented on an intuitive level in this paper be verified by reference to the data, to actual interviews with parents? Thus, the next step with respect to this aspect of a child therapy program is to return to the data and examine it more rigorously.

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## Endnotes

<sup>1</sup>In interviews with parents in a Child Therapy Program the preliminary interview usually is equivalent to the first interview with other adults. This is the case because the preliminary interview invariably involves the beginning of the therapeutic relationship with the parent, as well as "business" arrangements. I believe the structure and use of this first contact with the parents also bears investigation—some other time.

<sup>2</sup>Usually it is the mother who comes to the Center and with whom I form a relationship. Therefore, hereafter, for the sake of clarity in presentation, I shall use the term parent to refer to the mother, unless otherwise indicated. It is not my intent, however, to ignore the fathers or other significant persons in the family. The problems faced in relation to them are very similar.

<sup>3</sup>The only difficulty we have with parents in category 4 is that sometimes the parent is inclined to assume all the responsibility for the existing situation and fail to recognize the part contributed by the child in the interpersonal interactions. However, we seem much more able to help the person who internalizes, takes too much responsibility, than the one who externalizes, takes too little responsibility.

<sup>4</sup>It is possible, of course, that no discrepancy exists within the parent. If such is the case, neither the therapist nor the parent will be aware of any and the focus will be entirely upon the child. Under the circumstances, such a state of complete congruence is difficult to imagine, however.

<sup>5</sup>In fact, it seems to me that this situation calls for a deep sense of commitment in two directions: first, toward the parent—a real willingness to stay with the parent wherever she goes (including a choice not to enter therapy) and, second, toward the process of therapy—a real belief that there is order in the process and that, at least until proven otherwise, in the long run it will provide the help the parent is seeking. However, we should remain aware that some parents may not wish to change, nor to examine their own attitudes and feelings. A person has a right not to be fully functioning—even if it is detrimental to the mental health of the child. We can then simply try to give the child the opportunity to become more fully functioning and hence more able to cope with the parent.

<sup>6</sup>This certainly is not a new idea: see the many discussions in the literature of therapy with adolescents and with "the reluctant client."

## Appendix

### ***Theoretical Bases for the Therapist's Assumption that Therapy for the Individuals Involved is Most Effective for Improving Interpersonal Relationships***

The parent who comes in for an interview is concerned (usually) about a disruption of some kind in interpersonal relations within a family or between members of the family and persons outside. Whether the emphasis is upon internal (intrafamily) or external (extrafamily) disruption, there is almost always a feeling of concern over the relationship between the parent and child—even if limited to one specific area. Thus, the relationship is a deteriorating one rather than an improving one and the parent wants to



change it to an improving one (in order to help the child, the rest of the family and herself).

1. According to Rogers' (1956, pp. 76-80, [see also 1959, pp. 235-244]) theory of interpersonal relations and the theory of therapy as applied to family life, the following conditions are necessary in order for a relationship between a parent and child to change from a deteriorating one to an improving one:
  - a. The parent must be willing to be and be at least minimally in contact with the child and to receive communication from him.
  - b. The child must be willing to be and be at least minimally in contact with the parent and to receive communication from her.
  - c. Either parent or child must have enough unconditional self-regard and congruence to meet the other in a "helpful" way, at least in the areas of stress and misunderstanding.
    - 1) The more the parent experiences unconditional self-regard, the more she will be congruent (genuine) in her relationship with the child, the more she will experience unconditional positive regard toward the child and the more she will empathically and realistically understand the child's internal frame of reference.
    - 2) The more this condition (1) exists, the fewer conditions of worth the child will experience, the more able he will be to live in terms of a continuing organismic valuing process and therefore the more congruent he will be and the more unconditional self-regard he will have.
    - 3) The more (2) exists, the more the child will be congruent in his relationship with the parent (et al.), the more he will experience unconditional positive regard for the parent (et al.) and the more realistically and empathically he will understand the parent's internal frame of reference.
    - 4) The more (3) exists, the more (1) will exist. Thus, the relationship will be an improving one.
2. According to the theory of therapy, conditions a, b, and c described above can be established by means of a therapy experience for one or more of the individuals involved.