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# How Can I Put Parenting On Hold?

## *Is it possible to successfully engage in a "double journey" of concurrent individual and parenting therapeutic work?*

**Bev George**

This was the key issue raised by a parent sitting with me and her psychologist in a Community Mental Health Centre (CMHC) office in late 2013. As a member of a Children of Parents with Mental Illness (COPMI) team, based in an Auckland Child and Adolescent Mental Health Service (CAMHS), I was meeting with a mother I will call Elizabeth. We were discussing her parenting goals, possible avenues of parenting work, and the timing of this given her current personal therapeutic journey which included eye movement desensitization and reprocessing (EMDR) for devastating relational experiences in childhood and in her early adult years. Elizabeth is an intelligent, caring single parent who wanted to work on her own well-being as well as be the most sensitive and responsive parent she could be. Did she have enough internal resources and external support to engage concurrently in therapeutic work for herself as an individual, and parenting work for her daughter, then 6 years of age, whom I'll call Jenny? While acknowledging the challenge of engaging in both simultaneously, her response essentially was "How can I put parenting on hold?"

This is a question faced by many parents with mental illness and their mental health clinicians. In this article I will discuss how Elizabeth, her psychologist, and I worked together to support this double journey. In doing so, I make five main points: Firstly, to highlight how important it is to take into consideration the parenting role of all adult clients we see in our offices. Secondly, I will refer to Hosman, van Doesum, and van Santvoort's (2009) multi-component developmental model as a useful delineation of relevant factors to consider when contemplating the feasibility of the double journey. Thirdly, I describe Elizabeth's parenting journey and the two main parenting approaches I took to support her. Fourthly, the factors that, for Elizabeth, made this double journey possible. Finally, I will discuss the reciprocal benefits of a double journey to both the individual and the parenting work.

### Is my client a parent and how is this currently working out for him/her and his/her children?

This may sound obvious, but anyone who is a parent knows how children add both delight and demands to our lives, and tend to push the very buttons we've tried to conceal through the years. Mothers, especially of young children, are at risk for mental illness, particularly depression and anxiety; especially if they have insufficient social support and financial and healthcare resources (Mistry, Stevens, Sareen, De Vogli, & Halfon, 2007). Parental mental illness, in turn, increases child and adolescent risk of developing psychological problems. Some studies indicate this risk to be as high as 50% (van Loon, van de Ven, van Doesum, Witteman, & Hosman, 2013) with higher risk being associated with an unhealthy balance between risk and protective factors (Hosman et al., 2009). Child internalizing and externalizing difficulties can then add further challenge to the parenting task. So consideration of your client's parenting role and parenting stress and satisfaction is a crucial component of their treatment, and is an opportunity for prevention/early intervention for their children. Unfortunately, research has indicated that children in New Zealand, Australia, the US, and Sweden perceive that their parents'

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mental health professionals fail to give adequate attention and support to them (Hosman et al., 2009).

**Factors to consider when contemplating the double journey**

So, after discovering that your client is struggling with his/her parenting role and would like support for this, as well as continuing with their own personal therapy, how do you decide if they have capacity for the double journey? The multi-component developmental model of inter-generational transmission and prevention of mental illness summarizes the last two decades of COPMI research (Hosman et al., 2009). It also provides a useful delineation of personal, familial, and contextual factors to consider when discussing this issue with a client who wants to undertake the double journey. Factors to discuss include your client's current resources, supports, and challenges:

- *Parental factors:* the nature of a parent's mental illness and its impact on his/her present life, illness chronicity, and current coping and parenting skills.
- *Familial factors:* the presence or absence of another parent; relational support or discord; family life events, income, and stability; and, the other parent's well-being, parenting skills, knowledge of their partner's mental illness and support needs.
- *Child factors:* the number of children; the child/ren's temperament, stress reactivity, age (sensitive periods), and gender; quality of attachment, parentification; cognitive and social skills; understanding of their parent's mental illness; self-esteem and resilience; mental well-being, and perceived supports.
- *Social network and professional care factors:* the level of social support versus isolation and stigmatisation amongst family, neighbours, friends, and school; and, the availability and quality of professional care.
- *Parent-child interactions:* the level of parental involvement, sensitivity, hostility and rejection, abuse and neglect; and, the child/ren's response and problem behaviours.

I would like to add to Hosman et al.'s (2009) list another critical factor to consider; namely the feasibility and nature of the possible *collaboration* between yourself, as your client's individual therapist, and the parenting specialist. Parenting work is likely to raise issues about responding to a child's needs that may trigger difficult emotions regarding your client's own family of origin experiences. Therefore, a careful collaboration between therapists is essential to support your client with this double journey. Fraiberg, Adelson, and Shapiro (1990) described these experiences as *ghosts in the nursery*. They may include traumatic memories, interpersonal scripts and expectations (internal working models of relationship) that come to play in the client's parenting and in other relationships. In my view, the exploration of these relational models is usefully supported by both individual and parenting therapists, and there may be benefit in the concurrent analysis from two different angles (individual work and parenting work) *if* the client is sufficiently resourced and supported, and *if* there is good conceptual match and communication between therapists.

**Elizabeth's double journey**

Consideration of resources, supports, and challenges in Elizabeth's case resulted in a positive balance. Here was a single, educated, working mother with parental and sibling support, and a good relationship with her CMHC psychologist. Jenny's dad was geographically absent, and his periodic contact was confusing and distressing for Jenny. Elizabeth had sought professional support for Jenny on two previous occasions, but was experiencing Jenny's emotional sensitivity and oppositional behaviour to be challenging. Elizabeth had a

rich innate and acquired knowledge of parenting, yet was uncertain how to respond in specific parenting situations. Elizabeth was clear that she wanted a *dyadic* intervention; she wanted to be seen with her daughter rather than having them receive separate and compartmentalised work such as they'd previously experienced (play therapy and parenting guidance). Following Elizabeth's clearly stated need, I offered to her and Jenny parent-child interaction therapy (PCIT).

PCIT[1] is an evidence-based behavioural parent training programme for 2.5–7 year olds that works to enhance parent-child relationships and assists parents in reducing children's oppositional behaviours through intensive didactic live parental coaching by means of a bug-in-the-ear microphone and a one-way mirror (McNeil & Hembree-Kigin, 2011). It was developed by Sheila Eyberg in the 1980s and has been adopted and adapted for various clinical populations. The strongest evidence is for behavioural disorders, but there is increasing evidence for anxiety, post-traumatic reactions, abuse and neglect, and the autistic spectrum. It requires an intensive commitment from parents as it involves weekly sessions of 1–1.5 hours of live coaching of parent-child play interactions in the clinic, and 5–10 minutes of play homework each night.

The first stage of PCIT, child directed interaction (CDI), works on relational enhancement. Parents are taught to sensitively follow their child's lead and respond with therapeutic statements including labelled praise (e.g., "I love how you are concentrating so well on that drawing."), reflections (reflecting back or paraphrasing what the child says), and behavioural descriptions (e.g., "You're drawing headphones on your duck!"). Parents are coached to avoid all statements that direct the child's play including questions (e.g., "What's your duck's name?), commands ("Let's draw your duck a pond!"), and negative statements which can range from sarcasm to more subtle criticism (e.g., "I don't think that pond's deep enough for your duck!"). Ignoring is coached for mildly annoying behaviours (e.g., whining).

The second stage of PCIT, parent-directed interaction (PDI) increases child compliance through coaching parents in effective command-giving and consequences (either labelled praise or a time-out sequence using a specific script and a flow-chart of response-dependent consequences). Apart from the CDI and PDI didactic teaching sessions which are attended by parents alone, all other sessions are coached parent-child play sessions.

Progress is monitored through a weekly 36-item parental questionnaire regarding behaviour difficulties (the Eyberg Child Behaviour Checklist, ECBI; Eyberg & Pincus, 1999), and coded observations of parent-child behaviour with an observational coding (Dyadic Parent-Child Interaction Coding System, DPICS; Eyber, Nelson, Ginn, Bhuiyan, & Boggs, 2013) which codes parenting skills and child compliance. Progression through the programme is determined by achieving mastery of parenting skills in the CDI, then PDI phases, and reductions of child behaviours on the ECBI to below 114. PCIT is typically considered indicated when initial ECBI scores are above 131.

In early 2014, Elizabeth decided that she could commit to this rigorous parenting programme in addition to her weekly sessions with her CMHC psychologist. Elizabeth's depressive and post-traumatic symptoms had reduced to moderate levels. She had a useful medication regime, and had decided she was sufficiently resourced to focus on her parenting. It was agreed that Elizabeth, her individual psychologist, and I

[1] There are about forty clinicians trained in PCIT in New Zealand and training is available locally. Tania Cargo is the Regional Coordinator for PCIT Aotearoa-New Zealand and Caryn Trent is the Supervision Coordinator.

would touch base throughout our concurrent work with Elizabeth to ensure that we remained sensitive to periods of high stress in either aspect of her therapeutic work. In February 2014, Elizabeth and Jenny came in for their baseline assessment — a 20-minute video-taped play session in which Elizabeth was instructed to let Jenny lead for the first 10 minutes, Elizabeth should take the lead for the next 5 minutes, and Elizabeth should instruct Jenny to clean up the toys for the last 5 minutes. I observed from behind the one-way mirror and coded the interactions. The toys presented for this and future play sessions included Mr. Potato Head, a farm scene, a play garage and cars, blocks, play food, and art supplies. Elizabeth and Jenny undertook their play with these items with great grace, submitting themselves to this unusual environment in which both knew their interactions were being observed, recorded, and evaluated. Jenny's baseline ECBI was 142, above the clinical cut-off for PCIT.

Over the past several months, I have been privileged to witness the interactions between this mother-daughter dyad and to witness their individual and dyadic strengths and difficulties. I have seen Elizabeth reach "mastery" levels in CDI and PDI skills, problem-solve how to implement them at home, tie them in to house rules, play dates, and public behaviour. I have learned about the extra-dyad stressors which raised ECBI ratings in the early part of the program, and seen Elizabeth apply the CDI skills to support her daughter through these difficult times. I have had communications from Elizabeth's psychologist, informing me of periods of intense individual therapy where Elizabeth's capacity to implement the rigorous play homework has been somewhat reduced, and we needed to adjust expectations slightly. What I have seen throughout is a loving mother determined to do the best for her child and herself, and being rewarded with a drop in ECBI scores to subclinical levels (113), and with a more relaxed and open relationship with her daughter in which Jenny can more directly show her feelings and express her needs.

It is difficult for me to talk about Elizabeth's parenting journey without reference to the *circle of security* parenting model (Powell, Cooper, Hoffman & Marvin, 2013). This conceptual model of parenting describes a circle in which the parent (metaphorically indicated by a graphic of the parent's hands) is the secure base from which a child can go out to explore the world. The parent's job at this point on the "circle" is to support the child's exploration by watching over the child, delighting in the child, enjoying with the child, and helping the child. When the child needs to stop exploring and needs physical or emotional support, the parent's role is to welcome the child's return and to provide a safe haven by means of protecting, comforting, and delighting in the child and helping to organize their feelings (i.e., supporting emotional regulation by soothing and labelling emotions and sensations that the child is experiencing). Thus the circle of security is completed. The child is supported to go out and explore the world and they are helped to come back in for comfort and emotional support; they come full circle to their parent's hands. With repeated experiences of this circle, a child develops a secure attachment and can be both autonomous and connected, and able to express their feelings and needs in direct and healthy ways. The circle of security's mantra is to be a "Bigger, Stronger, Wiser and Kind" parent and "whenever possible, follow the child's need; whenever necessary, take charge."

In addition to working her way through the behavioural elements and specific skills of PCIT, Elizabeth and I had periodic one-to-one sessions to discuss what had occurred in the PCIT dyadic play sessions and at home. This provided opportunity for Elizabeth to discover and discuss how and where Jenny was presenting needs on the circle of security and which PCIT skills were being

called for at that moment. The CDI skills provided Elizabeth with reassurance that she was doing enough to support Jenny in her distress by simply being emotionally present, reflecting and paraphrasing Jenny's voiced experience, and describing what she saw Jenny experiencing. The PDI skills allowed Elizabeth to take charge immediately and calmly in a Bigger, Stronger, Wiser and Kind way when Jenny's behaviour became dysregulated; it allowed the dyad to put a boundary around acting out emotions negatively, and to invite a direct discussion of Jenny's emotions and support needs which Elizabeth could then meet. In this way, the circle of security conceptual model provided an understanding of the required moment-to-moment parental response, and PCIT provided the necessary parental skills to meet these needs.

PCIT also provided me with an opportunity in the live PCIT skills coaching to be a "secure base" or "hands on the Circle" for Elizabeth. Through the bug-in-the ear I was able to be with Elizabeth, encourage and support her to try out and master specific parenting skills, as well as to reflect her experience and stay with her in her experience of the strong emotions that naturally arose as she worked to develop certain parental responses that she did not consistently receive as a child (the ghosts in the nursery experiences).

**What made this double journey possible for Elizabeth at this particular time?**

As for my original question as to whether Elizabeth could, at this particular moment in her life, engage in both her individual therapy and parenting work concurrently, the answer for her was yes. The factors that I believe made this possible included, on Elizabeth's part, her capacity to mentalise and to reflect on her own emotions, thoughts, and urges while also holding her daughter's needs in mind; her willingness to work with the ghosts in the nursery; her cognitive strengths and coping skills; her resiliency and strong commitment to being the best mother she could be; and, her ability to be vulnerable and trust her two psychologists in this double journey. Supportive familial and contextual factors that may have contributed to the successful double journey included: Elizabeth's familial and friendship supports; a secure and stable work and living environment; and, Jenny's resiliency and responsiveness to the intervention. As far as the contribution of her CMHC psychologist and my own work with Elizabeth, I believe it was our coordinated effort (in terms of on-going communication before and during the double journey, and our compatible models of working with Elizabeth) and the strength of our individual relationships with Elizabeth that were most beneficial. I think Elizabeth summed this up beautifully by saying about us — "I now have two sets of hands on *my* circle!"

**Can the double journey add reciprocal benefit to both the individual and parenting work?**

I believe it can in the right circumstances, and I'll let Elizabeth have the last word on this! After reading a draft of this article, she named how mutually enhancing the concurrent individual and parenting work were to each other. Specifically she reported four major gains including:

- "Improving the effectiveness of my parenting has … made things at home easier when I am going through particularly traumatic personal work;
- I can relax to a point knowing that while my head may be muddled with painful memories, I have someone (you) watching out for Jenny's mental and emotional wellbeing throughout this journey;
- Dealing with the ghosts in the nursery with you has given me another way to access childhood traumas that may not have necessarily surfaced in my individual work; and,
- Having [individual therapist] has enabled me to work through my

> ghosts faster … so they don't negatively impact my parenting of Jenny."

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