

POST-DIVORCE THERAPY WITH HIGHLY CONFLICTED FAMILIES

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Children's responses to parental divorce have been the focus of many recent research efforts. Symptom patterns of anxiety, depression, and behavioral problems have significant effects on children's academic achievement and social adjustment for six months to one year after the divorce. The longer-term effects, measured five years post-divorce, show approximately one-third of the children continuing to be affected at school, at home, and interpersonally. Many factors have been identified as contributing to children's post-divorce problems including the child's sex, parental coping styles, financial and social stability, and the structure of custody and visitation (Fry and Addington, 1985).

Current literature allows for the categorization of a child's chronic poor post-divorce adjustment based upon whether a non-custodial or non-residential parent is (1) semi-absent, (2) rejected, (3) dysfunctional, (4) or whether both parents are anxiously or hostilely engaged. Clinically these issues have strong roots and pre-existing family dynamics but they also have current strong family dynamic issues, so that there really exists a post-divorce "ghost" family.

Semi-Absent Parent

The semi-absent parent visits erratically with the children. The pre-divorce parent-child relationship may have varied in quality but was not, truly dysfunctional. This semi-absent parent typically withdraws from involvement with the child. Financial disengagement is often associated with the semi-absent parent. The residential parent responds to the semi-absent parent typically with anger and unconscious dependency represented by a failure to assume responsibility for financial concerns and a failure to take responsibility for the child's time and relationship with the semi-absent parent. Ambivalence, projection and denial are transmitted to the child in such phrases as, "Your father (or mother) really loves you but ..." In turn, the child frequently responds with ambivalence towards the semi-absent parent, fantasy about the marriage, confusion and guilt (Benedek & Benedek, 1977), (Hetherington, et al, 1979) about double bind messages given by both parents.

Rejected Parents

Some children actively reject a parent. An alliance is often, but not always, developed with the emotionally weaker parent against the stronger parent. The child's symptom pattern has markedly hysterical and phobic features. The quality of the child's rejection of the nonresidential parent differs from the child's reaction to clearly dysfunctional parents in at least two ways: the rejection is not based upon objectively noted parental dysfunction such as abuse, alcoholism,

neglect, or mental disturbance; the child lacks the conscious ambivalent feelings normally seen in a child raised by dysfunctional parents. Wallerstein & Kelly (1980) observed that latency-age children exhibited these symptoms and that symptoms frequently eased with independence of judgement which adolescence brought, leading then to a rapprochement between the now adolescent and the previously rejected parent.

Dysfunctional Parent

Some 20 percent of all non-custodial parents, usually fathers, are significantly dysfunctional (Wallerstein, et al, 1980). They are physically abusive to wives or children, sexually abusive to children, alcoholic, drug abusing, or seriously emotionally disturbed. When these parents substantially decrease involvement post-divorce, the children tend to do better. When these parents remain actively and routinely involved in the child's life, special precautions are often required to attenuate the negative effects on the child. Of the possible dysfunctions, incest is a substantial issue. (Benedek & Schetky 1977) note that accusations of sexual abuse in child custody cases have risen markedly. The child's relationship with the paternal abuser may be marked with ambivalence (Rashkis & Capers, 1984). In keeping with current thought (Dixen & Jenkins, 1981), multicomponent treatment packages including conjoint or family therapy, visitation, or even reunification are frequently proposed for both intact families and divorced families.

Hostile Parent

Anxiously or hostilely engaged parents may be the sole or primary parent, the non-residential parent, or even engaged in joint parenting. These anxious or hostile parents have not successfully separated and remain, instead, actively engaged in the divorce process with issues of distrust, overinvolvement in the ex-spouse's life, and overinvolvement in the ex-spouse's parenting. High degrees of conflict during custody settlements and relitigation are also hallmarks of these families. The child's particular needs are ignored and the child is most often viewed as a possession which is not being adequately shared or surrendered by the ex-spouse (Fry, et al, 1985). The child frequently responds with consciously expressed attachment and, especially in latency and adolescence, with the verbalized desire to "be fair." Anxiety is unconsciously expressed in school deterioration, and symptoms such as classic separation anxiety, clinging, and regressive behaviors.

As Steinman (1985) states: "It is difficult to assess during the initial post-separation crisis, when parental functioning may be at its lowest point, whether the fear, anger, and distortion will diminish over time, or whether the parents are likely to remain enmeshed in a hostile, punitive relationship with the child acting as the vehicle for punishment" (p.95). The following study was undertaken to evaluate what methods of therapeutic intervention could be effected within a private practice, sole practitioner setting to assist chronically conflicted families in dealing with their issues. It was hypothesized that intensive efforts towards working with families could assist them in alleviating children's difficulties.

METHOD

Participants:

The participants were is consecutively referred families from the urban areas of San Bernardino and Riverside Counties in California. Ages of the children ranged from 22 months to 18 years. Of the 18 families, 16 had only children, 2 had same sex sibling pairs. The child's symptoms had been in existence for more than six months.

Subject Analysis:

Case records were reviewed to determine whether the families fell into the criteria of semi-absent, rejected, hostile or anxious, or dysfunctional. Of the subject families, 5 fell into the category of semi-absent parent. Six families, representing 7 children, fell into the category of rejected parent. Families in which anxious or hostile parenting was an issue were families with younger children, from approximately two years of age to approximately seven years of age: Four families fell into this category. Three clients were referred for issues of dysfunctional parenting. All three situations involved allegations of sexual abuse. In all three instances the fathers adamantly denied improper sexual advances to the child, there was no physical evidence to support the allegations, but the child adamantly maintained that the father had at least fondled them.

Intervention Strategies:

Problem focused intervention strategies were developed for each of the four categories.

Semi-Absent Parents:

With the residential or primary parent, efforts were made to increase that parent's sense of power and control over the custody situation. Often this involved assisting the parents in understanding the nature of the child custody orders with regard to visitation and encouraging the parent to regularize and control visitation schedules. Specific recommendations were frequently made to parents for immediate backup plans for the child in the event that the semi-absent parent again failed to make a visitation. For children and parents who were latency age and up, parents were encouraged to empathize with the child's sense of betrayal without offering excuses to the child for tile parent's absence. The therapist would frequently assist the parent in actually scripting the information which the patent needed to share with the child regarding the semi-absent parent. This was designed to help the child clarify the reasons for the parental divorce and to assist the child in recognizing that the semi-absent parent's behavior was not the result of any behavior on the part of the child. In the family sessions the child was encouraged to express his fantasies about the divorce situation to the primary parent.

Rejected Parent:

The therapist in working with issues of a rejected parent tried two different therapeutic approaches. In both, the therapeutic approach was to treat the parental rejection as a phobia with

hysterical features. First, desensitizing cognitive and behavioral methods of dealing with phobias were promoted within the therapy session. The therapy sessions were typically individual therapy sessions with the rejecting child followed by introducing the rejected parent, debriefing the child subsequent to the introduction of the parent, and then gradually increasing the involvement between the child and the parent both in therapy and also outside the therapy session. Because of the strong collusive elements between mother and child, mother was also involved in individual and joint therapy sessions with the child. Strong, directive efforts to control mother's anxiety about the child's interactions with the rejected parent were a predominant part of the individual therapy efforts made with the mother. In addition,, family sessions with mother, father, and rejecting child were frequently held so that the therapist could assist both parents in scripting cognitive interventions with the child and reducing both verbal and non-verbal collusive behaviors. Family sessions also allowed the therapist to ascertain the role of the rejected parent in maintaining the behavior of the child. The rejected parent was also seen in individual therapy to work on any of his/her behaviors or attitudes which maintained the rejection of the child.

A second method of working with the parent rejecting child was also developed. This method is consistent with the "flooding" technique. The rejecting child was placed for an extended period of time, from six weeks to two months, with the rejected parent. The child was seen at least weekly for individual therapy and family therapy with the rejected parent, combined. Strong, directive interventions were made with the child initially to control the increase in phobic and hysterical symptoms. Continued work on an as-needed basis was also done with the primary parent to contain his/her anxiety, give him/her appropriate feedback as to the child's well-being, and reduce his/her conscious or unconscious efforts to increase collusive behavior with the child. Continued individual and joint therapy efforts were made on a weekly basis after the child was returned to the primary parent to contain the parental anxiety and hostility so that a routine pattern of visitation could be continued.

Hostile and anxious problems were treated in a combination of individual therapy for the child and family sessions involving the child and both parents. In addition, parents were seen together for a minimum of five sessions to continue work on mediation efforts. The mediation efforts between the parents focused on assisting the parents in drafting or redrafting custody arrangements. The traditional mediation approach was not, however, taken because of the highly conflictual issues which remained from the divorce situation itself. Instead, a family systems approach to couples therapy was intermingled with the goals of mediation. The therapist worked towards developing in each parent a sense of basic respect and trust for one another as parents, a capacity to tolerate existing differences, and a capacity to let go and not interfere in the other parent-child relationship. Mediation efforts were focused on the parental capacity to suppress anger and divert it away from the children and maintain a "conflict-free sphere" around the children. Other goals, consistent with those in Steinman (1965) were seen as important, but secondary issues. The therapist frequently required both parents to make overt, planful statements with regard to the child and encouraged both parents to actively participate in the child's individual therapy, often requesting that each absorb half the cost and half of the transportation. In this way, the therapist attempted to increase the sense of parity that each had with the other and consistently reinforced a neutral role. The therapist also rapidly disengaged parents from a covert attempt to rework the existing custody agreement. The therapist attempted

to remain neutral with regard to the values that each parent brought into the parenting situation, whenever possible.

In individual therapy with the child, the therapist used traditional interventions. The therapist did not attempt to draw the child's attention back to the parental conflict but, instead, in a problem-oriented fashion drew the child's attention to arenas such as school and peer activities. The therapist also routinely diffused the child's sense of responsibility in the family situation by noting to the child that the parent, Judge, and Mental Health professionals had already determined what the plan would be for the child. The therapist also attempted to help the child with his/her cognitive rigidity; eg., the concept of "fairness," to increase the child's sense of being able to flexibly meet his or her own needs.

The dysfunctional fathers seen were referred exclusively because of allegations of sexual abuse. In these instances, the evidence was not clear cut. Also, two of the three children exhibited classic ambivalence with regard to the father. In all instances, mediated visits in the presence of the therapist, parental guidance, psychotherapy for the parent and additional supervised visitation by a third party were formulated as part of the treatment plan. The therapist began first by carefully assessing whether the primary parent was vindictive and tending to try to fortify his case would otherwise exacerbate an already difficult situation. Under those situations "attempts at reconciliation with the other parent may cause the child to feel disloyal and vulnerable ... the clinician must weigh whether serving the child's relationship with the non-custodial parent is worth the trauma to the child that surrounds visitation" (Benedek and Schetky, 1985). Mediated joint therapy sessions between the child and the father were then put into effect. The father was given specific directions by the therapist as to how to handle the child's anger and the child's accusations with regard to sexual abuse. Even when the father adamantly denied the allegations of sexual abuse as was the case in all of these instances, the therapist advised that blatant, argumentative denial on the part of the father would not further the parent-child relationship. The father was assisted, in individual therapy, in exploring the ambiguities of the situation. In particular, the therapist focused with the father on whether he wished to have a relationship with his child which might gradually redevelop into a positive relationship with possible later clarification on the issues of sexual abuse accusations or whether the father was interested primarily or exclusively in clearing himself of the more immediate charges. The therapist further advised that use of the therapy sessions to grill the child or deny the charges was inappropriate. In all instances the father felt extremely uncomfortable accepting the fact that the child had made and continued, even in the father's presence, to make charges with regard to sexual abuse. The child was assisted in dealing more comfortably with the father in a safe situation and was encouraged to explore with the father positive as well as negative aspects of the pre-divorce parenting relationship. In two of the three instances the child also had an individual therapist who was not the present therapist. In that way, the child could, feel comfortable expressing more negative feelings with regard to the father outside the therapy situation. The therapist also felt that the child was more comfortable having her own available advocate.

Results of Therapeutic Intervention:

Effectiveness of the therapeutic interventions was judged on three criteria. The first criterion was the reduction of symptomatology of the presenting patient. The second criterion was increased

comfort expressed by both parents with regard to their interactions with each other. The third criterion was an absence of continued litigation with regard to the child custody matter.

Children of semi-absent parents were uniform in reporting a reduction in symptomatology. Parents also confirmed a reduction in symptomatology. These clients all terminated voluntarily with an expression that therapy had been successful. The semi-absent parent was seldom seen. However, the residential parent reported increased comfort in dealing with the child and increased understanding of the child's post-divorce dynamics and needs. There were no relitigated cases.

One parent-rejecting child reporting a marked reduction in symptomatology, This was a child who was placed with the rejected parent for an extended period of time with ongoing psychotherapy. Even after being returned to the primary parent, who retained sole physical custody of the child because the mother was in fact the better of the two parents, the child continued to maintain an adequate relationship with the father and had, by mother's report, markedly improved in her ability to handle general conflictful situations.

Of the remaining cases, all treated with phobia reduction techniques, success was far less significant. In one case, the child was able to tolerate the father, and fantasy about the father's negative characteristics diminished. In another case, efforts to increase parent-rejecting children's contact with the rejected parent resulted in a decline in the child's academic performance. The primary parent did report a decrease in the child's overall anxious symptomatology including a reduction in sleep disturbance and other hysterical phenomena. In three other cases, the primary parents collusive involvement with the child was so strong that the interests of the child were not served by continuing to work in a phobic reduction manner. Extended placement was not tried. The therapist never recommended a change in custody because the child's attachment to the primary parent was always strong and the child was always adequately adjusted within that parent's home.

Three of the four children treated for hostile or anxious parenting showed overall mild to moderate improvement in symptomatology. The children were better able to tolerate transitions between the homes of both parents, whether in a sole or primary custody arrangement. The children were better able to disengage themselves from parental conflicts and reported less concern with "fairness." In one case, an improved relationship between the non-custodial and custodial parents was inversely related to the child's symptoms as shown in separation anxiety behavior and a deterioration in school functioning. In three of the four instances, relitigation of the child custody matter occurred despite the therapist's efforts and even though the child had improved.

The dysfunctional parent situations were uniformly mildly to moderately successful in reducing the child's symptomatology. Despite reports by the mothers of initial increased fearfulness and some anxiety on the part of the children, that initial anxiety dissipated as the child continued to see the abusive father. The fathers reported positive feelings about seeing the child although the fathers continued to express anger over what they termed false accusations. The fathers confined the anger to the individual sessions. One father, after receiving feedback from the therapist that his daughter still maintained he had molested her, chose to terminate his contact with the

daughter, stating that neither he nor his daughter could tolerate the continued stress within the relationship. The other fathers moved gradually toward nonsupervised, but limited, visitation with their daughters.

Discussion:

The data suggests that even families experiencing chronic and severe post-divorce problems can be assisted by therapeutic intervention. Styles of therapeutic intervention can be designed to meet the specific problems of the children and families. Within a therapeutic environment parents do have some capacity to develop more trust, empathy, and tolerance for existing differences. They also have the ability to develop the specific behavior and cognitive strategies necessary to assist their children in working through specific problems of divorce.

As is true with general therapy, some situations are more amenable to change than others. Across problem areas, the more collusive, distrustful parents had the most difficulty assisting their children with post-divorce problems. These parents had the most difficulty putting therapeutic recommendations into effect. Parents who had the least concern that the other parent would have a substantial role in the child's life seemed to have the most ease in dealing with their child's post-divorce difficulties.

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