

# **Annotated Bibliography: Working with Caregivers in Meeting the Mental Health Needs of Children Involved in the Child Welfare System**

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## **Introduction: The Need to Better Understand How to Help Caregivers of Children Participating in Mental Health Treatment**

Numerous studies have demonstrated a high level of clinical need in children involved in child welfare (Burns et al., 2004; Leslie, Hurlburt, Landsverk, Barth, & Slymen, 2004; Hurlburt, Leslie, Landsverk, Barth, Burns, & Gibbons, 2004; Kerker & Dore, 2006; Kinard, 2002; McMillen, Scott, Zima, Ollie, Munson, & Spitznagel, 2004; Shin, 2005). For many children, this may entail the need for child therapy to address trauma, loss, and behavioral issues. One basic component present in such work is the reality that clinical social workers, psychologists, and psychiatrists who work with child clients must also have contact with their clients' caregivers. Unlike adult treatment, child psychotherapy depends on someone other than the client to initiate treatment, schedule sessions, secure payment, and arrange transportation. Furthermore, those who are charged with caring for children have the responsibility to review progress in treatment, protect the child from potential harm, and terminate any treatment that appears to be inappropriate for the child. Therefore, caregivers' understanding of, support of, or opposition to treatment is critically important to continuation of the child's treatment.

The working relationship between the child therapist and the caregiver of a child client introduces complexities that child therapists must negotiate in addition to the therapeutic work with the child.

Establishing a working relationship with caregivers presents child therapists with many dilemmas and can be one of the most difficult aspects of child therapy (Siskind, 1997, p. 3). A leading author in the field proposes that the challenges encountered in contacts with children's parents may even cause child therapists to "limit, reduce, and even give up the practice of child psychotherapy" (Siskind, 1997, p. 3). The issues presented in work with caregivers include (among others) considering whether child therapists should offer ongoing services to caregivers; whether a separate therapist should be enlisted to do work with the caregivers; the type, frequency, and structure of contact with caregivers; the aim of work with caregivers; the caregivers' reactions to the child therapist; caregivers' feelings of shame and guilt for their child's troubles; caregivers' positive motivations to seek help; caregiver psychopathology; the therapist's countertransference toward caregivers; children's rights to confidentiality; and dilemmas related to balancing the sometimes disparate needs of caregivers and their children.

A comprehensive review of the literature regarding child therapists' work with caregivers was conducted using more than 60 sources from the clinical and empirical literature. Despite the complex considerations involved in working with parents and caregivers, many authors have noted the lack of literature pertaining to this work. This gap includes a lack of literature addressing direct work with caregivers (Rustin, 2000; Sutton & Hughes, 2005; Tsiantis, 2000), the caregiver's role in child treatment (Chethik, 2000; Hill, 2006; Siskind, 1997; Stallard, 2006), caregiver engagement

in their children's treatment (Kazdin, 1996), guidelines or an adequate theoretical model for work with caregivers (Gaines, 2003; Novick & Novick, 2005; Rosenbaum, 1994; Siskind, 1997), and countertransference issues in child treatment and work with caregivers (Gabel & Bemporad, 1994; Meschiany, 1994; Schowalter, 1986). Beyond the literature, there has also been a notable lack of seminars and insufficient training for child therapists on working with the parents or other caregivers of their clients (Englise-Frick, 2000; Rustin, 2000, Siskind, 1997; Sutton & Hughes, 2005).

In child welfare, the person responsible for and invested in the child's treatment may be a biological parent, a caseworker, a foster parent, or a combination of those caregivers—all of whom are responsible for supporting the child's treatment. For children who are placed outside of their homes, caseworkers act as the representative of the state, which is the child's legal guardian; foster parents have physical custody and daily caregiving responsibilities; and biological parents continue to have rights to visitation, rights to be informed of their child's condition and plans, and a shared history with the child. Frequently, the goal is reunification of the child and parent, up until the courts rule on reunification or termination of parental rights (Molin & Palmer, 2005, p. 153). Given the multiple potential caregivers and systems involved in child welfare, the complexities involved in treatment of children are potentially multiplied, which may further deter child therapists from engaging or continuing in this field.

However, the limited literature on the subject rarely refers to caregivers other than biological parents of children who have never been removed from their homes. Although the literature that does exist focuses on mainly on biological parents, some insights from the literature may be helpful in working with foster parents or caseworkers who are responsible for the children's care as well. Whereas most

authors refer to "parents," the more inclusive term *caregiver* is used in this review to indicate biological parents, foster parents, relative caregivers, and adoptive parents as appropriate. Despite some deficits in the literature, there are some quality sources that can start to answer questions and lead the way for future research and theoretical development in this important area of clinical work with children.

Empirical studies have consistently shown high rates—40 to 60%—of premature termination from child therapy, across a wide variety of modalities of child treatment (Kazdin, 1996). In a review of empirical literature related to child treatment, Kazdin proposes that the caregiver-therapist bond is central to preventing premature termination for child clients, because of the caregivers' role in sustaining the therapy through ongoing transportation, payment, and investment in the treatment (1996, p. 151). Empirical research across cognitive behavioral and psychodynamic treatments has found that the quality of the relationship between the therapist and caregiver is a significant predictor of premature termination (Garcia & Weisz, 2002; Kazdin, Holland, & Crowley, 1997; Midgley & Navridi, 2006; Miller & Prinz, 2003). Clinical wisdom seems to align with these results, as a survey of practitioners found that they ranked parental cooperation as the most important factor contributing to positive outcomes in child treatment (Kazdin, Siegel & Bass, 1990). Authors of clinical and theoretical literature also note that the caregiver-therapist relationship is critical to preventing premature termination (Englise-Frick, 2000, Gaines, 2003, Midgley & Navridi, 2006, Novick & Novick, 2005). In fact, Novick and Novick posit that the lack of a model for working with parents of child clients is the "reason why many therapies don't get started, are interrupted, or terminate suddenly" (2005, p. 2).

### Summary

Although there has been no comprehensive empirical work on this

subject, all of the relevant empirical, clinical, and theoretical literature indicates that the relationship between the caregiver and the child therapist is important to sustaining a child's treatment. This may indicate that therapists working with children in foster care may need to develop working alliances with foster parents, caseworkers, and biological parents, and perhaps even guardians ad litem, to ensure that the therapeutic relationship between the child and therapist is not terminated prematurely or abruptly. This would entail efforts far beyond the weekly hour of direct treatment for the child. Future research should examine how treatment for children in foster care may be disrupted or maintained, with a focus on the working relationships between the multiple caregivers and treatment providers.

## What Should Be the Focus of Child Therapists' Interaction with Caregivers?

As to work with caregivers of child clients, there are a variety of opinions in the small body of clinical literature that does exist on what the focus of that work should be. At the least involved level, authors encourage practitioners to engage the caregivers to gather information, explain the methodology and purpose of the treatment, and obtain informed consent for the treatment (Landreth, 2002; McGuire & McGuire, 2001). This may also include the aim of simply maintaining contact to keep the caregiver favoring treatment, to prevent disruption (Schowalter, 1985). Others define the goal of work with caregivers as extending the child's treatment into his or her wider world, to maximize the benefits of the treatment through psychoeducation or supportive therapy involving caregivers (Cates, 2006; Gaines, 2003; Hughes, 2004; McNeil, Bahl, & Herschell, 2006; Shaw & Magnuson, 2006).

Alternatively, some authors focus on parenthood as a developmental phase,

and use work with caregivers to increase the level of caregiver functioning so as to increase caregivers' ability to help their children (Bailey & Sori, 2005; Englise-Frick, 2000; Furman, 2001; Green, 2000; Horne, 2000, Sutton & Hughes, 2005). Yet another primary focus is on strengthening the caregiving relationship and helping caregivers gain insight into the child (Bromfield, 2007; Emanuel, 2006; Green, 2000; Rustin, 2000, Siskind, 1997). Finally, some also believe that the therapist can function as a nurturing parent toward caregivers, to sustain them through times of stress so they can give their children the kind of support they are receiving from work with the therapist (Chethik, 2000; Rustin, 2000).

### *Summary*

The clinical literature suggests a variety of ways to conceptualize work with caregivers. There is clearly some overlap among these goals, and they are not mutually exclusive, but, as Siskind (1997) notes, even the most practical decisions about how to work with parents should be guided by the goals and assumptions of that work, which necessitates clarifying therapists' goals for engaging with caregivers of their child clients. Beyond addressing pragmatic concerns such as scheduling and transportation, child therapists need to be thoughtful about potential goals and benefits of working with caregivers of their child clients, so that they can then consider how they wish to engage those caregivers.

For therapists working in child welfare, this may mean establishing unique goals in working with each of the child's caregivers, including foster parents, biological parents, and caseworkers. Additional potential goals for caregivers in the child welfare system might include:

- psychoeducation as to the effects of trauma and separation on children
- work on repairing disrupted attachments with parents or establishing attachments with a

- foster or adoptive parent
- helping the caregiver contain and respond to the child's strong emotions evoked by abuse and separation
- helping caregivers with their own reactions to the abuse and separation, so that they can better support the child
- helping the caregiver establish appropriate boundaries and systems of behavior management for a child who has been maltreated.

Both Hill (2006) and Hughes (2004) note that although treatment that includes a caregiver can promote and expand the treatment of an abused child, such caregivers will likely need assistance from the therapist to cope with their own feelings related to the abuse and trauma before they can appropriately support the child.

## How Should Child Therapists Structure Their Interactions with Caregivers?

Even with the aims of treatment clarified, another issue to consider when working with caregivers is the structure of interactions with caregivers. This includes the possibilities of meeting with caregivers with or without the child, meeting prior to or after meeting with the child, determining the optimal frequency of caregiver-therapist contact, and a range of ways of defining the caregivers' roles in treatment. With children under five years of age, the literature fairly consistently promotes seeing the child with the caregiver (biological or foster parent), along with some sessions during which the caregiver meets alone with the therapist (Ben-Aaron, Harel, Kaplan, & Patt, 2001; Emanuel, 2006; Harel, Kaplan, Avimeir-Patt, & Ben-Aaron, 2006; Van Horn & Lieberman, 2006). Others have extended this modality to older children through Parent-Child Interaction Therapy (PCIT), which focuses on caregivers learning new skills; or Filial

Therapy, which focuses on caregivers learning and applying play therapy techniques (Landreth, 2002; McNeil, Bahl, & Herschell, 2006).

However, one empirical study found that caregivers are more likely to drop out of treatment when the therapy focuses on the parent alone or on child-parent sessions (Miller & Prinz, 2003). This may be due to caregiver frustration that arises when they request help for their children but find that the therapy is focusing on them as parents/foster parents rather than focusing clearly on their child. Some have also critiqued these methods for not emphasizing the emotional content of treatment or support for the child (Bailey & Sori, 2005). Studies have also shown that family therapists who work with caregivers also tend to focus solely on treating the adult caregivers, even when the child is the identified patient, and often do not treat the children with the family, which may lead to the same kind of caregiver dissatisfaction and a lack of direct support for the child (Bailey & Sori, 2005; Johnson & Thomas, 1999; Korner & Brown, 1990).

In the literature, child therapists tend to acknowledge that there are many variations on ways of working with caregivers in child treatment (Bromfield, 2007; Chethik, 2000; Emanuel, 2006; Englise-Frick, 200; Green, 2000; Horne, 2000; Rustin, 2000; Stallard, 2006). This can include variations in the role of the caregivers, such as including them as facilitators, co-therapists, or clients in their own right (Stallard, 2006). Work with caregivers can include meeting alone with the caregiver for guidance, to offer support and nurturance, or to work on unconscious dimensions of the caregiving relationship (Chethik, 2000). It can consist of periodic reviews with the caregiver; meetings with both the caregiver and the child; weekly child-focused caregiver meetings without the child present; or meetings with any combination of family members, including siblings, each caregiver separately, caregiver-child dyads, or caregivers together

as a couple (Bromfield, 2007; Rustin, 2000). Different therapists may focus their work in a specific direction, but most agree that flexibility in determining the caregivers' role and the structure of sessions is key to effective work with caregivers (Bailey & Sori, 2005; Bromfield, 2007; Emanuel, 2006; Englise-Frick, 2000; Green, 2000; Siskind, 1997). Responsiveness to caregivers' needs and limitations is important in this line of thought, and requires careful consideration of the caregivers' motivation, the time available for sessions, and conflicts between caregivers, which may entail the need for couples sessions, a referral for couples therapy, separate sessions for each caregiver to focus on the child, or a referral for mediation to develop agreements regarding child care between caregivers in conflict.

### *Summary*

Child therapists must carefully consider how they will structure their interactions with caregivers, to facilitate engagement with the therapist and to ensure that expectations are clear and achievable. Although dyadic work with children and their parents has been shown to be effective, particularly with younger children, flexibility in determining the structure of interactions is also important. The child welfare system encompasses many overworked and strained caregivers who may be responsible for a number of children with complex needs, which may limit the caregivers' availability and willingness or ability to engage in weekly dyadic, family, or individual sessions. Child therapists in child welfare may have to be more creative and collaborative with caregivers to find the time and space to ensure that the caregiver is engaged, supported, and informed by the child therapy process. Deciding on a structure for the caregiver interactions also requires child therapists to consider the level of engagement with biological parents, foster parents, and caseworkers.

## Should the Same Therapist Conduct Ongoing Work with Both the Caregiver and the Child?

Some authors strongly encourage the child therapist to work closely with the child's caregivers as well, as clients in their own right or in support of the child's therapy. These authors argue that the child therapist's work with caregivers:

- lowers the level of distortion in countertransference regarding the parents (Gabel & Bemporad, 1994)
- keeps caregivers from feeling excluded and potentially shamed (Hill, 2006)
- allows caregivers to come to know and trust the person who is treating their child (Harris, 1968; Novick & Novick, 2005)
- allows the therapist to address concerns that arise in vivo in the waiting room (Bromfield, 2007)
- allows the therapist to learn about the representational worlds of both the caregiver and the child (Chazan, 2003)
- permits the therapist to work directly on the issues facing the caregiving relationship (Bailey & Sori, 2005; Chethik, 2000; Emanuel, 2006).

However, other authors strongly advocate separate therapists for caregiver and child (Englise-Frick, 2000; Green, 2000; Landreth, 2002; Sutton & Hughes, 2005). Sutton and Hughes emphasize the difficulties in managing the multitude of complex issues that arise from working with both the caregiver and the child, which could be overwhelming to a single therapist (2005, p. 181). Other authors have also acknowledged that maintaining a point equidistant from the child and the caregiver during therapy is a challenge to the therapist who works with both (Brennan, 2005; Joelson, 2007). Altman (2004) acknowledges this dilemma and the difficulty inherent

in containing the strong emotional and unconscious needs of both caregivers and children, but also points out practical limitations on collaborative work between two therapists in the United States, given that much of this work takes place in private practice or independent agencies rather than through a comprehensive national health system wherein two therapists work within the same system.

Confidentiality is also often regarded as a challenge if the same therapist is meeting with both the child and the caregiver (Cates, 2006; Hill, 2006; Harris, 1968; Landreth, 2002; McNeil, Bahl, & Herschell, 2006; Siskind, 1997; Sutton & Hughes, 2005). Therapists frequently become concerned about the child's right to confidentiality or privacy, while still acknowledging that caregivers have a right to be informed about the progress of treatment. The child's right to privacy is particularly problematic if the therapist feels that the child may withhold feelings, or feel less free in treatment, if the child believes that the caregivers will know what he or she does or says. Finally, some methodologies have used two therapists in part to maximize the time in the office, so that the caregiver and the child can have simultaneous sessions (Kazdin, 1996). This minimizes the burdens of time, transportation, and supervision of the children during the caregivers' sessions that may interfere with individual caregiver sessions.

### *Summary*

Given the concerns and persuasive arguments on both sides of these issues, and given the practical limitations that inevitably exist, there is no clear direction from the current literature regarding whether the child therapist should also work directly with the caregivers. However, there is strong sentiment that if a separate therapist is involved in work with the caregiver, that therapist should collaborate closely with the child's therapist. The child therapist can then help the caregiver's therapist hold the

child in mind as central to the caregiver's treatment, so that the treatment maintains a focus on the caregiving role (Horne, 2000; Rustin, 2000). Thus, in child welfare, the therapist working with the child and the therapist working with the parent should regularly collaborate to ensure that the child's needs are being considered in treatment of the parent. This entails not only the extra time necessary for collaborative discussions between the two therapists, but also a coordination between agencies to obtain consent from the legal guardian and the caregiver so that relevant information can be shared across treatment providers.

### **Is Referring Caregivers to Their Own Therapists Sufficient Care?**

There has been a widespread assumption that referring parents to their own treatment providers addresses any caregiving issues affecting child clients. However, caregiving is only one part of an adult's total personality. Caregiving is often not the focus of adult individual treatment; the relationship between the caregiver and the child's psychotherapist may not be addressed in individual treatment, and the caregiver's individual treatment may not keep pace with the child's ongoing developmental needs (Chethik, 2000; Landreth, 2002; Novick & Novick, 2005; Rustin, 2000). Furthermore, therapists who conduct adult work may have difficulty keeping the needs of the child in mind, as the child is not their primary client and they may never even meet the child whose well-being is partially dependent on the caregivers' progress in treatment (Horne, 2000). Rustin comments that practitioners of some forms of therapy hold that, at least initially, treatment inevitably reduces caregivers' use of defenses and functionality, causing the caregivers to be more fragile and less able to maintain the caregiving function on behalf of their child (Rustin, 2000). Such treatments have obvious disadvantages for caregivers who are already stressed by caring for maltreated children.

### Summary

In child welfare, biological parents are often referred to their own treatment that is separate from the therapy for their children. Though this is often necessary, there is a risk that child therapists and others in the child welfare system may think that the parents' treatment is adequate to ensure progress in their ability to parent their child. However, the arguments discussed in the preceding section highlight the need for active and frequent collaboration between the parent's therapist and the child's therapist, to ensure that the child's developmental, emotional, and psychological needs are understood and balanced with the parent's needs. Certainly, this collaboration will require a fair amount of case management to secure consents from all parties to release information, to gather contact information, and to find time to make the initial contacts—but collaboration may be critical to successful treatment and reunification of child and parent. Furthermore, collaboration between the two therapists does not rule out the need for direct engagement between the child therapist and parent. The parent will need the therapist's help to address any concerns the parent has about the child and/or the therapy, to offer insight into the child's developmental and clinical needs, and to solidify the alliance with the therapist.

### What Issues Is the Caregiver Likely to Need Help with from the Child's Therapist?

In one study that focused on family therapy for families identified by the child welfare system, the researchers demonstrated empirically that families needed to agree to goals and to experience the therapist as a warm and trusting person in order to make positive changes (Johnson & Ketring, 2006, p. 351). To gain such agreement, therapists working with caregivers need some understanding of both the positive and the troublesome aspects of the child therapeutic work for parents/caregivers. Many authors have

acknowledged the positive motives that allow a parent/caregiver to seek help for a child (Bailey & Sori, 2005; Brennan, 2005; Bromfield, 2007; Furman, 2001; Green, 2000; Houzel, 2000). It takes love and courage for a parent/caregiver to expose his or her family to professional scrutiny, and it takes time, money, and effort to facilitate the child's therapy; the therapist's acknowledgment of these qualities and sacrifices can be an essential tool in building a working relationship with the caregiver. Parents/caregivers may also find opportunities to benefit personally from engaging with a therapist on behalf of their child, including the opportunity to face fundamental issues in their own past and to grow as individuals through their development as caregivers (Furman, 2001; Rustin, 2000; Siskind, 1997; Sutton & Hughes, 2005).

However, parents and other caregivers may also be experiencing intense feelings of guilt or shame about their child's need for treatment. Many authors have written about how parents struggle with feelings of failure, shame, and guilt, and how they often expect to be blamed by others for their child's difficulties (Bailey & Sori, 2005; Bromfield, 2007; Cates, 2006; Chethik, 2000; Englise-Frick, 2000; Furman, 2001; Green, 2000; Harris, 1968; Hill, 2006; Horne, 2000; Houzel, 2000; Midgley & Navridi, 2006; Siskind, 1997; Sutton & Hughes, 2005). Furman (2001) states that parental guilt can be a sign of healthy feelings of responsibility toward a child which can motivate treatment seeking and commitment to treatment. However, internal feelings of guilt can also lead to caregiver wariness, if they believe their child's therapist will blame them for their child's difficulties. Some parents/caregivers may become defensive, resistant, or hostile toward the therapist as a way to avoid or lessen feelings of shame. Thus, the child's therapist must be aware of the potential for these feelings and be capable of managing them within the therapist-caregiver relationship. These dynamics are likely to be greatly intensified

if the treatment is mandated and the parent has already been found unfit by the court system. Such feelings may also be present for relatives and foster parents, who may perceive that their ability to help the child in their care is being questioned when caseworkers insist on therapy for the child.

Sensitivity to caregivers' feelings, and respect for their role as the child's caregiver, leads to some important considerations regarding offering advice and empowering caregivers. Authors repeatedly warn that the therapist should respect the caregivers' roles and not offer solutions to caregiving issues (Harris, 1968; Horne, 2000; Houzel, 2000; Rosenbaum, 1994; Shaw & Magnuson, 2006; Siskind, 1997). Instead, these authors emphasize that the therapist should help caregivers explore what they want to do, give limited developmental information, seek to facilitate caregivers' decisionmaking process, and reinforce their right and responsibility to make decisions regarding their child and family. By limiting advice-giving, the therapist neither undermines caregivers' position nor makes them dependent on the therapist; instead, the therapist reinforces caregivers' capacities, confidence, and intuition as the persons who know the child best (because of their daily care for the child). However, a few authors do suggest that giving helpful advice to caregivers can bolster their confidence in the therapist and feel less alone with their struggles (Bromfield, 2007; Englise-Frick, 2000).

### *Summary*

Child therapists need to consciously develop their appreciation of the caregiver's love for the child and the caregiver's potentially intense feelings of guilt and shame. Particularly in child welfare, parents who have maltreated their children are under intense scrutiny. Therapists can and should encourage parents to take responsibility for their behavior, but they also need to be able to build a working relationship with parents on behalf of the child and keep in mind that the parents' maltreatment of the

child stems from maltreatment the parents have experienced (in their family of origin, through societal traumas in the community and society, or both). Therapists working with children may be able to establish a trusting relationship with caregivers through showing respect for caregivers' roles, empowering caregivers to make appropriate decisions, limiting directive advice while facilitating decisionmaking, and acknowledging the love and courage it takes for caregivers to engage with professionals on behalf of their children.

### **What May Caregivers Evoke in Child Therapists?**

Beyond practical and structural considerations of work with parents/caregivers, therapists must also contend with the feelings that work with caregivers and their children evokes within the therapists. Issues of countertransference and the potential for complex feelings may arise in work with children and caregivers to an even greater degree than in work with individual adult clients. Kohrman, Fineberg, Gelman, and Weiss relate that when a prominent child analyst was asked why countertransference in work with children was not discussed more, he simply stated, "Because there is too much of it" (1971, p. 492). Child therapists must contend with complex feelings not only toward their primary client, the child, but also toward the child's parents and other caregivers (Green, 2000; Meschiany, 1994). These feelings may be complicated by the therapist's conscious and unconscious feelings about his or her own children or own parents (Bernstein & Glenn, 1988; Englise-Frick, 2000; Gabel & Bemporad, 1994; Schowalter, 1985).

Overidentification with either the parent, other caregivers, or the child can also be an issue. The overidentification is complex because the therapist has multiple individuals to attend to, leading to possible convergent or divergent reactions, including overridealizing the child and caregiver, devaluing the child and caregiver,



overidealizing the child and devaluing the caregiver, or devaluing the child and overidealizing the caregiver (Bernstein & Glenn, 1988; Gabel & Bemporad, 1994; Meschiany, 1994; Schowalter, 1985). Authors note that child therapists more often overidentify with their primary client, the child, leading to a poor child/awful parent dynamic that feeds into the therapist's rescue fantasies and competition with the parent or other caregivers (Bernstein & Glenn, 1988; Harris, 1968; Horne, 2000; Malawista, 2004; Schowalter, 1985; Siskind, 1997).

Some theories reinforce this potential risk of devaluing caregivers by identifying the caregiver as simply an object who satisfies (or does not satisfy) the developmental needs of the child. Relational theorists, in particular Benjamin (1990, 1995), have begun to challenge this point of view and assert that caregivers are both objects with regard to children and subjects with their own needs and desires apart from the children. This point of view redirects the therapist's attention not only to how the caregiver functions for the child, but also to the caregiver as a whole person, which may counteract simplistic dualities such as poor child/awful parent. Still, this dynamic may be hard for therapists to negotiate as they contend with the child as a subject, the caregiver as an object for the child, caregivers as subjects themselves, and the child as an object for the caregivers. This may be why child therapists stress the difficulty of maintaining balance between attending to the needs and experiences of both children and their caregivers (Brennan, 2005; Green, 2000; Joelson, 2007). Clearly, introducing alternative caregivers such as foster parents multiplies this inherent complexity, as the therapist will be reacting to a triad of child, caregiver, and biological parent.

In addition, families in high conflict may present another level of challenge when one parent subtly or blatantly attempts to influence the therapist to identify and align with him or her against the other parent or

caregiver, trapping both the child and the therapist in loyalty conflicts (Garber, 2004). This leaves the therapist with not just two potentially conflicted individuals (parent and child), but multiple individuals, including mother, father, foster parents, caseworkers, and children (Bromfield, 2007). The task of negotiating the dynamics among these relationships, in addition to the child therapist's own responses to each individual and the families as a whole, can potentially overwhelm the child therapist. Even if contact with some or all caregivers is limited by the therapist's choice of interaction strategies, the "ghosts" (or meaningful intrapsychic presences, per Selma Fraiberg's famous paper) of these figures linger and may potentially derail the child's treatment.

### *Summary*

Child therapists face complex and conflicting emotions about both their clients and their clients' caregivers, and these issues are only intensified in the child welfare context. Rescue fantasies may be difficult to resist when treating abused and neglected children, and may lead to intense feelings of hostility toward parents or other caregivers that may be difficult to contain. Furthermore, the therapist may be pulled into alliances against the child welfare system or caseworker if he or she does align with the family and does not maintain an open working relationship with the casework agency (Bentovim, 2004). The potential for so much emotional reactivity on the part of the therapist may require a high degree of reflection, supervision, collaboration, and support for therapists, so that they remain able to manage their emotions and provide thoughtful and effective treatment in child welfare cases.

## Are There Any Specific Guidelines for Child Therapists Interacting with Caregivers within the Child Welfare System?

Although the literature is often silent on the complex and neglected subject of therapist-caregiver interaction, particularly in a child welfare context, one report has outlined some guidelines for therapists treating children in out-of-home placements (Molin & Palmer, 2005). Molin and Palmer acknowledge that issues surrounding the role of legal guardians and noncustodial parents of children in child welfare have been ignored previously (2005, p. 152); hence, they attempt to outline critical issues and guidelines based on research, ethical and legal considerations, and clinical experience. They note that foster parents and biological parents involved in child welfare may be overlooked or excluded from their child's treatment, and that caregivers' feelings about this exclusion are often transmitted to the child and can have a negative effect on the treatment (p. 153). Furthermore, the exclusion of the caregiver undermines parents' and foster parents' sense of responsibility for and importance to the children (p. 153). Finally, the authors note that caseworkers may be unsure about their role in monitoring the treatment and neglect to follow up on issues regarding the treatment (p. 154). Molin and Palmer identify the therapist as responsible for determining who the client is, deciding on the goals of treatment, and clarifying the therapist's role with all parties (p. 154).

Molin and Palmer then go on to propose an approach for informed consent and participation for everyone involved in a child welfare case (pp. 155–156). Caseworkers, as the legal guardians, give consent for the child's treatment, and are responsible for reviewing the treatment on a regular schedule as well as when there is any significant change in treatment. Caseworkers should understand the focus of treatment, and any diagnoses and recommendations for interventions, before

treatment proceeds. They also authorize disclosures of information to other caregivers, including parents. The authors explicitly propose that parents have the right to be informed about the evaluation and treatment of their child; to contribute to their child's treatment; and to know who is providing treatment, how the treatment is progressing, and how the treatment is evaluated, unless their parental rights have been permanently terminated. If the parent's involvement could place the child at risk or limit the effectiveness of services, involvement should be limited to the extent necessary, but parents should be informed of the reasons for the restrictions and their involvement in the treatment should be reviewed throughout the course of treatment (p. 156). Therapists have the responsibility to weigh the best interests of the child, the consent of the legal guardian, respect for the child/parent relationship, and the parent's opportunity to improve parenting (p. 154). The levels of parental involvement proposed by the authors cover a range of options, including family therapy, regular consultation with the child's therapist, contact with other therapists who consult with the child's therapist, and attendance at meetings or clinical staffings by both the therapist and parent.

The authors also extend certain rights to foster parents. They state that foster parents have a right to be included in the treatment process unless it is specifically contraindicated (p. 156). Child therapists must consider the privacy rights of the children and parents, but can also work toward obtaining collaboration and legal permission for limited disclosure of information to promote the therapeutic progress. The authors believe that although foster parents' participation in the child's treatment should be limited to the degree necessary for the child's well-being, they have a right to be informed of the reasons for any restrictions on their involvement (p. 156). Finally, the authors argue that processes should be in place, for both parents and foster parents, to have decisions regarding their involvement in the child's treatment reviewed if they are excluded from that treatment.

### Summary

Although the ideas presented here are drawn from only one article, Molin and Palmer's work is of great importance in understanding the clinical, legal, and ethical issues faced by therapists who treat children in the child welfare system. Their article details specific considerations and guidelines clearly and thoughtfully. However, the guidelines do not address other complex considerations, such as how to establish trust with children, parents, and other caregivers; how to manage therapists' complex feelings in such cases; how to manage hostility between caregivers; how to manage multiple demands upon the time and energy of caseworker, parent, and foster parent; or how to help parents and foster parents contain and manage their own feelings and reactions to the child's treatment.

### Conclusion

The challenges identified by the clinical literature include issues regarding the structure of treatment, the parents'/caregivers' feelings surrounding treatment, and the potential for complex countertransference reactions in the therapist. Child therapists face a daunting task in considering these complicated issues in each case, with no clear or easy answers. In fact, Siskind argues that it is not possible to address these issues in the abstract "outside of the clinical material that raises them[,] because the answers must be shaped by the total conditions of each case" (1997, p. 210). Therapists working in child welfare must also consider and deal with the multiple systems and individuals involved in the care of their child clients, in addition to the direct caregivers and the child clients themselves.

In my experience as a child therapist working with children and families involved in child welfare, I found that the challenges and complexities of engaging caregivers—including foster parents, biological parents, and adoptive parents—were more demanding than the direct work with the children. The potential for

misunderstandings, defensiveness, and even hostility among and between caregivers and professionals was real and required thoughtful and empathetic responses. The potential for productive, efficient, effective, hopeful, and successful work that aided both the caregiver and the child was also a reality in my experience, when both caregiver and therapist maintained a respectful and supportive relationship that centered on the child's best interests.

As a supervisor of child therapists working with children involved in child welfare, I have had the pleasure of working with thoughtful and skilled professionals. However, even the most skilled therapists needed time in supervision to process, reflect upon, and develop their skills in working with caregivers of their child clients. They frequently noted, early in their experience, that finding effective ways to work with caregivers was their greatest challenge. Reflection, support, and dedication allowed them to repeatedly face this challenge and develop warm, supportive, and effective relationships with caregivers who were initially disengaged, defensive, or even openly hostile when services for the child were started.

As a scholar, I am frustrated by the lack of theoretical development and empirical research addressing this important clinical issue, but I am also excited by the possibilities for future research and development. I hope to spur more research and literature in this critical area through my own research and writing. Such a vast amount of knowledge in this area remains unexplored or unarticulated, save for a few thoughtful articles and books, that there is room for a great deal of innovation in this area. I invite my colleagues, in child welfare and other disciplines, to add their own insights and develop their own research into such work to help guide future generations of child therapists, and to help them sustain themselves through the challenges and opportunities inherent in work with children.

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