

The parentified child in a child psychotherapist: A systematic literature review of the parentified child, exploring its effects on the countertransference process in child psychotherapy

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## **Attestation of Authorship**

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except when explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

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## **Abstract**

This dissertation explores the countertransference of a child psychotherapist with a history of parentification. Parentified children are those who attempt to fulfill the parental role at the expense of their own developmentally appropriate needs and pursuits. Parentification implies that the process of becoming a parentified child involves subjective distortion of the parent-child relationship, which comprises the parameters of overt role assignment, internalized expectations and commitment characteristics. A modified systematic literature review has been adopted as a research method for this study to explore the internal and interpersonal world of a parentified child. Literature was gathered from a range of theories, such as family system theories, developmental theories, psychoanalytic theories combined with many studies of the parentified child in order to understand the impact of a parentification history on the countertransference of a child psychotherapist. The synthesis of the findings through the reviewing process is represented in three themes, which are: 1. Hiding the true-self or false-self adaptation, 2. Drowning in the emotional sea or putting up the firewall, and 3. The resilience of a parentified therapist. The findings of this study concluded that the parentification process denotes a relationship between a child and a parent, which involves multi-layers of impact on the child's development. This relationship may easily be revived in the therapeutic process when a parentified therapist is working with a child. The caretaker role seems to be a mechanism of coping with the emotional pain that arises in parentification. While in a therapeutic process with children, a parentified therapist's emotional pain may easily be triggered in countertransference and the therapist may unknowingly change from a therapist's role to a caretaker role to defend off the over-identification of the child's suffering. On the other hand, she may unconsciously dissociate from feeling the pain and focus by intellectually re-parenting the child in the

therapeutic process. It is important that a parentified therapist gets enough holding and containment to understand her history of parentification and attune to her own wounds, thus she is able to use this 'inner 'parentified child' wisely to benefit the therapy with children.

## **Chapter One Introduction**

This study is about the countertransference of a child psychotherapist with a parentification history when working with children. A systematic literature review is adopted as a research method to understand the internal and interpersonal world of a parentified child. Effort has been made to find out the impact that this parentified child who is still living inside a child psychotherapist has on the countertransference occurring in the therapeutic process when working with children.

### **Defining the terms**

The term ‘parentified child’, which is very often used by mental health professionals to describe a pathogenic family dynamic, occurs when there is a boundary distortion in the family subsystems, which impel the child to take on a parental role or spouse role (Boszormenyi-Nagy & Spark, 1984b; Minuchin, 1977). Parentified children are those who attempt to fulfill the parental role at the expense of their own developmentally appropriate needs and pursuits. They are sensitive to their parents’ moods, wishes, and vulnerabilities, and work hard to attune to their parents’ needs (Chase, 1999).

Parentification implies the phenomenon or the process of becoming a parentified child, which involves subjective distortion of a parent-child relationship through wishful fantasy or dependent behavior of the parent (Karpel, 1977). This relationship pattern comprises the parameters of overt role assignment, internalized expectation and commitment characteristics, which denote the features of the parentification process (Boszormenyi-Nagy & Spark, 1984b).

In this dissertation, the word ‘parentified’ is used as an adjective to describe any

person or any relationship that has characteristics defined by the above two terms. For example, parentified therapist is a therapist who was a parentified child. Parentified mother-child relationship is a relationship involving parentification.

### **Initial literature review related to the research question**

Several scholars have investigated the phenomenon of the parentified child and the consequences on the psychosocial and emotional development of children. Jurkovic (1997) postulated from a psychoanalytic perspective that early interpersonal deprivation unconsciously disposes parents to regard their children as parental figures. In the development of their intergenerational, contextual approach to family therapy, Boszormenyi-Nagy and his colleagues (1984a) recognized a related dynamic in the family with a parentified child. They discovered that the parentification of children arises as a form of reciprocity, a payback involving “invisible loyalty” (p. 37). This loyalty may become a “ledger” (p. 53) of entitlement or indebtedness of parents to their own parents or loyalties of children to their parents for services received (Boszormenyi-Nagy & Spark, 1984a). This pattern of family relationship may repeat from one generation to the next, and that can sometimes extend over three generations (Winton, 2003).

It is also realized that parentification is “a ubiquitous and important aspect of most human relationships” (Boszormenyi-Nagy & Spark, 1984b, p. 151) and is suggested that one does not automatically pathologise these relationships. The phenomenon of parentification may occur for every individual at certain times in his/her childhood. When parentification occurs over a short period of time and does not impede a child’s development seriously, it can advantage the child to learn to identify with responsible roles for his/her future life (Boszormenyi-Nagy & Spark, 1984b). The

ability to be responsive to parental needs may help a child to develop sensitivities and reciprocity with others (Chase, 1999). It is only when parents overly exploit these virtues of their children to gratify their own needs that their children may feel trapped into the perception that his/her needs are less important than those of others. Moreover, if parents construct a guilt-laden atmosphere of obligation to bind the children in compliance with their demands there is a greater chance for the children to develop into parentified children (Chase, 1999).

Jurkovic, Morrell, & Thirkield (1999) delineate four categories of roles on a continuum of responsibility according to duration and extensiveness of caretaking. On one end, a child who is over-functioning extremely in a parental role is identified as “destructive parentification”; whereas on the other end, the child who is under-functioning extremely in a parental role but is fulfilling the parent’s emotional needs of a dependent child is regarded as “infantilization”. In the middle range of this hypothetical continuum are “healthy non-parentification” and “adaptive parentification”. These two categories entail some appropriate responsibility for the child. In the adaptive category, caretaking responsibility may increase or intensify because of crisis or acute stress, but such contributions by the child are recognized and expected for a limited time only (Jurkovic, et al., 1999, p. 94).

Miller (2007) observes that the cause of an emotional disturbance is to be found in the infant’s early adaptation. When a mother is unable to be emotionally available to her child, the child’s needs for respect, echoing, understanding, sympathy, and mirroring have to be repressed, and can result in several serious consequences. This child becomes unable to experience consciously certain feelings due to the fear of losing the love of the mother, and instead develops the ability to attune and echo the mother’s needs. Miller

(2007) also points out that the accommodation to parental needs often leads to an “as-if personality” (Malcolm, 1990) wherein the child reveals only what is expected of him/her and fuses completely with what he/she reveals. In fact, the child is consciously or unconsciously hiding his/her true feelings behind this “false-self” (Winnicott, 1965b).

Psychotherapy includes working with transference and countertransference in the therapeutic process. Countertransference is described by Heimann (1950) as a relationship between two people characterized by the presence of strong feelings in both parties. This phenomenon may also occur in a therapeutic process with children. Tsiantis, Sandler, Anastasopoulos, & Martindale (1996) claimed that when working with children, their early life traumas are communicated in nonverbal and regressive modes which tend to evoke early life issues in the therapist. In his study of the parentified child, Jurkovic (1997) discusses how the parentified child can grow up to be a somewhat wounded healer who brings his/her own past trauma to the therapeutic relationship. Wells & Jones (1999) identified that adults who grow up to be a parentified child, tend to form a “false-self-collusion”<sup>1</sup> in therapy with a therapist. They emphasize that the foundation of therapy depends on addressing this “false-self-collusion” empathetically in order to facilitate the clients to express their emotions honestly and have genuine relationships with others (Wells & Jones, 1999, p. 121).

From this initial review of the literature, it seems that parentification may have detrimental effects on children’s emotions and relationships with others. As these children learn to be a parentified child from the interaction with their primary object, this relationship may reenact in the therapeutic process. Without conscious awareness,

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<sup>1</sup> When in “false-self collusion”, the therapist may experience a difficulty in raising or challenging controversial issues with clients. Moreover, when under stress the therapist may feel gratitude to the client’s compliance (Well & Jones, 1999).

their countertransference may impede the therapeutic process.

### **Personal life experience and clinical experience**

When I started my training in child psychotherapy and studied psychoanalytic theories, such as Winnicott's false-self, role reversal, compulsive caregiving in attachment theories, and Mahler's separation-individuation process, I became more confused than before about who I was. These theories seemed to clash with some of the values I grew up with; at the same time, they seemed to help me better understand what was happening inside me.

My early life experience was full of ordeals, which I always managed to survive on my own and I had never felt like a real child. I was always very sensitive to others' needs and expectations and tried to work hard to please them or rescue them. To feel important and feel I existed, I had to be useful, and helpful. I had earned a lot of approval when I was a nurse in my home country. In a collective culture where I grew up and spent my early adulthood, the qualities of self-sacrificing, making no complaints and being compliant were always valued and demanded in females. However, when I came into another culture and changed my career from nursing to counseling and then to child psychotherapy, I started to realize the other side of these characteristics, which seemed to impact on my professional growth.

Through my personal therapy and supervision during my training, I began to acknowledge more of the pain of being a 'parentified child'. I noticed the heaviness, the fears, and the worries that my inner child had been carrying throughout my life. I was also more aware of how my countertransference could risk impeding the therapeutic process with my clients when in clinical placement. When I was not conscious of this and when I over-identified with some children's emotions, I could not contain them well,

or I misattuned to their emotional needs and attempted to rescue them from their pain. I also tended to please them and be a 'good mother' to nurture them and was unable to leave space for them to be angry with me. This sometimes unconsciously perpetuated the defense mechanism of splitting inside my child clients.

My personal life and clinical experience along with the initial literature review lead to the specific research question "What countertransference may occur in the therapeutic process when a child psychotherapist with a history of parentification is working with children?" The following three sub-questions were also asked to have a deeper understanding of the parentified child and allow for answers to the research question to slowly emerge. The three questions are:

1. From a psychodynamic perspective, how does a child develop into a parentified child?
2. How does the parentification process impact on an individual's self, emotion, personality and social development?
3. What are the special features of countertransference in child psychotherapy that may have a relationship with the countertransference of a child psychotherapist's history of parentification?

The assumption for this study is that the parentified child inside a therapist may have provided a pathway for the therapist to come into child psychotherapy training. The professional and personal growth in this training, which can be a journey towards discovery of the parentified child inside, may thrust the therapist back to emotions that were repressed in childhood. Being a parentified child could be a good survival strategy for early relational trauma. However, without an understanding of this wounded child inside, a therapist could be unconsciously repeating the relational trauma they

experienced during their childhood in the therapeutic process thereby perpetuating the distorted pattern of object relations. The exploration of these questions in this study may deepen a child psychotherapist's understanding of the emotional pain of a parentified child and enable them to make better use of the countertransference that can arise in the therapeutic process when working with children.

### **Structure of the dissertation**

This dissertation is divided into six chapters. The following chapter discusses the research methods used. Chapter three investigates the phenomenon of parentification under three categories: - the phenomenon of parentification in helping professions, the process of developing into a parentified child, and the impact of parentification on individuals. This chapter gives a comprehensive understanding of the parentified child, and its relationship with helping professionals. Chapter four describes psychoanalytic theories to deepen the understanding of the development of a parentified child. The next chapter is an overview of the process of countertransference for a child psychotherapist. The last chapter will synthesize the findings from the previous three chapters to identify the answers to the research question, followed with recommendations from the findings of this study. Limitations of this study are also discussed and suggestions are given for future research.

In order to keep a smooth flow in the writing, the pronoun *he* and *his* are used to refer to the child, infant or client, whereas the pronoun *she* and *her* are used to refer to the therapist. However, in both situations, they include the both genders of children and therapist.

## **Chapter Two      Method**

### **Introduction**

The aim of this study is to answer the research question which is: “What countertransference may occur in the therapeutic process when a child psychotherapist with a history of parentification is working with children?” In this chapter, concepts of qualitative research, practice-based research, evidence-based practice and systematic review will be discussed and links to the aim and purpose of this study will be made. The reasons for modification of this systematic review will be justified and the process of review will be identified.

### **Qualitative research approach and practice based research**

According to Leininger (1985), qualitative research focuses on identifying the qualitative features, characteristics, or attributes that make the phenomena what it is. The purpose of this study is to understand the countertransference of a parentified child psychotherapist, which focuses on qualitative features of this phenomenon. The themes identified in this dissertation are aimed at attempting to catch the essence of the internal world of a therapist’s countertransference and connecting her past with the present to increase the understanding of the two phenomena, parentified child and countertransference of a child psychotherapist. This is one of the functions of qualitative research, which is to find meaning and interpretation of the phenomenon (Leininger, 1985).

This study is also a practice-based research, which is based on the trainee child psychotherapist’s insight and life experience which form the structure to identify and frame the research question that are relevant to child psychotherapy and can improve

the practice of a child psychotherapist (Roberts & Yeager, 2004). Nevertheless, countertransference is one of the essential therapeutic tools that is used in everyday practice by a child psychotherapist to understand the client's inner world. With the awareness of the countertransference, the therapist may be able to facilitate the growth of the child's self and his relationship with the outside world. Therefore, by adopting a qualitative health research approach for the research question, my intention is to find more knowledge and awareness in the intra and interpersonal scope of practice (J. Green & Britten, 1998).

### **Evidence based practice**

Over the decades, many professional disciplines have adopted Evidence-Based Practice (EBP) as a model for improving their professional practice and consolidating their professional identity. This model originates from the concept of evidence-based medicine, emphasizing a scientific approach to clinical practice questions or dilemmas in order to find the effective and efficient treatment for health care (Corcoran & Vandiver, 2004). The process involves conscientious, explicit, and judicious use of the best available scientific evidence in professional decision-making (Sackett, Rosenberg, Muir Gray, Haynes, & Richardson, 1996). With this belief, professionals in health care have maintained that the most reliable evidence comes from randomised controlled trials (RCTs) and thus in order to generate new knowledge of their practice they rely a great deal on quantitative data to justify what the best practices are.

However, Fonagy, Roth, & Higgitt (2005) argue that evidence-based practice needs to look beyond the quantitative appraisal and look at practice-based evidence in order to establish comprehensively evidence-based practice. The complex decision-making process of EBP is not only based on the available evidence but also on

the client's characteristics, situations, and preferences as health care is individualized and ever changing and involves uncertainties and probabilities (Roberts & Yeager, 2004). In fact, most judgments by therapists in psychotherapy draw on many complex concepts and theories, including psychodynamic, developmental, behavioral, cognitive, family system, cultural, etc (Goodheart, 2004).

For the qualitative features of this research question and the purpose of this study, findings from many quantitative studies are summarized and interpreted with other theories; namely family, developmental and psychoanalytic theories. It provides an opportunity to compare and contrast some beliefs and concepts about the two ubiquitous phenomena and to bring the linking between them to benefit the child psychotherapist's clinical practice (Webb & Roe, 2007).

### **Systematic review and modified qualitative review**

Systematic review is regarded as one of the key sources of EBP and is also a method for practice based research to find the answers to clinical questions (Roberts & Yeager, 2004). A systematic review is a literature review which focuses on a single question. It attempts to identify, appraise, select and synthesize all evidence relevant to that clinical question (Petticrew & Roberts, 2006). Concerning the previous discussion of this research question and its relationship with practice based research and evidence based practice, along with the huge amount of literature about parentified child/parentification, a systematic literature review was selected as a research method for the exploration process of this research question.

However, as discussed before, the research question is qualitative and the data extracted and synthesized will reflect this as well, the systematic review is a modified qualitative systematic review. Mulrow & Cook (1998) assert that, "when the results of a

study are summarized but not statistically combined, the review may be called a qualitative systematic review” (p.7).

### **The process of systematic review**

This study follows the key components of the systematic review process identified by Dickson (2005). Firstly, the research question was defined. The main focus of this systematic search of literature has been around material related to parentified child/parentification and countertransference of a child psychotherapist. In order to link the parentified child with the countertransference of a child psychotherapist, three sub-questions were asked (Refer, to chapter 1, p.6) to track down psychodynamically oriented material related to the two phenomena that were being studied.

Secondly, the method for finding literature was identified. An extensive search was done through AUT’s database which included PsycINFO, PsycARTICLE, PEP; and ProQuest Dissertation and Theses---Full Text. The keywords used for search of evidence were as follow: Parentifi\$, Countertransference or Counter-transference, and Child psychotherap\$ or child therap\$. The tables of database search with keywords are attached in the appendix of this dissertation (Ref. Appendix, p.85).

From this initial search, many studies were found on parentified child/parentification and quantitative studies correlating to parentification to life events in family and psychosocial development. In order to find material to answer the question properly from a psychodynamic perspective, three other key words, false-self, role-reversal and compulsive caregiv\$ were selected to be included in the search of evidence from the database. Books related to the research question were searched from AUT library catalogue and Amazon.com. A hand search was also applied to find any material from the reference list of articles or books that appeared to be useful but were

not collected in the database search.

Thirdly, selection of studies was based on the inclusion and exclusion criteria set for this study. Literature related to parentified child/parentification specific to family system theory, developmental perspectives and psychodynamic approaches were selected as they gave a comprehensive view of a parentified child's life experience. Psychoanalytic theories focusing on children and relating to early mother-child relationships and the therapeutic process of child psychotherapy were also recruited in order to establish a deeper understanding of the parentified child. To meet the requirement of this dissertation, a decision was made to focus on three developmental theories in selecting materials. Another essential criterion for selection of the studies and theories was related to countertransference in psychotherapy with children and adolescents. The selection of evidence in this area was more related to the impact of a therapist's past history and some of the special features of the countertransferential relationship in child psychotherapy.

Studies or theories of parentified child using a sociological and anthropological approach and literature that focused on the transference of clients and adult psychotherapy were excluded.

Extraction and synthesis of the data are the fourth and fifth steps of this review process. When reviewing the literature, the focus was on the developing process of a parentified child as related to his characteristics and relational patterns; and the impact of parentification on an individual and helping professionals. The data is summarized in chapter three. Conclusions were made from this chapter about the positive and negative impact of parentification on an individual. From this review, it was found that false-self, role-reversal and separation-individuation are closely related to the development of a

parentified child. Therefore, three developmental theories, true-self and false-self, attachment and separation- individuation, were utilized to link the studies on the parentified child to gain an understanding from a psychodynamic perspective. After an overview of countertransference, focus was then placed on a child psychotherapist's internal process and the dyadic relationship and triadic relationship in countertransference. The data was synthesized and interpreted from a psychodynamic perspective to answer the research question. Three themes were identified to summarize the findings of this study in chapter six.

This chapter has discussed the research method used for this study by linking the concepts of qualitative research, practice-based research, and evidence-based practice to the purpose of this study. The reason for adopting a modified systematic review was justified. The research process for this study was also described. The following chapter will begin the process of this systematic review by summarizing data to understand the parentified child.

# **Chapter Three    The phenomenon of the parentified child and parentification**

## **Introduction**

There is a large quantity of literature discussing ‘parentified child’, ‘parentification’ and other related concepts. In this chapter, three categories, which are the phenomenon of parentification in helping professions, the process of developing into a parentified child and the impact of parentification on an individual, are identified to organize the material relevant to this study. Beginning with examining the phenomenon of parentification, I will focus on finding out the relationship between parentification and helping professionals. With this in mind, an attempt will be made to gain an understanding of the process of parentification in a child as well as the impact of parentification in adulthood. This knowledge will provide a broad sense of the construction of a parentified child from many different perspectives, including the relationship of self and other, emotion and personality development throughout the life span.

### **The phenomenon of parentification in helping professionals**

It is suggested that many who work in the field of psychotherapy have had excessive emotional demands placed on them as children (Miller, 2007). Therapists raised by narcissistic parents seem to struggle with narcissistic issues in therapeutic relationships, including extreme sensitivity, parentification, perfectionism, and impostor feelings (Glickauf-Hughes & Mehlman, 1995). In an intensive psychodynamic analysis, Racusin, Abramowitz & Winter (1981) found that the psychotherapists’ current professional functioning reflected their early experiences of helpless rage and conflict over the expression and acceptance of intimacy which engenders a sensitivity to

interpersonal stress and a need to control interpersonal relationships.

Miller (2007) believes that the abilities of therapists to be sensitive, empathetic and responsive may originate from their childhood experiences of fulfilling other people's needs while repressing their own. Lackie (1983) also points out that the caretaking role we experienced when we were children not only shapes our career choice but also colors our professional development. From their clinical experiences and theoretical perspective, they believe that without proper working-through of the past and a supportive, holding environment in training, therapists with a history of parentification, may transmit the exploitative relationship they experienced in childhood onto the therapeutic relationship with clients. Unconsciously, they may continue with the never-ending journey of looking for an understanding, empathetic "parent" in their children or clients (Miller, 2007, p. 21). They may also strive to be a perfect therapist, sensitive to external approval, which may induce the clients to fulfill this expectation (Lackie, 1983).

Several studies, which directly or indirectly examine parentification and its correlation with mental health professionals' career development, seem to agree with the above clinicians' point of view. Most of these studies are quantitative and use self-report measurements to collect data from participants. The result of these studies indicate that these professionals have a higher rate of parentification and report more traumas and dysfunctional family relationships in childhood when compared to other professionals such as those in business, art and computer sciences. Moreover, the findings suggest that firstly, professionals who have a dysfunctional family when they were children, very often were assigned to a caretaker role for the dysfunctional member such as for parents who are alcoholic or with mental or physical illness. As adults, they seem to feel

more comfortable in this caretaker role than those who come from less dysfunctional families (Elliott & Guy, 1993). Secondly, from a young age, parentified children learn to repress their own needs in order to take care of others. Unconsciously they extend this internalized caretaking role in interaction with others and enter into helping professions in adulthood (Nikcevic, Kramolisova-Advani, & Spada, 2007). Thirdly, when caring for others, the mental health professionals with parentification history can care for themselves at a distance, and, at the same time, obtain overt validation and recognition for their caretaking role (DiCaccavo, 2002).

It can also be argued that those who are in helping professions may be more sensitive to their early experiences due to their training and/or personal therapy. In this way, they are more ready to access memories of their childhood experiences and are more able to report what they are aware of than those who do not have this kind of training.

Weisshaar (2008) conducted a study on therapists' subjective feelings with clients in therapy, indicating that parentification may have an indirect impact on the therapists' vulnerability for feelings. Some of the common feelings the therapists identified in the therapeutic process are feeling insecure, confused, not in control, guilty, self-criticism and craving support. Several of them experienced more distressful feelings; such as high levels of anxiety, sense of feeling overwhelmed and threatened or fears of being under attack. Some of the therapists related these feelings to their own history of trauma or relational issues (Weisshaar, 2008).

Gracer (1993) also found that parentification positively correlates with

indicators of 'healthy empathy'<sup>2</sup>, however it also indirectly affects the relationship between narcissistic vulnerability and emotional concern. Individuals who were narcissistically vulnerable and parentified were found to be more able to feel emotional concern for others when compared to individuals who were narcissistically vulnerable but not parentified. The finding suggests that heightened empathetic abilities develop along with parentification; however, when compounded with narcissistic vulnerability there may be a distortion of empathy (Gracer, 1993).

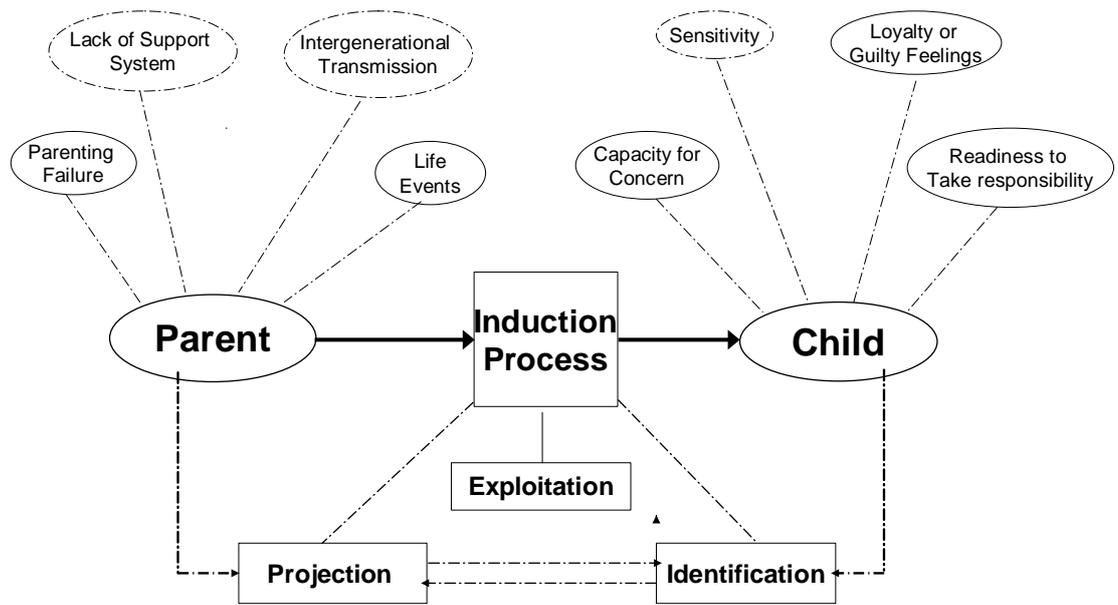
DiCaccavo (2002) reveals an interesting finding on the gender issue in relation to parentification among helping professionals. While both genders score high levels of parentification, the female participants who were parentified reported that their mothers abdicated from maternal care during their childhood. The male participants on the other hand reported receiving greater care during their childhood. It seems both genders fall in two ends of the parentification continuum (Jurkovic, 1997) (Ref. to chapter one). In both situations, the parent expects the child to act in a particular way to meet her needs at the cost of the child's development (Chase, 1999). From a psychodynamic perspective, both situations seem to display a lack of attunement to the child's needs and a failure to provide a good enough environment for mirroring the child's needs.

### **The process of developing into a parentified child**

Karpel's (1977) study seems to be the earliest qualitative study which looks at both the intrapsychic and interpersonal processes operating to create and maintain the relational structure of parentification. He believes both parents and children have their own issues and characteristics that contribute to this relational process (Ref. fig.1).

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<sup>2</sup> Healthy empathy includes emotional concern for others, fantasy ability and perspective taking.



**Fig.1. The process of developing into a parentified child**

With regard to aspects concerning the parent, the author finds that the ‘failure of parenting’ and ‘facticity’<sup>3</sup> of family life are the major preconditions of parentification. In relation to the child aspects, children’s capacity for concern and their readiness to take on responsibility seem to facilitate the development of parentification (Karpel, 1977).

The process starts when a parent’s early needs as a child were unable to be met by their real parent or other adult figures later, the deprived parent feels a need to induce their own child into being this parental figure (Karpel, 1977). This form of relationship

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<sup>3</sup> Facticity is a term used in existential philosophy, which describes how life events that happen in a family system can affect the system’s structure and survival

is described as “symbiotic therapist”<sup>4</sup> (Searles, 1973), which may install in the child a capacity for concern for their parents and lead them to act in a parental role. At the same time, children around the age of five begin to develop the ability of taking care of themselves and others in the family (Erikson, 1963). This readiness to be useful, to assume responsibility seems to complement the child’s natural sense of concern in the realm of participation through action in the life of the family. However, it may develop into parentification when the child’s ability to take on responsibility is exploited and when it interferes with the child’s normal course of development (Karpel, 1977). In this process, the parents seem to unconsciously project their own unmet needs onto the child and induce the child’s identification with their needs and feelings.

There have been many studies investigating the life events that correlate to the development of parentification in a family. These life events include parental divorce and conflicts, alcoholism or substance abuse in parents, family with abuse and violence, parents or siblings suffering from physical illness, mental problems or disability, poverty and immigration. The findings in most studies indicate that children who grow up in these family situations report higher levels of parentification, taking on more parental responsibility.

When life events such as divorce or alcoholism occur in the family and impact on the adults’ capacity to parent, the most willing or capable children from these families will be seduced by the parents into a caretaker role (Locke & Newcomb, 2004; Peris & Emery, 2005). These children are demanded upon to provide emotional or

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<sup>4</sup> Symbiotic therapist is a form of relatedness occur in a mother-child relationship which both the mother and the child’s ego-functioning is fixated at a same level of relatively infantile fragmentation and non-differentiation. At the same time, the child is required not to become a whole person but remain available for complementing the ego-incompleteness of the others in the family (Searlers, 1973).

logistical support to their parents in order to alleviate the parent's stresses and pressures and to protect the family system (Burnett, Jones, Bliwise, & Ross, 2006; Martin, 1996). It has also been found that these previously parentified children often resort to alcohol or drugs when faced with problems of raising their own children, thus repeating the parentification process (Bekir, McLellan, Childress, & Gariti, 1993).

Parentification is identified as one type of parent-child relationship of a non-symptomatic child in family with chronically ill member (Tsamparli-Kitsara & Kounenou, 2004). In a family with children suffering from illness, the family dynamics may recreate instrumental roles as well as expressive roles for children who do not suffer from the problems (Caruz, 2006; Lamorey, 1999). Moreover, parents with mental or physical problems, such as parent suffering from cancer or maternal depression seem to induce more of children's emotional involvement, as children are sensitive and feel more for their parents when they are unwell (Solantaus-Simula, Punamaki, & Beardslee, 2002; Thastum, Johansen, Gubba, Olesen, & Romer, 2008; Tompkins, 2007).

Parentification also occurs in incest experiences that were reported in some studies (Hays, 1987; Russell, 1998). In an abusive relationship, the person who was parentified is easily trapped into the feelings of guilt and family loyalty, compelling to assume the obligation of providing care for others without self-regard (Cotroneo, 1987).

Many of these life events reflect on the unpredictability of the family environment and the difficulty and stressful time a parent may have encountered that takes away their ability to be a parent (Burnett, et al., 2006). The parentification process seems to relate to how the parents coped with their life situation such as whether the mother felt burdened by her own illness or perceived a lack of support (Duryea, 2008). It is also correlated significantly with both early and current family support system

deficits in child abusing families (Hellman, 1981). In families with parental conflict, if the parents had enough support from an adult and did not need to go to the child for emotional support, these individuals scored low level of parentification in a study (Peris, Goeke-Morey, Cummings, & Emery, 2008).

The literature indicates there are multiple factors contributing to the parentification process. Jurkovic (1997) suggests an integrative framework of causation in parentification to analyze this phenomenon in six levels (Ref. table 1, p.22).

**Table 1 Levels of Analysis of Parentification**

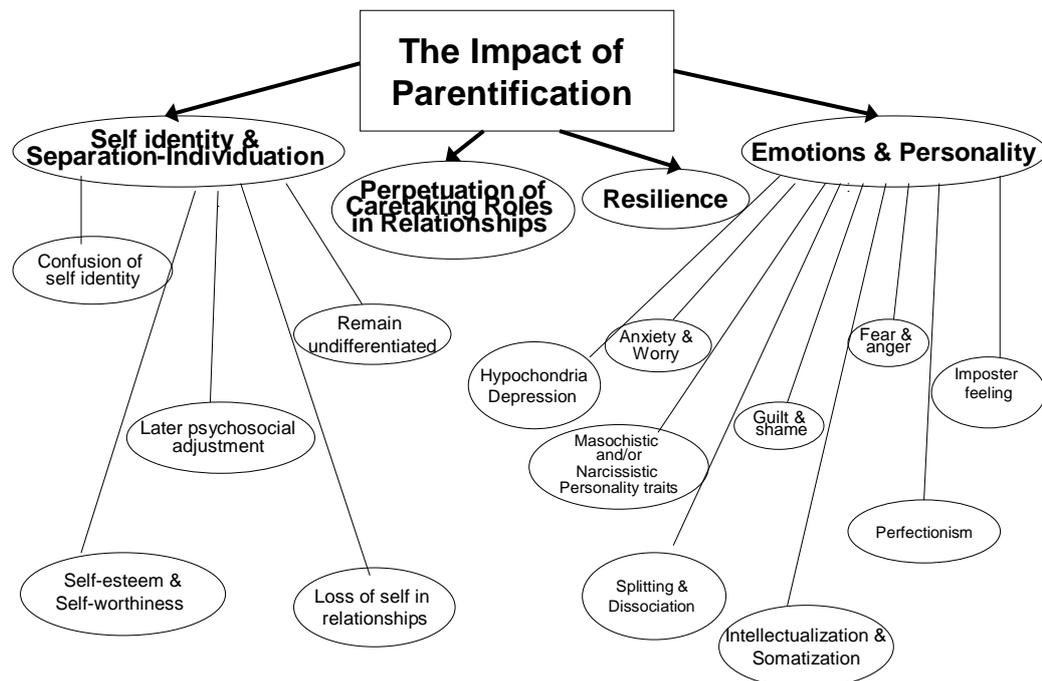
Individual Development (Ontogeny)	Proximal Settings (Microsystem)	Interrelation of Settings (Mesosystem)	Distal Settings (Exosystem)	Cultural Consistencies (Macrosystem)	Ethical Context (Co-being)
Parents	Family	Home-School	Neighborhood	Societal Attitudes	Balance of Fairness
Privation	Stressors				
Attachment	Role Induction	Parent-Peer	Employment	Social Legitimacy	Entitlement
Self-Differentiation	Boundaries				
Cognitive Schema			Social Service	Gender Roles	
	Peer				
Children					
Temperament	School				
Capacity to Care					
Attachment					

Note: The various settings are viewed from the perspective of the child.

**Source:** Jurkovic, G. (1997). *Lost childhoods: The plight of the parentified child* (pp.19). New York: Brunner-Routledge

## The impact of parentification on individuals

There are many studies and expert opinions about the impact of parentification on individuals. Even though, most of the results indicate that parentification has adverse effects on individuals, lately, more studies are attempting to find out the resilience in parentified children. The following subheadings are used to extract the material that is relevant to this study. (Ref. figure 2).



**Fig. 2. The impact of parentification on individuals**

### Impact on self- identity and separation-individuation process

Parentification is believed to affect the normal process of differentiation of self, self-definition and self-direction (Karpel, 1977). Less differentiation may cause more confusion of who they are and may cause them to experience loss of self in close relationships (Bowen, 1978). When serving as an object to a parent’s emotional needs, a parentified child may develop a “pseudo-self with pseudo-separation” (Bowen, 1978,

p.109) from their parents but they may remain undifferentiated from the parent or more generally from the object-role defined in the parentification process (Chase, 1999). For a long time in the parentification process, the children's self-perception may become distorted and they may regard being a "caretaker" or "go-between" as the only identity they can have (Karpel, 1977).

Studies show that the interruption of normal separation- individuation process by parentification, leads to adolescence and young adult problems of adjusting to transition in life, such as going to university or military service. Some parentified adolescents were found to have problems of social-emotional adjustment, and commitment to college education (Baumann & Mollen, 2006). Others who were preoccupied with conflicts with their parents were unable to free themselves as they were feeling anxious and afraid of separation (Mayseless & Scharf, 2009). However, Ackerman (2001) did not find the relationship between parentification and college adjustment, and the post hoc finding suggests that the attachment to parents has more influence on the young person's adjustment to college.

### **Perpetuation of caretaking roles in relationships**

The interpersonal pattern a parentified child first learned in childhood may carry over into their adult life in a form of over-responsibility for others' needs and diminishing their own sense of self (Valleau, Bergner, & Horton, 1995). When a parentified child learns to give up their own needs for others, it plants the seeds of "codependency" in relationships, which conveys the message that, the "other is more important than self." (Olson & Gariti, 1993, p. 200). Parentified individuals with a tendency for codependency relationships were found to have a shame-based organization of self, feeling intrinsically inadequate, defective and low self-esteem

(Wells, Glickauf-Hughes, & Jones, 1999; Wells & Jones, 2000).

To be able to be responsible for other's physical and emotional care, the parentified child develops two significant attributes: - the sensitivity to other's feelings and the commitment to the caretaker role (Karpel, 1977). Hyde (1986) observes that the caretaking role of a daughter can meet the parent's emotional needs and/or sexual needs in fantasy and suggests that the client may reenact this relational pattern in the therapeutic process.

### **Impact on emotions and personality development**

Parentification has been shown in clinical and research literatures to have significant correlation with emotions such as anxiety, worry, fear, guilt, shame, loneliness, and depression. Lackie (1999) uses metaphors to reflect on the inner world of the parentified child, one being: "Parentified children swim in a sea of internal, drowning objects, too many to save easily, yet too precious to be abandoned." (p.147). He links this to the burden that parentified children carry and develop into high levels of anxiety in adulthood, worrying about their inability to manage ambiguous situations (Lackie, 1999).

Parentified children seem to easily become the "family worrier" (Boszormenyi-Nagy & Spark, 1984b, p.258) and over-responsible for other's problem (Karpel, 1977). Parentification renders the parentified child vulnerable to feelings of helplessness, uncertainty and anxiety, thus becoming over-attentive to potential danger (Cervený, 2005). Besides, the loneliness a parentified child experiences seems to relate to the mother's physical and emotional unavailability in childhood and is mixed with fear when the young child is left alone to take care of younger siblings (Wiseman, 2008)..

The various life crises associate with parentification (ref. to previous section, p.19-21) seem to have great impact on the individuals' emotional well being. In comparison, parentification has a stronger effect on women's depression, anxiety and interpersonal sensitivity than parental divorce and parental depression (Martin, 1996). Children of workaholics (Carroll & Robinson, 2000) or mentally ill parents (Knutsson-Medin, Edlund, & Ramklint, 2007) report more negative emotions, such as depression, fear of abandonment, and loneliness. Parentification is also found to be a family's coping skill where child sexual abuse has taken place (Russell, 1998) which in turn leads to anxiety and posttraumatic stress in the victim (M. L. Green, 2001). More recently, studies have shown that children who take care of their mother with depression tend to present more anxiety-depression symptoms and lack of social competence in adolescence (Champion, et al., 2009). All these studies seem to represent the breakdown of family systems and disruption of the parent-child relationship. Consequently, the parentified child is not only burdened by parental responsibility but also loss of their childhood when their own emotional needs are not acknowledged.

Parentified individuals manifest masochistic (self-defeating) and/or narcissistic personality trait depending on what expectations are imposed on the child by their parents (Wells & Jones, 1999). If children are trapped into taking on a physical or emotional caretaker role, they are more likely to develop the masochistic (self-defeating) character style. On the other hand, if children are induced to live out a parent's dream, this may result in narcissistic character style (Jones & Wells, 1996)

Adults with parentification history tend to use defense mechanisms such as splitting, intellectualization, and dissociation to protect themselves from overwhelming feelings. Splitting is employed to protect the parentified individual from feelings of

badness about the “true-self” and to avoid intolerable anxieties that relate to separation, abandonment or disappointment in others (Wells & Jones, 1998). Intellectualization and avoidance were found to be a defense against the loss of a central self- identity associated with parentification (Reeves, 1999). The parentified child also relies to some degree on dissociation as an “anesthetic”, or “firewall” when suffering from strong internal emotional pain so that he can proceed with the caretaker role for others (Lackie, 1999, p. 143).

### **Resilience in parentified child**

Some researchers have been questioning why some children survive the difficult situations and grow up to do well in society (Godsall, Jurkovic, Emshoff, Anderson, & Stanwyck, 2004) and have argued whether most of the literature has focused on pathologising the impact of parentification (Barnett & Parker, 1998). Recent studies show that parentification in children may not negatively affect later autonomy development (Murphy, Greenwell, Resell, Brecht, & Schuster, 2008), or be associated with emotional distress and psychosocial adjustment (Fitzgerald, et al., 2008; McMahon & Luthar, 2007; Oznobishin & Kurman, 2009). In fact, early parentification predicted better adaptive coping skills and less alcohol and tobacco use (Stein, Rotheram-Borus, & Lester, 2007), strengthening the development of adolescents (Walsh, Shulman, Bar-On, & Tsur, 2006). In some immigrant families actual caregiving activities were found to be associated with higher competence and fewer acting out problems among boys (Kuperminc, Jurkovic, & Casey, 2009).

Some adult-like responsibility may actually be beneficial to the child’s growth and healthy sense of belonging and connection with the family (Telzer & Fuligni, 2009). When life crises happen in family, if the child has a greater attachment to their mother

or other attachment figure available it may mediate the impact of parentification (Schroeder & Kelley, 2006) and enhance an individual's self-esteem (Walker & Lee, 1998). This emphasizes the importance of early mother –infant relationship that may establish a foundation of coping and resilience in adverse situations.

During the parentification process, some children may be able to derive self-worth from their contributions to others outside the family and get the external approval they so hunger for. It is also possible that resilience comes from the individuals' learned and inherited characteristics thus enabling them to cope well in the parentification process. However, these resilient children may grow up retaining a deficit in the self, which may cause emotional problems in mid-life (Braverman & Paris, 1993).

A more recent study shows that parentification predicts a mild level of posttraumatic growth (Hooper, Marotta, & Lanthier, 2008). However, for the growth to happen, it takes time and developmental maturity to metabolize the adverse events and to make meaning of the trauma (Morris cited in Hooper, et al., 2008). Those parentified therapist who choose to enter psychotherapy training, may unconsciously attempt to find meaning for what had happened in their childhood and the early object relations. This may contribute to their capacity for being more self reflective and more open to awareness of their past.

When considering the impact of parentification, the culture of a person needs to be taken into consideration as well. In some Asian and African cultures, there is no such concept as parentified child or parentification. In collective cultures, descendent social roles and family patterns are fluid and interdependence is encouraged. These patterns may be misunderstood by someone from a Western culture as a sign of enmeshment or

co-dependency, and flexible family roles may raise concern about boundary definitions (Anderson, 1999). In the Chinese socio-cultural context, the mother-child relationship is defined by specific role requirements such as that children must show loyalty and respect to their elders, and the elders must responsibly teach, discipline, or govern the children (Lieber, Fung, & Leung, 2006). Each party must fulfill these role requirements in order to maintain social harmony, particularly in the family (Bond, 1991). Chinese children are expected to listen to adults, follow rules, self-monitor, and be sensitive to other people's needs (Wang & Phinney, 1998). Usually the individual identity (me-self) is embodied in the family self (we-self) which Fan (2008) regards as similar to Winnicott's concept of the adaptive false-self. Therefore, in a collective culture parentification seems to be a normal and acceptable parenting strategy. Children who grow up in these cultures may not have been influenced by the parentification on their self concept if they can get the approval from their parents and the outside society in performing the role assigned to them (Mun, Choi, & Choi, 2008). However, on a deeper emotional level, the mourning of the desire for independence and forgoing it to fit into the interdependent relationship could be painful and anxiety provoking (Fan, 2008), especially if they emigrate to Western countries. Yet, in Chinese culture, many adapt to the emotional constraint and resort to defend the emotional pain by intellectualization or somatisation.

## **Conclusion**

Parentified child/parentification seems to be a common phenomenon occurring in many individuals' life to different extents. There are many factors involved in the process of developing into a parentified child and the impact on an individual. Some inconsistencies of the research findings are noticed and these may be due to the design of the research method and the sampling of participants. Most of these studies are

quantitative, using self-report questionnaires to measure the level of parentification in correlation with the conditions and impact on a person's psychosocial development.

The parentification assessment, which proved to be valid, relies heavily on the person's recollection of the childhood. As reviewed in the literature, a parentified individual tends to use defense mechanisms to defend off their childhood pain. This may possibly affect how deeply they may be aware of the parentification process and its impact on them. Another limitation of the measurement is that it restricts the age of participants, while most participants in the study are adults and adolescents, only few studies use projective measurement in late school age children (8-11 years old) (Leon & Rudy, 2005; Pola, 1992). Overall, however, the literature provides valuable evidence to support the prevalence of parentification. It indicates that when life events occur in families, it may affect the balance and reciprocity of parent-child relationship. On the other hand, even though Karpel's study had a very small sample of six families, the data the author presents is very rich and meaningful. It offers an in depth understanding of the dynamic of parentification in a relational context.

All those situations that have found to highly correlate with parentification can be referred to as a "not good-enough environment" (Winnicott, 1965a). The impact that they have on a parentified individual can be attributed to a disruption in the mother-child relationship. This relationship issue may also influence a therapist working with children in a therapeutic process as this relationship may be unconsciously revived. Herein lies the inspiration for a deeper understanding of the parentified child from a psychodynamic perspective and the countertransference in child psychotherapy which is the focus of this dissertation.

## **Chapter Four    Understanding the parentified child from a psychodynamic perspective**

### **Introduction**

From the literature review in the previous chapter, the phenomenon of the parentified child was explored. Parentified child is understood to develop out of multi-factors involving the parent and the child, and which may have a positive and/or negative impact on an individual throughout the life span. This chapter will examine this phenomenon with the help of three psychoanalytic -developmental theories, Winnicott's true-self and false-self theory, attachment theory, and Mahler's separation-individuation theory. The purpose is to have an understanding of the parentified child from a psychodynamic perspective, which may enhance the parentified therapist's understanding of her countertransference in the therapeutic process when working with children.

### **Winnicott's true-self and false-self theory**

Winnicott (Winnicott, 1965b) believed that an infant's true-self develops out of relationship with a good enough mother who is able to meet the omnipotent needs of the infant. He suggested that the true-self has a characteristic of spontaneity and comes from the aliveness of the body. The false-self on the other hand develops when the mother repeatedly misses the spontaneous gestures (the true-self ) of the infant, instead imposing her own needs onto the infant; thus the infant learns to meet her expectations. After a while, the infant represses his own spontaneous needs in order to maintain the relationship with his mother (Bacal, 1990a).

The concept of how false-self develops seems resonant with the process of developing into a parentified child. The characteristics of sensitivity, compliance, independence, industriousness and caring of most parentified children, may have come from the false-self hiding the needs of the true-self in order to earn recognition from outside. Internally, the parentified child may be longing for love and connection with a “responsive mother” (Winnicott, 1965a).

Winnicott (1971) suggested that by mirroring, the mother acknowledges the baby’s uniqueness and creativity, thus giving back to the baby his own (true) self. He observed that, “When I look I am seen and so I exist” (p.114). Faced with a lack of mirroring, the parentified child may have to rely on being compliant to other’s needs or expectations, for his existence. Without being seen by a mother, a parentified child may be left with feeling invisible and unimportant from an early age.

A mother’s inability to empathize with her infant's needs may contribute to a variety of unthinkable anxieties in the infant such as: going to pieces, falling forever, having no relationship to the body, and having no orientation (Winnicott, 1965a). When a mother responds to her child inconsistently, the important function of the false-self is to comply with the environmental demands by hiding the true-self and protecting it from annihilation by defending it against the unthinkable (Bacal, 1990a).

In this sense, Winnicott’s concept of self-development can be identified as a continuum of the false-self and true-self. Depending on the relationship context, there may be differences in which way the false-self functions with the true-self, whether the false-self totally represses the true-self or the false-self gives way for the true-self to express itself. For the parentified child probably the false-self has repressed a great part of the true-self, especially those who are identified by Jurkovic (1997) as having

destructive parentification. How these two parts of the self function with each other may affect the spontaneity and aliveness of a child therapist which may impede the therapeutic process.

Parentified children may perform the caretaker role in order to maintain an emotional connection to their parents and receive validation. However, when difficulties arise in meeting other's needs and expectations, the parentified child may have high levels of anxiety concerned with the fear of not being loved and feeling inadequate (Castro, Jones, & Mirsalimi, 2004). They may never feel they have done enough or be good enough and may become obsessive in pursuit of perfectionism to meet other's needs and get approval (Jurkovic, 1997). When they grow up, these feelings of in-authenticity and inadequacy may remain part of their identity and manifest into imposter feelings of incompetence and fear of discovery (Kets de Vries, 1990). They may continue to work excessively hard to please others but discount evidence that they are in fact skilled or talented, and continue to feel like 'frauds' (Langford & Clance, 1993). Moreover, some intelligent people may employ the mechanism of intellectualization to cooperate with the false-self in cutting off true-self feelings from the body (Winnicott, 1965b). Therefore, they tend to solve personal/emotional problems with their intellect only and may not attend to their feelings (Mitchell, 1984).

Hanna (1992) suggests false-self compliance is characterized by compulsive caretaking accompanied by evidence of masochistic self-denial. The individual may have strong feelings of rage, envy, and greed in response to unacceptable primary needs of love and nurture which are repressed since childhood. Individuals with false-self compliance seem to experience resentment and depressive fantasies of being used up by the neediness of others (Hanna, 1992).

The process of creating a parentified child is partly due to the reinforcement by the parents of the child's sensitivity, intelligence or extraordinary power. This sensitivity of a parentified child may have developed out of the capacity for concern that Winnicott proposes. The capacity for concern, which develops in early infancy originates from the infant-mother relationship. It develops out of guilt when a child attempts to destroy an "object mother" who frustrates his omnipotent needs (Winnicott, 1965a). When the actual mother can survive this attack and give space for reparation, a child is able to develop the 'me' and 'not me', and be able to differentiate from the object mother and develop the self and object representation (Bacal, 1990a).

When the child's capacity for concern is being exploited to meet the mother's own needs, the parentified child may have to repress his omnipotent needs and use the false-self to hide the true-self. Driven by feelings of guilt, a parentified child may overly develop the capacity for concern for others and assume a caretaker role to keep searching for the "mirroring object" (Bacal, 1990a) and connection in a relationship. High levels of guilt may also develop into masochistic personality traits in the parentified child (Wells & Jones, 1999).

### **Attachment theory**

Attachment is a deep emotional bond that exists between a child and an adult wherein the child invests strong emotions to keep close to and from whom he seeks security and comfort, especially at times of distress (Cassidy, 2008). There are three key features about an attachment relationship: firstly proximity seeking to a preferred figure, secondly the 'secure base' effect and thirdly separation protest (Bowlby, 1969).

Ainsworth (1990) suggests that for parents to be able to establish a secure attachment with their children, they need to have intuitive and sympathetic

understanding of their child's attachment behaviors and a willingness to meet their needs. Otherwise, insecure attachment patterns, such as anxious or ambivalent attachment<sup>5</sup> may develop (Karen, 1998). Attachment behavioral system<sup>6</sup> is a system based on 'set goals' to keep close enough to the mother, using her as a secure base for exploration, and protest when separation arises (Holmes, 1993). It interplays with other behavioral systems, such as exploration, fear, sociability, and caregiving (Cassiday, 2008).

Research in the previous chapter showed, parentified children usually experience failure of parenting in their life (Karpal, 1977). This implies that the parentified child may have difficulty in experiencing a secure base. It is likely these children's attachment system can be easily activated whenever the fear system is activated due to their mothers' inability of assuming the responsibility for maintaining proximity (caregiving system is deactivated) (Cassidy, 2008). This may deactivate the child's exploratory system (Marvin & Britner, 2008). Nevertheless, it will lead to the parentified child feeling anxious and worried, resulting in the child relying on his own resources, such as being self-reliant or become compulsively caregiving in order to maintain the proximity with an attachment figure (West & Keller, 1991)

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<sup>5</sup> Children who are anxious or ambivalent attached, have been able to form a focused relationship with a discriminated and preferred attachment figure, but whose attachments show an unusual amount of conflict regarding the perceived physical and emotional availability of the attachment figure (Lieberman & Pawl, 1993). These children usually are exposed to some form of pathogenic parenting such as persistently unresponsiveness of parents to the child's care-eliciting behavior, loss of an attachment figure permanently or temporarily, or threaten children with rejection and abandonment as a form of discipline (Bowlby, 1979)..

<sup>6</sup> Attachment behaviors are behaviors that the child uses to attain or retain proximity to the mother. There are a variety of attachment behaviors that are organized into an "attachment behavioral system" for responding to cues for attachment relationship (Bowlby, 1979, Cassidy, 2008).

The concept of “internal working model” represents the relative whereabouts of the self and the attachment figure (Holmes, 1993). The basic problem of anxious attachment is maintaining attachment with a care-giver who is unpredictable or rejecting (Bowlby, 1979). Traumatic events in a family such as abuse or neglect, which are associated with a high level of parentification or role-reversal, may also evoke feelings of rejection and abandonment in children (Alexander & Anderson, 1994). When parents were parentified or abused when they were children, they unconsciously expect care from their own children by repeating what their parents did to them, such as abusing their children, or by demanding care and nurture from their children (Alexander, 1992). Here the internal working model will be based on coping, in which the caregiver must be accommodated to (Holmes, 2001). In this sense, the parentified child’s internal working model may be one that like an ambivalent attachment, is a coping strategy that has made them very sensitive to their mother's needs, to take on the responsibility to comfort and nurture the parent and become the parent of the parent (Howe, 2005).

Compulsive care-giving is one of the patterns of mourning the loss of an attachment figure (Bowlby, 1980). Children with parents who appear to be frightened and/or frightening to the child, may develop disorganized attachment (Hess & Main, 1999) and later become parentified and controlling of the parent (Main & Cassidy, 1988). When the child has to comfort a frightened, helpless or needy parent who is dis-regulated by unresolved traumas, the self-representation is that of rescuer or compulsive caregiver who is responsible for the other’s safety (Howe, 2005).

Compulsive caregivers are able to engage in many close relationships but the only affectional bond they can find available is one where they must always be the caregivers (West & Keller, 1991). These children suppress their yearning for love and

care from their parents beneath a parentified surface, fearing that they may cause their caretaker even greater distress and anxiety (Alexander, 1992). However, when under pressure, their emotions may erupt, and they may become explosive and tearful (Howe, 2005).

Guilt induction is seen as a tactic of psychological control which denies the children's free expression of desires and activities and coerces them to comply with the parents' desires and expectations (Mayseless & Scharf, 2009). A community sample of adults, who were induced with guilt to please their parents, were found to have higher levels of anxiety and depression (Mayseless, Bartholomew, Henderson, & Trinke, 2004). Eagle (2003) in a case study, connects the concepts of "survivor guilt" and "separation guilt" (Modell cited in Eagle, 2003, p.31) with anxious-ambivalent attachment in order to understand a client's internal process of loyalty to an object. He finds that when parents subtly convey to the child the need for companionship or threaten them with guilt if the child leaves them, the child becomes parentified in order to protect and care for the parent (Eagle, 2003).

### **Mahler's theory of separation-individuation**

Mahler, Pine, & Bergman (1975) propose that psychological birth is a process whereby the infant develops into an independent self through separation and individuation from the mother. Before this "hatching" process occurs, the infant needs to go through phases of "normal autism" and "normal symbiosis" (Mahler, et al. 1975, p. 53). After establishing a very close relationship with a mother figure, the separation-individuation process begins with dim awareness of differentiation of self from others (Newman, 1990). In the practicing sub-phase of this process the child perceives "the world as his oyster", developing a sense of "narcissism" and

“omnipotence” in the relationship with self and other (Mahler, et al., 1975, p. 71). With the toddler’s increased awareness of separation from the mother, he experiences a “rapprochement crisis” which is ambivalent feelings of love and hate for the mother object. As the mother continues to be emotionally available in this process and serves as the “auxiliary ego” for the infant by providing gratification of needs and preventing excessive frustration, the toddler finally develops “object constancy” which enables him to consolidate his individuality (Mahler, et al., 1975). In other words, during the process the child develops his own self by early awareness of “I am” to later awareness and confidence of “who I am” (St. Clair, 2004).

As discussed in the previous chapter, many parentified children seem to have an interruption in this process which affects their self-identity, adjustment to the transition in life and may impact their personality traits and emotions. Johnson (1994) claims that to adjust to the difficult task of individuation, every character structure developed before or during the rapprochement sub-phase, may be found to have a certain extent of narcissistic characteristics. When a child lacks an intact ego structure and a sympathetic understanding environment to go through the individuation process, he may suffer from narcissistic injury, burying his real-self expression and replacing it with compensatory false-self. These children cannot use the mother to negotiate the powerful emotions of defining the emerging and separate self, instead they are used by the mother for understanding and mirroring that she herself needs (Miller, 2007).

According to Mahler et al. (1975) infants from the second month to around six month-olds are in a period of normal symbiosis. Symbiosis is optimal when the mother promotes sensory responses such as eye contact, touch and talking to the baby to prevent the baby from moving out of the symbiotic relationship too early (St, Clair,

2004). In some cases, the mother is unable to stay with the sensory interactions and mirror back to the baby to facilitate his development of a good “self representation” (Newman, 1990, p. 105). These infants seem to develop an early adaptive ability for mothering themselves and some signs of “false-self” (Mahler, et al., 1975).

Stern (1985) also observes that infants at seven to nine months old develop a sense of subjective self and intersubjective relatedness. The infant can now hold the other in mind and be able to read, match, and attune to the other while the mother may respond accordingly. To experience the intersubjectivity between the mother-infant, there must be some shared framework of meaning and means of communication such as gestures, posture, or facial expressions (Stern, 1985).

It is probably at this stage the parentified child begins to develop that sensitivity to the other when finding the meaning of the nonverbal message that a mother unconsciously transfers onto him. For example, a depressed mother preoccupied with her own emotions may not be able to attune to the infant’s needs but with this intersubjectiv relatedness the infant may develop sensitivity to those gestures, facial expressions of mother and be able to attune to the mother’s needs. Thus, the parentified child learns to repress his omnipotent needs and find ways to please the mother, such as by smiling, making gestures of caring or by being self-reliant.

Bick (1968) comments on the infant’s need for a containing object as primal (psychic) skin to hold parts of personality together. Disturbance in the primal skin function can lead to a development of a “second-skin” formation through which dependence on the object is replaced by a pseudo-independence, by inappropriate use of certain mental functions, or perhaps innate talents, for creating a substitute for this skin container function (Bick, 1968, p.484). Infants may learn to develop a second skin by

visual tracking and auditory reception in order to hold a mother in their minds that facilitated their adaptation to the physical and emotional distance of a mother figure but still have connection with her. These may give them some sense of security in order to calm themselves from the fear of being abandoned. Perhaps the sensitivity of a parentified child can be considered to be a “second skin” or the innate talents the child develops at an early age as resources for maintaining a connection with the mother and to hold himself together (Briggs, 2002).

In a study of mother-son interaction and its prediction of parentification, the result indicates that sons who have peer-like interactions with his mother and who initiate higher-than-average amounts of eye contact with their mother, are more likely to report higher levels of parentification (D. R. Johnson, 2001). Eye-contact was also used by a child as a protective mechanism for coping with life crises in a case study. Some of the coping strategies may not look so healthy, but may help parentified children to regain strength from an early attachment figure, or to construct a “safe space” to contain their anxiety (Eisold, 2005, p. 420). This seems to support the hypothesis that the second skin development in early infancy may have a protective factor for the parentified child. Other than eye contact, the parentified child may use ‘fantasy’, ‘day-dreaming’ for the purpose of recreating an idealized internal object in order to keep the hope of searching for a mirroring object.

Breakdown of “mutual cuing”<sup>7</sup> or unpredictable, hostile mirroring of mother object may lead to low self-esteem in the child, as he does not have a reliable frame of reference to check back to (Newman, 1990, p. 106). As revealed in the previous chapter,

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<sup>7</sup> Mutual cuing is a form of mother-infant interaction and develops into mutual verbal communication.

parentified children seem to have parents who are unable to mirror their needs. This theory may well explain why they usually develop low self-worth and sometimes feel they are invisible in social settings. They may feel undeserving of having their needs being communicated and understood and met in a relationship but work hard to contribute by taking care of others in order to maintain their worthiness in a relationship. When demands are made on children to grow up prematurely, they may engage in reaction formation against the recognition of their deeper needs. However, the fear of being abandoned may be reactivated later in life when they come across any separation, which produces a sense of profound anxiety (Newman, 1990). This may also contribute to a parentified therapist's anxiety in terminating the therapeutic relationship with children in therapy.

## **Conclusion**

This chapter used psychoanalytic and developmental theories to investigate the phenomenon of the parentified child which provided a framework for understanding a child's internal world when this first relationship is interrupted or damaged, and the long-term impact of separations, losses, wounds and deprivations. The first relationship depicted in these theories seems to have a strong influence on a parentified child's self, emotions and the relationship with others. The parentified child may grow up with a false-self and an insecure attachment pattern in relationship with the outside world. At the same time, the 'second skin' the parentified child developed for mothering himself from an early age may have contributed to his sensitivity to other's needs and to take on a caretaker role in relationships. Some therapists may be unconsciously motivated by this factor to choose child psychotherapy as their career path. However, this parentified child inside the therapist may have an impact on the countertransference relationship in the therapeutic process. This is the focus of the next chapter.

## **Chapter Five      Countertransference in child psychotherapy**

### **Introduction**

The therapeutic process involves countertransference, which is described by Heimann (1950) as a relationship between two people characterized by the presence of strong feelings in both parties. There are two approaches to define countertransference. The classical view regards countertransference as an unconscious response of the therapist to the client's transference (Tansey & Burke, 1989). The source of the countertransference originates from the therapist's past conflicts or difficulties and can hinder the therapeutic process. (Lakovics, 1983). However, from the totalist viewpoint, countertransference response could be conscious or unconscious; the source of countertransference is not just from the therapists' past, but also their present conflicts or feelings, as well as their life events and their interpersonal responses to their clients (Tansey & Burke, 1989).

In a wider sense of the term, countertransference includes the personal factors prior to the therapeutic relationship. However, rather than impeding the therapeutic process, it helps the therapist's capacity for empathy and her sensibility to have a better understanding of the child client's internal world (Bonovitz, 2009; Dube & Normandin, 1999). Bonovitz (2009) believes doing therapy with children may stimulate memories of the therapist's own childhood experiences, which are vital resources for understanding a child's inner conflicts and relationship with others. Dube and Normandin (1999) regard countertransference as a basic tool which links the therapist's professional and personal development. In her comparative study trainee child psychotherapists who had therapy were compared with those who did not have therapy. Those who had had personal therapy were less prone to block out or act on their first

impressions. They also have more capacity for elaborating formulations of the inner world of the children.

Hayes (2002) suggests that in order to be able to have a deep empathic understanding of a client's internal process, a therapist needs to continuously and actively search her own history her wounds inside which brings about greater self awareness. As such, a parentified therapist may be able to function as a "wounded healer" to use the woundedness of the healer to understand her clients (Sedgwick, 1994). What needs to be addressed is the therapist's awareness of her parentification history and its influence on her countertransference in the therapeutic process. This chapter therefore focuses on an overview of the countertransference process and some countertransference phenomena that may occur in child psychotherapy in order to find out how parentification may have an effect on the countertransference of a child psychotherapist.

### **The internal process of countertransference**

Countertransference is an interactive process involving complicated psychological mechanisms of projection, identification and introjection within and between the therapist and the client (Tansey and Burke, 1989). According to Racker (1968) countertransference is a therapist's reaction to the client's use of projective identification, leading the therapist to identify with the client's self or object representation. At the same time, the client also identifies with what he has projected out and what is experienced by the therapist. Projective identification is believed to be not an isolated defensive operation but a way of relating that occurs in all human beings (Malin & Grotstein, 1966). Bion's (1962, 1963) interaction model of the container and the contained, which is based on the mechanism of projective identification, well

illustrates this concept. It suggests that when a therapist acts as a container for a client, she receives the projection from the client and contains it. The therapist then metabolizes the intense feelings and thoughts and returns it back to the client to achieve 'reverie'<sup>8</sup>, which is a connecting moment in the therapeutic process (Waddell, 1998).

Ogden (1979) identifies three steps of projective identification in the relating process:- Firstly, some aspects of the self is projected into another person; secondly, the other person as a recipient is induced to contain the projected materials; thirdly, the projected self-elements are re-internalized. Caspary (1993) believes what occurs in between Steps 2 and 3 is essential for the therapy with children. During the therapeutic process, the client not only needs to develop empathy for the projected self-representation and object representation, but must also empathize with the elements of the therapist that relates to the projected elements. In this way the client may experience his problematic self and its object relation in the therapist. Caspary (1993) emphasizes that, "The fate of the projected elements depends a great deal on how they are dealt with while being contained by the therapist" (p.215).

Caspary (1993) observes that the structure of the session and the playroom may allow the therapist to encounter with the client's toxic introjections in a transitional space and deal with this therapeutically. As a therapist pays full attention to both the child and her own inner world, she may be able to detoxify the self-elements the child projects and return it back to the child. Gradually, the child will integrate this new experience and achieve a higher level of personality integration as Malin and Grotstein

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<sup>8</sup> Reverie, in Bion's term, is a state of mind in which a mother unconsciously in touch with the emotions the baby communicate and use her inner resources to empathetically understand and respond with a 'right fit' of the baby's emotions. In such a state, the mother is calm and loving and is able to think and feel at the same time, in which the baby feels being loved and understood (Waddell, 1998)..

(1966) recognize,

*The environment must meet the needs of these projections and be able to reinterpret for the developing individual the inner workings of their psychic apparatus and to demonstrate that these are not destructive, "bad" parts. The external object must confirm those constructive and "good" aspects of the developing individual and thus facilitate higher ego integration which will mitigate the effect of the destructive components of the self (p. 28)*

In this process, the person of the therapist seems to play an important role and influences the effectiveness of therapy. It is suggested that the reactions of the therapist to the projections of the client may stem either from the therapist's personality structure, or from the feelings and fantasies that are generated by the client's transference. Therefore, the more the therapist is emotionally ready to accept the projection, the more likely it is that there will be powerful countertransference reactions which can be used to understand the child's inner world during therapy (Anastasopoulos & Tsiantis, 1996).

### **The special features of countertransference in child psychotherapy**

Similar to adult therapists, child therapists also experience a range of affects in countertransference when working with children but this may be more intense (Piene, Auestad, Lange, & Leira, 1983). The child therapist may experience higher levels of fear and anxiety because of children's unpredictability, strong emotions, and their closeness to the unconscious (Kabcenell, 1974). Biggs' (2003) qualitative study agrees with other clinicians' case studies (Bloom-Trentacoste, 1997) that therapists who are working with children suffering from traumatic experiences may have strong countertransference reactions during the therapeutic process. They very often struggle with strong feelings revived from their own childhood (Krieger, Rosenfeld, Gordon, & Bennett, 1980) and unable to be firm and understanding at the same time (Canham, 2004).

The developmental stage of the child and the moment to moment interaction in therapy, may challenge the child therapist in communicating with the child about her countertransference. Sometimes the child therapist will need to rely on the metaphor of play or tone of voice to convey her countertransference feelings indirectly to the child (Bonovitz, 2009). To play, think and interpret at the same time may challenge the child therapist's capacity in shifting from one stance to another in the therapeutic process (Bernstein & Glenn, 1988). Lacking confidence in herself combined with feeling anxious about the ambiguity in the therapeutic situation, the parentified therapist may unknowingly stay in the child mode to play with the child, and she may lose her stance as a therapist. This may happen when regression is used by the therapist for defense instead of serving the ego (Bernstein & Glenn, 1988). Moreover, children are action oriented and sometimes impulsive. When combined these characteristics along with children's low tolerance for frustration and little capacity for delay, may push the therapist to rely on her intuitive understanding to respond to the child's transference, rather than staying calm to observe and interpret (Palombo, 1985).

### **The countertransference occurs in dyadic relationship between child and therapist**

The special features of countertransference in child psychotherapy may easily hook onto the therapists' rescue fantasies. Unknowingly, the therapist projects out her repressed anger or hostility but defends off with reaction formation of being a rescuer and a nurturer in the therapeutic process (Malawista, 2004). The "rescue fantasy" of a therapist may be a countertransference reaction to the child's "family romance". "Family romance" is when a child rejects the fact that his parent is his real parent and has a fantasy of an idealized parent (Freud cited in Malawista, 2004, p.375). It may be a way, children deal with the natural disappointments and apparent failures of their real

parents as well as the ambivalent feelings in relationship with their real parents (Deutsch cited in Melawista 2004). Both the rescue fantasy and the family romance are means of regaining the idealized omnipotent parent of early childhood (Frosch, 1959). It is suggested that when working with children, the nature of the therapeutic situation is the prevalence of rescue fantasies, in which the therapist may identify with the idealized parent of the family romance. Both the child's and the therapist's fantasies may be enacted in the therapeutic process as the child wishes to be rescued and the therapist wishes to rescue the child (Melawista, 2004).

Waksman (1986) suggests that the child therapist who has two internal objects to repair, may still carry the pain from childhood while longing for the ideal parents of the early age. Unknowingly, many child therapists may attempt to repair these internal objects by defense mechanisms, such as sublimation through their vocation choice of being a child therapist (Schowalter, 1986). When coping with their own infantile longings on top of what the child client projects onto them in the therapeutic process, the therapists tends to repress these feelings and become permissive and gratifying (Anastasopoulos & Tsiantis, 1996). They also tend to reinforce the dependency and clinginess in children in order to gratify their own dependency needs and their desire to feel loved and needed by their clients (Gabel & Bemporad, 1994). This seems to resonate with the development of parentified child and therefore it may be suggested that the parentified therapist may have a higher prevalence of rescue fantasy and a similar struggle with countertransference problems in the therapeutic process with children.

It is easier for a child therapist than an adult therapist to see the child client as a victim and unconsciously over-identify with the child, perpetuating the splitting of good and bad object (Ables & Aug, 1972). The therapist may encounter difficulties when

experiencing strong feelings of childhood pain. When overwhelmed by the child's vulnerability, these strong feelings may unconsciously drive a therapist to shift from the therapist role to the 'good mother' role (Piene, et al., 1983). The therapist may overuse complimentary remarks and/or belittle herself to please the child, but may not attune to the child's emotional needs of understanding and having his feelings acknowledged (Ables & Aug, 1972). Besides the helplessness and vulnerability of the child, the development of over-identification in a child therapist, may also be due to unresolved conflicts that the therapist may have with her own parents and the therapist's own needs in connection with the losses in her early childhood (Piene, et al., 1983).

Children at a stage of going through oedipal complex may feel annihilation and destructiveness when parents attack each other in their relationship (Cancrini, 1998). The child may have difficulty in the identification process when caught in the conflict of his parents and may split off unlikable parts of the self and project them onto the therapist in the therapeutic process. The therapist working with these children may encounter difficulties when they experience strong feelings of emptiness, loneliness, helplessness, hopelessness, rejection, stupidity, uselessness, worthlessness, uncontrollable rage and other difficult emotions (Piene, et al., 1983).

In order to be able to tolerate the pain of bearing children's unhappiness and suffering, the therapist will need to work through her own depression and grief issues. Otherwise, this may affect the therapist's ability to empathize (Piene, et al., 1983). If the therapist's wish for caretaking or rescuing children is too intense, she may abandon a therapeutic stance and instead gratify her client's neurotic need to be looked after (Bernstein & Glenn, 1988).

## **The countertransference occurs in the triadic relationships among child-therapist-parent**

The therapeutic alliance in child psychotherapy not only involves the child client but also the child's parents (Anastasopoulos & Tsiantis, 1996). Besides the interactions between the therapist and the child in the playroom, there are also direct and indirect interactions among other family members outside the playroom (Moser, Jones, Zaorski, Mirsalimi, & Luchner, 2005). These interactions may give rise to a therapist's countertransference which is liable to disrupt proper functioning (Godfrind, 1996). On the other hand, countertransference can also be very useful to understand the child's family interaction. It may help to identify the child's relational dynamic and his involvement in the family problems (McCarthy, 1989)

When parents are intrusive and controlling, this may affect some therapists' confidence in making their own judgments of understanding the symbolization and interpretation of the child's verbal and non-verbal interaction in the session (Godfrind, 1996). Underlying this situation, it may be the therapist's countertransference which relates to her history of relationship with her own internal object, such as an abusive mother. Rather than maintaining an adult mode, the therapist may unknowingly be drawn back into a child mode and becoming irrationally anxious. At the same time, this may trigger a mixture of internal anger and fear which confuses the thinking ability of the therapist.

Parents may also transfer their own feelings of being rejected or inadequate onto the therapist and over-idealize the therapist as the ideal parent, complying with the therapist's authority or become hostile by testing the limits (Anastasopoulos & Tsiantis, 1996). This may either reinforce the parentified therapist's need of being the good parent or increase her level of anxiety of being rejected. She may defend off by being

compliant to the parents, and may 'intellectually re-parent' the child client in the therapeutic process (Reeves, 1999).

## **Conclusion**

In child psychotherapy, countertransference is a ubiquitous phenomenon and exists among the triad, child, parents and therapist. Countertransference may be a reaction to the transference of the clients but it also has its roots from the developmental histories brought by both the therapist and clients to the therapeutic process. When reviewing these articles of countertransference, it was found that the childhood experience of the therapist may unconsciously put the therapist at risk of enacting the countertransference reaction, namely over-identification and enactment of rescue fantasy in the therapeutic process. The loss of childhood in a parentified child may be a central issue in some child therapists, which can be at risk of impeding the therapeutic process. It needs to be brought into awareness in order to be worked through. It is suggested that in order to cope with these countertransference issues, the therapists may need to recognize and tolerate the countertransference reaction and get in touch with their own feelings in order to understand the connection of the past and the present (Bonovitz, 2009). Along with self-awareness and supervision, the therapist may be able to make use of her countertransference to deepen the understanding of the children's emotional and mental world. However, it is important not to deny or diminish its influence in the work with children (Bonovitz, 2009).

## **Chapter Six      Discussion and Conclusion**

### **Introduction**

The research question at the beginning of this dissertation was: “What is the countertransference of a child psychotherapist with a history of parentification when working with children? Three sub-questions were asked to streamline the collection of literature and formulate the path in order for the answer to this research question to slowly emerge. The review of literature in Chapter 3 & 4 addressed the answer to the question how does a child develop into a parentified child and how this process impacts on an individual’s self, emotion, personality and social development. These two chapters along with Chapter 4’s overview of the countertransference in child psychotherapy provide the answer to the research question. In sum, the parentification history of a child psychotherapist may have a positive and negative impact on her countertransference when working with children in the therapeutic process. In this chapter, the findings from literature in the previous three chapters will be synthesized into three themes for discussion and recommendations will be offered. Moreover, the limitation of this study and suggestions for future study will be discussed.

### **Synthesis of findings**

The process of developing into a parentified child may easily be revived in the transference-countertransference process involving projective-identification between two people. The parentified therapist who experiences the failure of parenting and life crises, suggested by the psychoanalytic and developmental theories may have lost an idealized object to meet their omnipotent infantile needs at an early age. The two objects (the idealized parental object and the omnipotent infantile self), which are waiting to be repaired (Waksman, 1986) may influence the child psychotherapist’s

ability to be a “thinking container” (Bion, 1962) when they over-identify with their child client’s emotions. She may shift from her role as a therapist to a caretaker role driven by her “rescue fantasy” (Malawista, 2004); and this can impede her capacity to metabolize what the child projects, making her unable to give back what the child needs. Instead, the therapist may unconsciously project the parentified child’s longing for the mirroring object needs perpetuating the distorted parent-child relationship in the therapeutic process.

Two themes, ‘hiding the true-self or false-self adaptation’, and ‘drowning in the emotional sea or putting up the fire wall’ are identified from the literature in relation to the parentified therapist’s countertransference. An opposite point of view to the negative impact of parentification on countertransference is the theme of the resilience in the parentified therapist.

### **‘Hiding the true-self’ or ‘false-self adaptation’**

The findings in chapter 3 and 4 seem to suggest that during the parentification process, the parentified child develops a false-self, which is a coping strategy but may also have an effect on his relationship with others. As Eckler-Hart (1987) points out, the fundamental source of doing meaningful psychotherapy is in the creativity of the therapist’s own being and her openness to a deep relationship with the client. In order to be a child psychotherapist, it is important to have the confidence and security to allow certain parts of the therapist’s true-self to come out in the therapeutic process, so that they meet with the child in the illusionary place in play (Winnicott, 1971). This spontaneity and creativity in the therapist may be compromised when a therapist with a parentification history develops a false-self in relating to others.

When working clinically with very deprived children, it is likely the parentified

therapist will meet with a parentified child. The child client may react as a ‘good child’ in the therapeutic process and this may trigger a countertransference in the parentified therapist. Likewise, the therapist may also strive to be a good therapist; and work hard to meet the child’s expectation of her. The family romance and rescue fantasy may enact in this therapeutic process. The false-self in both the therapist and child client may impede the trust in the relationship for the child to express and understand his real internal feelings, such as anger and hate. The therapist is thus less able to help clients work through negative transferences or to process the idealization in the therapeutic relationship. Furthermore, the therapist is less likely to confront the client or set limits when appropriate, for fear of breaking the “narcissistic collusion”<sup>9</sup> (Glickauf-Hughes & Mehlman, 1995, p. 217).

Parentified therapists who grow up with a false-self may unconsciously use intellectualization as a defense mechanism in the therapeutic process to cope with childhood feelings that are brought up in countertransference. For example, being attacked by a child physically or verbally in play, may arouse the therapist’s primitive fear of annihilation and destruction. These may be the child’s feelings that are projected onto the therapist, which trigger the parentified therapist’s early loss of a responsive mother to manage the impingement that she had. However, without awareness, the therapist may react intellectually and/or mechanically to manage the behavior but avoid the feelings inside, thus miss the opportunity to use the countertransference to connect with the child’s emotional needs. This may perpetuate the child client’s relationship with his real parents. Reeves (1999) points out that therapists who have not worked

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<sup>9</sup> Narcissistic collusion occurs when a therapist’s narcissistic and dependency needs are not met properly in her personal lives. The therapist may unconsciously attempt to get these needs met from clients (Glickauf-Hughes & Mehlman, 1995).

through their own parentification may be limited to intellectually re-parent the client as they too are defended against their own authenticity and sense of loss.

When a therapist reveals countertransference response to others, she may seem to be admitting an inability to maintain appropriate objectivity. The therapist may feel like a failure because the countertransferential reaction very often seems infantile, and driven by the unconscious in which the therapist is unsure about the source (Gessner, 1995). This fear and worry may be very common in parentified therapists, especially trainee psychotherapists. As in their histories, they tend to be strong and adaptive; it may be difficult to see their own internal infantile needs. The desire to be a good therapist may prevent them from feeling what is real out of the fear of upsetting the client, which could result in them being rejected by the client. The parentified therapist may adapt by adopting a false-self to avoid facing the true-self.

In order to be able to contain what is projected by the child client, the therapist needs to be honest with herself about the countertransference in order to be able to return what is experienced back to the client (Alvarez, 1983). Winnicott (1949) seems to be the first one to acknowledge that intense negative feelings may be aroused in a therapist by child patients but that this can be healthy and therapeutic. The need to hate a client is like the need of a mother to hate her baby, it is an essential part of the capacity to relate fully (Tuber, 2008b). Winnicott (1949) describes his countertransference of feeling hate when working with a very disturbed nine year-old boy. He was able to put his feelings of hate into words and action that were containing and connecting. He points out that,

*The analyst must be prepared to bear strain without expecting the patient to know anything about what he is doing, perhaps over a long period of time. To do this, he must be easily aware of his own fear and hate (p.72).*

A parentified therapist may need to be aware of her own history and develop the capacity to differentiate in her countertransference feelings of what belongs to her and what belongs to the child. In this way, she may be able to de-toxify the child's toxic projections and give them back to the child the experience of a good object in an authentic way (Tuber, 2008a).

Orbach (2002) emphasizes that "the false-self is no less real than the true-self" (p.127), and is used to express the self as the true-self is hidden behind fear. She suggests that during the process of therapy, the true-self will grow in the context of the therapeutic relationship. The false-self and true-self will then need to make a new accommodation with one another. She believes the false-self is valuable and cannot be given up or lost which she sees as "a real self in its own right" (p.128). In this sense, if a therapist can work through her history of parentification and be able to understand and accept both the true-self and false-self within, she may be able to mobilize the false-self into healthy functioning. Consequently, she may feel secure enough to access her childhood feelings in an adult mode to understand the child client's feelings in the therapeutic process.

In a study, Eckler-Hart (1987) observes that when the trainee psychotherapist is able to mobilize the false-self to work for the true-self's fear, the psychotherapist's false-self is seen to take the form of confidence that makes risk-taking and the aliveness of the true-self possible. This suggests that the positive function of the false-self contributes to the therapist's professional growth. The confidence that comes from the false-self adaptation may be a strategy a parentified child learns to cope with from being a pseudo-adult in childhood. This may be well needed for novice child psychotherapists to cope with the complex and ambiguous countertransference that occurs in the triadic

relationship among child, therapist and parent. It may grow into true-self confidence if the therapist is aware of how these two parts of self are interacting with each other to serve what the true-self needs. Otherwise, when the stress is too intense and/or if there is a lack of a holding environment, this unstable confidence may be shattered. For a parentified therapist, she may perpetuate with a false-self to hide the true-self feelings and become defensive or being trapped in the imposter feelings of inadequacy (Castro, et al., 2004).

### **‘Drowning in the emotional sea’ or ‘putting up the firewall’**

When working with children, especially those who are traumatized, the sensitivity and capacity for concern that a parentified therapist have had since childhood, may predispose her to over-identify with these children’s suffering of emotional pain. If a therapist does not work through her history of parentification and is unable to attend and tolerate her own pain, she may become overwhelmed by the child’s vulnerability, triggering her repressed childhood feelings, such as, worry, anger, anxiety, depression, etc. During this time she may feel like drowning in the emotional sea which is Lackie’s (1999) metaphor of the parentified child’s inner world. Without awareness the therapist may resort to the coping pattern she is familiar with, which is the caretaker role. This caretaker role could be a repetition of the “parentification script” in the family (Byng-Hall, 2002, p. 378), which may seem compulsive and may result in alleviating the therapist’s anxiety and mis-attuning to the child’s needs. At the same time, the parentified therapist may also rely to some degree on dissociation as an “anesthetic”, or “firewall” when suffering from strong internal emotional pain so that she can proceed with the caretaker role for others (Lackie, 1999).

Lackie (1999) looks at the therapeutic process and the dilemmas that arise when

a parentified therapist works with a parentified client. While in therapy, a parentified client may attempt to hold on to the therapist in order to delay differentiation and inevitable separation. This may be the child client's sensitivity of the parentified therapist's need to be needed. The therapist is then unknowingly drawn into overworking for providing the child client a 'good' mother object. Both may become lost in a "hall of mirror" and the therapist may never be able to prove she is a good parenting figure (Lackie, 1999, p.152). This may lead to self-criticism and feelings of failure in a parentified therapist. The perfectionism and unstable self-esteem of a parentified child may drive the parentified therapist to exceed their capacity to respond to other people's needs which may lead to them frequently becoming burnt out (Glickauf-Hughes & Mehlman, 1995).

If the therapist is caught in the need of providing because of her own needs to be useful and to be important, then there may be a dynamic of the parentified child idealizing the parentified therapist and feeling bad inside of himself. Likewise, the parentified therapist may reinforce the splitting employed by the masochistic personality trait of the child (Wells & Jones, 1999), reviving the parentified mother-child relationship in the therapeutic process. Borgogno (2008) observes that the parentified therapist may defend off her own pain from the parentification history by idealizing her own parents and the child's mother object and may have trouble identifying herself in children who are experiencing painful conditions of deprivation.

The projective identifications that occurs in the internal process of countertransference, offers the child therapist a channel to experience the child clients' inner world, especially their emotional experiences. At the same time, the emotional pain a parentified therapist repressed since childhood may also project into the

therapeutic process, which may impede the therapist's capacity for containing the child's emotions. As suggested by self psychology, the disturbance of self may occur when a selfobject is unable to provide empathetic responses, which deprive the child's omnipotent need to merge with an idealized object (Wolf, 1988). With such a deprivation, the child may have difficulties in establishing a solid self to regulate affects such as anxiety and fear (Bacal, 1990b). When training to be a child psychotherapist, the therapist may become more aware of her internal processes and at times may feel flooded with emotions when triggered by countertransference reaction in the therapeutic process. This may also shatter her self-identity as a strong, independent person that she may have previously had. At times, the parentified therapist may suddenly lose her confidence and feel she is not good enough for the child client. This may also trigger the therapist's childhood hunger for the mirroring object. It is important for the therapist to be aware of her selfobject needs and be able to seek proper holding from others who can attune to these primitive needs and introject into the ego to restore a cohesive self (Wolf, 1988). In this way the parentified therapist may be able to use her wound to get in touch with the client's wound and to use this connection to help discover the client's ability to heal (Hayes, 2002).

### **Resilience in the parentified therapist**

Some research about parentification is beginning to prove that parentification does not always impact negatively on the individual's development, however there is a lack of empirical study looking at what contributes to resilience in the parentified child. I argue that from a psychodynamic perspective, the sensitivity, the caretaker role and the capacity for concern, and attunement ability of a parentified child which are developed and reinforced in the process of parentification; seem to be a second skin development. This second skin may help the parentified child to create a secure space for himself and

continue to maintain some connection and belonging in a relationship. The familiarity of the caretaker role may motivate some parentified individuals to choose to be a child psychotherapist and through this way unconsciously they may also attempt to find the healing of their inner 'wounded child'.

This resilience and the caretaker role perpetuated in the parent-child relationship may have helped the parentified children survive their childhood traumas. Yet, it can also enable the child psychotherapist to experience the child client's inner world more closely and facilitate the emotional understanding that provide for a mutual affective experience in the therapeutic relationship (Stern, 1985). At the same time, with good enough holding environment, the child psychotherapist may have an opportunity to find meaning of the parentified child inside herself and be able to grieve this loss in order to grow out of the trauma from early life as suggested in Hooper et al.'s (2008) study.

### **Recommendation based on a parentified therapist's self and other relationship in training**

Miller (2007) cautions therapists about facing their own history. By experiencing the pain and accepting the 'true-self', the therapists then can be free from the illusion of finding an understanding, empathic "parent". Otherwise, clients they work with may well be at their disposal for this illusion. The countertransference identified in the findings of this study, could be an unavoidable process experienced by many in training to be a child psychotherapist. It may need time and support to work it through and make sense of it. However, when in training the parentified child within the therapists may feel not good enough to be a child therapist when unable to contain their own emotions well. At the other extreme, they may be completely unaware of any emotional response and become over-caring or protective of the children. The need to be perfect and the shame of not doing well may make the novice therapists more anxious due to their drive

to do well resulting in them becoming more sensitive to external criticism. At the same time, the shame and guilt the parentified child has carried may hide the true-self feelings and being self-reliant, may result in them presenting with a false-self adaptation externally. Inside the parentified therapist may feel very alone and helpless.

A parentified therapist needs to be aware of how to be sensitive to her own feelings and needs while being sensitive to those of others, and be able to differentiate and understand the internal process of countertransference while working with children. It is important to remember when the experience of countertransference stirs up strong feelings, the therapist needs to stay calm and silently analyze her own reactions. It may increase the therapist's insight and decrease the difficulty when the therapist is more able to use her countertransference to understand the client (Jackson, 1998). To be able to carry out this self-analysis, the parentified therapist may need to work through her 'critical self' and find the compassion for this 'parentified child' inside her.

It is important for parentified therapist to grieve and mourn her loss of childhood so as to find the true-self and to integrate the goodness and badness in the self in order to balance the effects of parentification (Lackie, 1983). This grieving process may be painful as it brings up all the repressed childhood feelings in a parentified therapist. It may require supports from outside, such as personal therapy and a holding environment in professional training. Lackie (1983) suggests that in professional education it requires a professional holding environment to encourage a trainee therapist to slowly accept the less-than-perfect, but good-enough self. This has to come from a forgiveness of self as Lackie said, "We are not as good as we look; but forgiveness comes when we discover we are not as bad as we feel" (Lackie, 1983, p.319 ).

The high prevalence of parentification in professionals suggests that many who

come for child psychotherapy training may still long for the loss of a mother object in their early childhood (Waksman, 1986). This unconscious desire may project into the relationship with the tutors or supervisors in the training institute. The tutor/supervisor may easily become an object for transformation sought by the trainee therapists to establish their confidence and competence in their professional identity (Rizq, 2009). Rizq (2009) suggests that tutors/supervisors work with the projections of the trainee and survive the strong emotions the trainee brings. This may facilitate the relationship process shift from object relating to object usage (Winnicott, 1965a), promoting the potential for transformation in psychotherapeutic training.

The need to be recognized by the training institute (Rizq, 2009), the insecure attachment pattern and the unstable self development of the parentified child may increase the level of anxiety that already exists in a parentified therapist. At times, the parentified therapist may feel like what Skovholt and Ronnestad (cited in Rizq, 2009) calls an “orphan distress”. This distress may be related to the parentified therapist’s anxiety of performance and evaluation of her clinical work and the fear of failing. Skovholt & Ronnestad (cited in Rizq, 2009) describe the urgent need for support and guidance of these novice therapists,

*The novice wants and needs mentors to be available, supportive, positive and helpful in specific ways. The absence of a mentor leaves the needy novice with ‘orphan distress’, searching for one’s way on the high seas without experience. Equally distressing is the novice’s disillusionment with a mentor who has failed to provide the intensely needed support and instruction. Examples include the absent, critical and confusing professional adult. The term ‘orphan distress’ and ‘novice neglect’ summarize this fear (p.55).*

To provide ‘holding’ for the parentified trainee therapist, the training institute may consider a consistent learning environment to support the novice therapist in

coping with the ambiguity and uncertainty in the therapeutic process. Therefore, I suggest if it is possible for those novice therapists who have not worked through their parentification history to stay with one supervisor, at the same placement as long as they can. Ideally, the supervisor the parentified therapist has will understand what it is like to be a parentified child and the transference and countertransference enacting in a supervisor-supervisee relationship. Moreover, it will be helpful if a parentified trainee could have a long- term client to work with at the beginning of training under the intense guidance of an experienced clinician who knows what countertransference may be triggered in the parentified therapist. By suggesting this, I am aware I still have that fantasy of a 'perfect mother' as the parentified child's wish. This leads me to the final recommendation.

Personal therapy is recommended for trainee therapist from the beginning of training. As the parentified child develops from a dyadic relationship involving object loss at an early age, therapy may provide the parentified therapist an opportunity to grieve properly for her loss in a secure consistent therapeutic relationship, thus the parentified child can express more of her true-self and increase the aliveness and spontaneity in the therapist when working with children. When the therapist experiences the "reverie" moment with a "thinking container" (Bion, 1963) in her own therapy, she may be more able to tolerate the strong emotional pain of her clients and will not be compelled to take on the caretaker role, which is at risk of impeding the therapeutic process.

In sum, one of the goals of child psychotherapy is to understand and contain the emotions of the child, which allows time and space for the child to use the 'secure base' in the therapeutic process to be a real child, a true-self. The child then is able to grow

from object relating to object usage (Winnicott, 1965a) in the therapeutic relationship, which facilitates his emotional and interpersonal development. For this to happen, the parentified therapist will need to re-experience the feelings of her own parentified child inside and to make a new accommodation of the false-self and true-self (Orbach, 2002). This experience may enhance the therapist's capacity to work with her child clients' negative transference, relating to them with a good object in an authentic way (Tuber, 2008a). To achieve this therapeutic goal, the parentified therapist will need a holding environment provided by the training institute and personal therapy. With these three relationships together, the parentified therapist is also able to grow from object relating to object usage, finding the true-self in relationship with others and reaching a true confidence in professional identity.

### **Relevance of this research**

The research perspective taken here offers a deeper understanding of the parentified child's inner world and her interpersonal process with the outside world. It also adds to the knowledge of countertransference in child psychotherapy. From the findings and recommendations of this study, it may contribute to the child psychotherapists, especially the trainee therapists' personal and professional growth. Clinically, it may also increase clinicians' awareness of their own history of parentification and its impact on countertransference when working with children. Nevertheless, this study provides some input to training institutes for training child psychotherapists.

Other mental health professionals who work with children or adults may also benefit from this research in increasing their awareness of the self and other in a helping relationship, thus preventing the overuse of their caretaking role, creating boundary

dissolution. Moreover, it highlights the acceptance of the true-self needs of self care and the care from others to prevent the empathy strain and burnout in these professionals.

### **Limitations of this research and suggestions for future research**

Most of the material recruited in this study about parentified child/parentification was quantitative studies and many focused on adolescents and adults. Only 10 out of 101 pieces of literature in PsycARTICLE and 6 out of 150 in PsycINFO were qualitative studies. From the 16 articles, only 9 were useful for this study. However, they were not directly related to the countertransference of a child psychotherapist. As the strength and weakness of the quantitative study have been discussed in chapter 3, here what needs to be addressed is the studies with the psychodynamic perspective and the countertransference in child psychotherapy were mostly based on case studies and expert opinions. Nevertheless, they do give an in depth understanding of the parentified child and provide answers to the research question. However, due to the limitations of time and the research method, this study did not interview any child psychotherapists for their lived experience of parentification and countertransference at work. Therefore, this may limit the validity and the richness of the data collected for this research question. Moreover, it is not statistically represented which loses the strength of objectivity and generalization as in quantitative studies.

Due to the limitation of time and word limit, this research does not go in depth to explore the cultural aspect of the parentification and how this may affect a child psychotherapist's countertransference in the therapeutic process, in particular, Chinese parentified therapists working in a Western country with a Western model of child psychotherapy.

Another area that has not been investigated in this study is the alternative attachment figure, which was mentioned in some studies as a mediator of the impact of parentification. It may be interesting to explore sibling attachment in the parentified child. A thought is that sibling attachment may be a life-saving strategy in some parentified children. With this attachment, paradoxically, the parentification may prevent the parentified child from developing serious psychosocial problems even though they may still have the emotional pain of being a parentified child.

The resilience of a parentified therapist may require more research to find empirical evidence in supporting their function in enhancing the process of therapy and contribution to the personal and professional growth in child psychotherapists.

This study may seem to focus more on the mother-child relationship as my focus is on the countertransference of the child therapist. However, I believe the first mother-infant relationship may have significant effects on the parentified child inside the therapist, especially from a psychodynamic developmental viewpoint. I also realize that there seems to be more females than males working as child psychotherapists, especially in New Zealand. I wonder whether it has any relationship to the phenomenon of parentification. There were studies that specifically investigated or discussed the mother-daughter relationship, father-daughter relationship and mother-son relationship in relation to parentification but the research lacked studies in father-son relationship in this area. The gender issue of parentification may lead to the belief that males are less parentified than females. It may be related to society's expectation of the gender-role function, where women are expected to take on the caretaker role more than men. However, recently, there seems to be more single fathers parenting children on their own. It may be worthwhile to explore this father-son relationship which my help

increase the understanding of parentification from this aspect.

### **Concluding remarks**

The aim of this research study was to explore the countertransference of a child psychotherapist with a history of parentification. The various studies explored in this dissertation show that parentification has a positive and negative impact on a child psychotherapist's countertransference. The parentification process denotes a relationship between a child and a parent, which involves multi-layers of impact on the child's development. This relationship may easily be revived in the therapeutic process when a parentified therapist is working with a child. The caretaker role seems to be a mechanism of coping with the emotional pain that arises in parentification. While in a therapeutic process with children, a parentified therapist's emotional pain may easily be triggered in countertransference and the therapist may jump into the caretaker role to defend off over-identification of the child's suffering. On the other hand, she may unconsciously dissociate from feeling the pain and focus by intellectually re-parenting the child in the therapeutic process. It is important that a parentified therapist gets enough holding and containment to understand her history of parentification and attune to her own wounds, thus she is able to use this 'inner 'parentified child' wisely to benefit therapy with children.

While working with this dissertation, I experienced strong emotions of love and hate in the process. Most of the time I had a passion for this topic as it was an opportunity for me to integrate my personal and professional development in this long journey of training to become a child psychotherapist. The hate came from when I re-experienced the pain of a parentified child and feelings of inadequacy and feeling not good enough. The love and hate of this research thrust me back to more recollections of

my childhood experiences causing me to re-experience the burden carried as a parentified child but this time with more understanding and forgiveness. Lackie's word always sneaks into my mind, "We are not as good as we look; but forgiveness comes when we discover we are not as bad as we feel" (Lackie, 1983, p.319 ). With the holding of my therapist, supervisors, tutors, peers and family in this journey, I begin to not only feel more secure in expressing my true-self but also to accept the false-self as a treasure in my life.

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## Appendix

### AUT Library Catalogue

Keyword	Result	Relevant
Parentified child	0	0
Parentification	1	1
False-self	31	2
True-self	71	1
Role reversal	8	0
Compulsive caregivers	1	0

### PsycINFO

#### Combination of three Main keywords

Keyword	Result	Relevant
Parentifi\$	150	105
Parentifi\$ <i>and</i> Countertransference or Counter-transference	2	1
Countertransference or Counter-transference <i>and</i> Child psychotherap\$ or Child therap\$	242	52
Parentifi\$ <i>and</i> Child psychotherap\$ or Child therap\$	2	2
Parentifi\$ <i>and</i> Countertransference or Counter-transference <i>and</i> Child psychotherap\$ or Child therap\$	0	0

#### Combination of three main keywords with keyword false-self

Keyword	Result	Relevant
False-self or False-self <i>and</i> Parentifi\$	1	1
False-self or False-self <i>and</i> Countertransference or Counter-transference	30	4
False-self or False-self <i>and</i> Countertransference or Counter-transference <i>and</i> Child psychotherap\$ or Child therap\$	0	0
False-self or False-self <i>and</i> Parentifi\$ <i>and</i> Countertransference or Counter-transference <i>and</i> Child psychotherap\$ or Child therap\$	0	0

**Combination of three main keywords with keyword role-reversal**

<b>Keyword</b>	<b>Result</b>	<b>Relevant</b>
Role reversal <i>and</i> Parentifi\$	11	10
Role reversal <i>and</i> Countertransference or Counter-transference	10	2
Role reversal <i>and</i> Countertransference or Counter-transference <i>and</i> Child psychotherap\$ or Child therap\$	0	0
Role reversal <i>and</i> Parentifi\$ <i>and</i> Countertransference or Counter-transference <i>and</i> Child psychotherap\$ or Child therap\$	0	0

**Combination of three main keywords with keyword compulsive caregiver**

<b>Keyword</b>	<b>Result</b>	<b>Relevant</b>
Compulsive caregiv\$ <i>and</i> Parentifi\$	1	1
Compulsive caregiv\$ <i>and</i> Countertransference or Counter-transference	3	2
Compulsive caregiv\$ <i>and</i> Countertransference or Counter-transference <i>and</i> Child psychotherap\$ or Child therap\$	0	0
Compulsive caregiv\$ <i>and</i> Parentifi\$ <i>and</i> Countertransference or Counter-transference <i>and</i> Child psychotherap\$ or Child therap\$	0	0

**Search for qualitative studies in parentified child**

<b>Keyword</b>	<b>Result</b>	<b>Relevant</b>
Qualitative or Qualitative study or Qualitative research <i>and</i> Parentifi\$	6	3

## PsycARTICLE

### Combination of three Main keywords

Keyword	Result	Relevant
Parentifi\$	101	42
Parentifi\$ <i>and</i> Countertransference or Counter-transference	15	6
Countertransference or Counter-transference <i>and</i> Child psychotherap\$ or Child therap\$	76	12
Parentifi\$ <i>and</i> Child psychotherap\$ or Child therap\$	7	3
Parentifi\$ <i>and</i> Countertransference or Counter-transference <i>and</i> Child psychotherap\$ or Child therap\$	2	2

### Combination of three main keywords with keyword False-self

Keyword	Result	Relevant
False-self or False-self <i>and</i> Parentifi\$	6	4
False-self or False-self <i>and</i> Countertransference or Counter-transference	65	5
False-self or False-self <i>and</i> Countertransference or Counter-transference <i>and</i> Child psychotherap\$ or Child therap\$	4	3
False-self or False-self <i>and</i> Parentifi\$ <i>and</i> Countertransference or Counter-transference <i>and</i> Child psychotherap\$ or Child therap\$	0	0

### Combination of three main keywords with keyword role-reversal

Keyword	Result	Relevant
Role reversal <i>and</i> Parentifi\$	16	12
Role reversal <i>and</i> Countertransference or Counter-transference	25	3
Role reversal <i>and</i> Countertransference or Counter-transference <i>and</i> Child psychotherap\$ or Child therap\$	1	1
Role reversal <i>and</i> Parentifi\$ <i>and</i> Countertransference or Counter-transference <i>and</i> Child psychotherap\$ or Child therap\$	0	0

**Combination of three main keywords with keyword compulsive caregiver**

<b>Keyword</b>	<b>Result</b>	<b>Relevant</b>
Compulsive caregiv\$ <i>and</i> Parentifi\$	3	1
Compulsive caregiv\$ <i>and</i> Countertransference or Counter-transference	0	0
Compulsive caregiv\$ <i>and</i> Countertransference or Counter-transference <i>and</i> Child psychotherap\$ or Child therap\$	0	0
Compulsive caregiv\$ <i>and</i> Parentifi\$ <i>and</i> Countertransference or Counter-transference <i>and</i> Child psychotherap\$ or Child therap\$	0	0

**Search for qualitative studies in parentified child**

<b>Keyword</b>	<b>Result</b>	<b>Relevant</b>
Qualitative or Qualitative study or Qualitative research <i>and</i> Parentifi\$	10	6

**PEP**

<b>Keyword</b>	<b>Result</b>	<b>Relevant</b>
Parentification	14	6
Parentification <i>and</i> Countertransference	6	2
Parentification <i>and</i> Child psychotherapy	4	1
Parentification <i>and</i> Child psychotherapist	0	0
Parentified child	28	8
Parentified child <i>and</i> Countertransference	26	8
Parentified child <i>and</i> Child psychotherapy	20	4
Parentified child <i>and</i> Child psychotherapist	4	1
Child psychotherapy, Countertransference <i>and</i> Parentification	3	2
Child psychotherapy, Countertransference <i>and</i> Parentified child	11	2
Child psychotherapist, Countertransference <i>and</i> Parentification	2	0
Child psychotherapist, Countertransference <i>and</i> Parentified child	0	0

**ProQuest Dissertation and Theses---Full Text.**

<b>Keyword</b>	<b>Result</b>	<b>Relevant</b>
Parentified child	8	3
Parentification	62	33
Parentified child <i>and</i> Countertransference	0	0
Parentification <i>and</i> Countertransference	1	1
Countertransference <i>and</i> Child therapist	3	2
Countertransference <i>and</i> Child psychotherapy	3	3
Countertransference <i>and</i> Child psychotherapist	1	0
Parentified child <i>and</i> Child therapist	0	0
Parentified child <i>and</i> Child psychotherapy	0	0
Parentified child <i>and</i> Child psychotherapist	0	0
Parentification <i>and</i> Child therapist	0	0
Parentification <i>and</i> Child psychotherapy	0	0
Parentification <i>and</i> Child psychotherapist	0	0