Child Psychotherapy: The Contribution of Control-Mastery Theory

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The author would like to thank William Dickman, Harold Sampson and Joseph Weiss for their support.

Abstract

Control Mastery theory is a cognitive psychoanalytic theory of psychotherapy developed by Joseph Weiss and tested empirically by the San Francisco Psychotherapy Research Group. It offers unique tools in the practice of child and family therapy. This paper reviews Control Mastery Theory and its contributions to child psychotherapy, using two clinical cases to illustrate the development of pathogenic beliefs, how children attempt to disconfirm these beliefs, how they use therapy to overcome their problems, and how the therapist can ally himself with the patient's plan to get better.

Paper

Control Mastery theory offers a new appreciation of how a child engages the clinician in psychotherapy based on each child's specific psychopathology. It does not prescribe a specific approach or technique of how to conduct therapy with children. It does give a theoretical framework to shape a therapeutic strategy to a child's particular needs.

The theoretical assumptions of the Control Mastery model are reviewed elsewhere (1,2) but will be highlighted briefly here to illustrate its application to child patients. Control Mastery theory assumes that children strive to grow and develop, but in the course of their developmental strivings may encounter traumatic experiences which derail or discourage healthy developmental progression. These traumatic experiences, if they are enduring, become "understood" by the child and internalized in the form of "pathogenic beliefs". Pathogenic beliefs are the child's distorted beliefs about himself in relation to the world derived as a consequence of real experiences, which impair the child's self esteem, inhibit progressive development, inspire self destructive behavior, and may generate other symptoms such as depression and anxiety.

It is assumed that as part of the child's powerful developmental strivings, he is also striving to overcome the obstacles to his developmental goals, to be free of these pathogenic beliefs. It is also assumed that the child, first outside and then within the therapy, has a personal strategy, usually unstated and unconscious, to debunk these pathogenic beliefs and then get on with attaining developmental goals. This personal strategy has been called the patient's "plan". According to this model, the goal of the therapist should be to become an ally to the patient, working in consonance with the patient's plan to overcome obstacles to the patient's developmental strivings, i.e., to overcome pathogenic beliefs, and to help the patient become free to pursue normal developmental goals and get better.

Two case examples will be described to illustrate how Control Mastery theory contributes to an understanding of the child's problem and helps shape what the therapist should do in therapy. Each example will illustrate 1) how the child develops pathogenic beliefs, 2) what the child does at home and at school in response to these pathogenic beliefs, 3) how the child behaves in therapy to work on these problems, and 4) what the therapist should do to help the child.

Development of Pathogenic Beliefs

Children develop pathogenic beliefs as a result of real pathological interactions with their families. Pathogenic beliefs are always at least inferred from these pathological interactions and often reflect statements which were directly expressed to the child. The beliefs may be reinforced or partially undermined by what parents or other significant others say.

The Case of The Sexually Abused Child: Development of Pathogenic Beliefs

Generally, the sexually abused child is an exploited child, usually at the hands of a trusted family member or family friend, and often repetitively over a period of years. The sexually abused child develops a multitude of pathogenic beliefs. The first is that the abuse is deserved. This belief keeps the child in a position of having to endure the abuse over and over without being able to successfully stop it or get away. This belief is often reinforced by mother or other family members who don't listen to or won't believe the child's protestations. They may even blame the child for making up such a story. The child is often led to believe that the abuse never happened, and even if it did, it shouldn't be talked about.

The child automatically assumes that whatever horrible thing the abuser is doing is not actually the abuser's fault but the child's own. The child takes responsibility for the abuse, believing he or she is seductive or powerfully corrupting of the abuser. Since the child feels deserving of the abuse, he or she might recreate abusive relations in the future, playing the role either of victim or perpetrator. Repeating the abusive relationship with others in the role of victim by allowing repetition of the abuse confirms the child's belief that such treatment is what the child deserves. Repeating the abusive relationship with others in the role of perpetrator morally justifies the correctness of the original abuser's behavior in the child's mind and undermines his or her sense of rightful indignation for being abused.

In addition to taking responsibility for the abusive behavior itself, the child feels responsible for the entire dysfunctional family system. One reason the abused child won't blow the whistle on the abuser is the fear that such a public revelation would send the abuser to jail, break up the parent's marriage, and destroy the family. Often the child is explicitly told this by the abuser or others in the family. Often it is simply inferred. These children almost always put the needs of the family above their own. If they do make accusations, they do it in a confusing and unconvincing way, or retract the accusations later, which is designed to invite others to discredit them (3).

In cases of sexual abuse, as in many other severely dysfunctional families, the abused children are told that what they experience isn't true, what they see is an illusion, black is white and white is black. Seeing clearly and speaking the truth is taboo. The child believes it is wrong to see clearly and worse to tell. Such victimized children feel they are supposed to be confused and silent. They are told they are crazy and they believe it to a great degree.

Illustrating this is the case of two siblings, John, a 6 year old boy and Amy, his 5 year old sister who were both sexually molested by their 18 year old half brother. Immediately after the disclosure of the molestation by a different half sibling, the children were both removed from their maternal grandmother's house, where the molestation occurred, and were put into temporary foster care. After several months in foster care, they were put back into their grandmother's house. The abusive half brother was removed from the house and was forbidden by the court to visit the children. The grandmother consistently denied that the molestation ever occurred and secretly allowed the accused half brother to see the children. The children had spent most of their lives in their grandmother's custody because their mother was a drug addict who was either in jail or was otherwise unavailable. Their father was never known to them. The grandmother ran a board and care facility for retarded adults in her home.

In addition to the abuse, both children experienced being taken away from their grandmother's home as a severe trauma. Both felt the sexual abuse was actually their fault for which they were punished by banishment to a foster home. The abuse was never acknowledged by the grandmother. Talking about the abuse was seen as a further crime which would result in potentially being taken away from grandmother again rather than as an opportunity for the children to get support or protection.

The children developed the pathogenic beliefs that they were bad and worthy of punishment. They did not see themselves as victims but as troublemakers. They believed they did not deserve protection. They were relatively neglected and felt undeserving of attention, especially John who was the less favored of the two children. Amy, who was more flamboyant, and always impeccably dressed like a doll, felt great pressure to act perfectly for her grandmother. Both children felt tremendous responsibility for their grandmother and had the pathogenic beliefs that their needs were unimportant and only drained their grandmother who was already stressed by her health problems and the demands of her board and care clients.

The Case of The Delinquent Teenager: Development of Pathogenic Beliefs

Sam was a delinquent teenager whose parents were inconsistent in their discipline and acted rejecting of him. The mother was uncomfortable setting limits at all and the father was over punitive. The parents battled back and forth, swinging between laxness, letting Sam "get away with murder" and then punitiveness, morally condemning him as if he were a murderer. Sam was always in trouble. The parents both felt like failures and blamed each other for the other's "horrible" parenting style which ruined Sam.

Both parents were right. The mother wanted to protect Sam from the excessive punitiveness of the father. The father wanted to protect Sam from the mother's lack of setting any limits. Both correctly saw Sam was suffering because of the weaknesses of the other parent. But neither parent was really tuned in to his needs and neither could set appropriate non-punitive limits.

Sam had complex pathogenic beliefs. He believed every disparaging thing his father ever said about him, that he was a failure, a criminal, a moral degenerate, and a source of pain for his parents who loved him. The father thought that his harsh criticisms of his son were necessary because they were the son's only chance to do better. But Sam sensed that his father's goal was to criticize and humiliate him. He believed that his father must be right to treat him that way. He came to believe his father's criticisms and acted in a way that justified them.

In addition, Sam complied with what he felt his mother expected of him, which was very little. She covered over his failures and hid them from the father. She blamed the school for not providing a good enough curriculum which she believed left her son bored and understandably truant. She said he was wonderful no matter what he did and she tried not to pay attention when he lied to her, stole from her, and spoke disrespectfully to her. Even though she tried to be supportive by attempting to counter the unending barrage of criticism from his father, Sam perceived her as neglectful for not effectively dealing with his behavior. He knew that she didn't perceive him clearly and he couldn't feel supported by her.

His mother didn't address Sam's misbehaviors and in fact let herself be victimized by them. He felt terribly guilty for being allowed to walk all over his mother without consequence. His pathogenic beliefs were that in addition to feeling like a morally bankrupt failure (which his father told him), he felt like an all powerful monster who couldn't be stopped or controlled (which he inferred from his effect on his mother). He felt responsible for his parents' unhappiness, their shame in themselves as parents, and their ongoing conflicts over him.

The children in these examples developed distorted beliefs about themselves in relation to the world as a consequence of real, traumatic experiences with often well meaning, but in various ways, impaired family members. The children developed beliefs that they were deserving of their traumatic experiences and of their sad circumstances. In all cases, they felt responsible for their own condition as well as for the condition of their families. Because she was sexually abused, Amy believed she was a seductive man-killer. Because he was neglected, John felt his needs were essentially burdensome to others. Because Sam's parents couldn't set limits, he felt like an out of control monster who deserved both condemnation and the rejection he received.

Usually parents and other caretakers are completely unaware of the pathogenic beliefs of their children. They may incorrectly view the child as selfish, lazy, lying, or hopeless. They don't see the child's strategy to cope with what is worrying them in the family. They don't perceive the child's attempts to protect the parent by complying or identifying with them. The parents are often caught up with feelings of shame in the child, and with their compulsion to repeat the way their own parents treated them. The parents' beliefs about the child may be the source of the child's pathogenic beliefs. Or the parents may come to believe the child's convincing portrayal of him or herself which is consistent with those pathogenic beliefs.

The Child's Strategy at School and Home

Children who are traumatized begin to attempt to master what the trauma means about themselves immediately following the traumatic situations and in an ongoing way even before entering psychotherapy. They may reenact the traumatizing situation at school or at home to test out "how true" are their pathogenic beliefs, using other people in their lives such as teachers or parents as judges. These reenactments are both adaptive and non-adaptive. To the degree that the children repeat the traumatizing situations because they

believe they deserve to be traumatized or punished, the reenactments are non-adaptive. To the degree that the repetitions reflect the children's attempt to undermine their pathogenic beliefs and see themselves more clearly, then the repetitions are adaptive.

The Case of The Sexually Abused Child: The Child's Strategy at Home and at School

The sexually abused child often draws attention to the problem with the development of symptoms or disturbed behavior. The symptoms can be nonspecific signs of distress such as sleep disturbance, bed wetting, depression, anxiety, hyperactivity, trouble concentrating, and school failure. The child may act out disturbed sexualized behavior which reproduces the sexual trauma in either of two ways: the child plays the role of the victimizer or the victim. As the victimizer, the child may pull his or her clothes off, poke other children in their genitals, and engage in sexually explicit behaviors such as humping or fondling. As the victim, the child may put him or herself in situations which invite other children and adults to repeat the molestation again. Since the abused child has already been accused of being a liar, the child presents his or her case unconvincingly and often bizarrely to justify the accusation that the child is a liar. Sexually abused children often appear exceedingly anxious, disorganized, and are often so intensely disturbed that they are mistaken for psychotic. The non-specific symptoms are a red flag that there is a serious problem that the child cannot communicate in a more effective manner. The symptoms are also a manifestation of intense internal distress based on fear, guilt, and self loathing.

The victim's bizarre sexualized behaviors and verbalizations are a specific reflection of the child's traumatic experience. Partly they represent an adaptive attempt to get help. The child hopes someone can see through the confusing role reversals, the retractions, the false stories, and see that he or she has been victimized. The child reproduces the horror and confusion in the onlookers at school and at home that he or she has felt as a victim in the ongoing abuse.

Partly the victimized child's behavior is non-adaptive and self-destructive in compliance to the abuse and in consonance with the child's own pathogenic beliefs. The child's bizarre behaviors arouse disgust and rejection from others, which the child feels is deserved. The child gets others to disbelieve and even abuse him or her again. Often, after an abused child has been raped multiple times, parents, neighbors, and even therapists will say that the child asked for it, wanted it, and provoked it. The burden will be shifted to the victim. Adults in the victim's life may start to believe the child's own pathogenic beliefs that he or she seduced the abusers, has power over them, deserved the abuse, is crazy and a liar.

In the case of John and Amy, both children showed nonspecific symptoms. John failed in school and Amy exhibited anxiety, sleep loss, and nightmares. Neither child exhibited bizarre sexual behavior at school which is typical of many sexually abused children. Their abuse might have gone unnoticed if it weren't for an independent half sibling who blew the whistle. The grandmother may have never noticed there was a problem given her preoccupation with her board and care clients and her lack of sensitivity to the children.

The Case of The Delinquent Teenager: The Child's Strategy at Home and at School

Sam was truant, failing in school, stealing, hanging around with the wrong crowd, using drugs and alcohol, and was arrested for joyriding in a stolen car without a license. At home he was somewhat destructive of property, punching holes in the wall when angry, leaving father's tools out to rust, and being disrespectful to his parents. The parents perceived his behavior as rebellious, motivated by anger, and completely incomprehensible since they thought they gave him everything he wanted. The son shared his parents view of him as a rebel without a good cause.

He failed at school and in every other aspect of his life. He thought he was a rebelling against his parents but was actually complying with his father's criticisms and his mother's lack of limits. By the age of 17, he believed fairly strongly that he was the kind of moral degenerate that he appeared to be. He went slam dancing with his friends at punk clubs, drank to excess nightly, and treated his girlfriend badly. He stole from his parents and associated with friends who stole from him and from each other. His behavior was largely a compliance with his parent's criticism and shame in him.

The partially adaptive element in his behavior was that he brought in outside help by involving the criminal justice system and by inspiring the parents to seek psychiatric help. Even though he acted defiantly and was

completely scornful of these outside agencies, he secretly hoped that someone could put limits on him or help his parents put limits on him. Also, hope against hope, he kept open the possibility that someone could see through his destructive behaviors, his compliances, and his identifications and understand him in a way which could help him out of his hellish cycle.

Children suffering from pathogenic beliefs struggle with them in any context or relationship open to them. They may seek solace from peers or other family members to bolster their low self esteem. They also may repeat the pathogenic traumatic situations experienced in their families in these other settings such as school, on the street, or in the home.

The traumatic situations get repeated in two ways. Either the child plays the role of the victim again or reverses roles and plays the role of the victimizer. As the victim, the child may be complying with the original victimization out of a conviction that the treatment was well deserved. The child invites others to repeat the abuse, partly hoping that this time, the parent or other authority figure would not repeat the trauma or would protect him, thereby helping to undermine his pathogenic belief that he deserved the original trauma.

In reversing roles and repeating the traumatic situation as the victimizer, the child justifies his family member being hurtful to him. The role reversal illustrates and demonstrates exactly how he had been helplessly victimized. He may hope that someone will stop him. Authority figures protecting him from being a victimizer helps disconfirm the belief that he is a monster. Authorities protecting his potential victim (e.g., younger sibling or weaker child at school) give him hope that such victimization can be defended against and undermine his pathogenic belief that he deserved to suffer such traumatization himself.

The traumatization the children suffered in these examples were of two types, 1) Victimization: directly being hurt by criticism, neglect, physical abuse, or sexual abuse, or 2) Omnipotence: feeling responsible for vulnerable, impaired caretakers which made the children feel excessively powerful and guilty.

The Child's Strategy in Therapy

Control Mastery theory assumes that the child's goal in psychotherapy is to disconfirm pathogenic beliefs. Even before coming into therapy, the child has been trying to disconfirm his or her beliefs by engaging parents, teachers, and peers in particular ways. But unfortunately, the world is full of people who are not particularly tuned in to each child's psychology. A child who presents himself as a deadbeat in school may get the teacher to believe he is a deadbeat, even if the child's disguised strategy is to identify or comply with a parent. A teenager may worry the parent to death with suicidal threats and drug abuse and the parent may not understand that the child's unconscious strategy is to reverse roles with the parent and illustrate how he is worried by the parent's depression or alcohol abuse.

The child's reenactments in the real world often just complicate and confuse the picture and may end up perpetuating the traumatic interaction and maintaining the pathogenic beliefs in a vicious cycle. The child may get no help getting a clearer picture of himself from parents who come to believe the child's pathogenic beliefs because the child is so convincing.

In therapy the child engages the therapist in specific ways in an attempt to overcome his or her pathogenic beliefs similarly to the way he or she engaged teachers, friends, and relatives outside of therapy. Hopefully the therapy can be a safer and more successful arena for the child to demonstrate and challenge pathogenic beliefs. The child has no guarantee of safety so he or she must test the therapist to see how safe it is to proceed, at what speed, at what depth, and into what issues.

Part of the child's strategy in therapy may be to actually talk about, or to play out a version of his or her problems in symbolic play with the therapist in an attempt to cognitively master the psychological dilemmas. At the same time, the child brings all of his or her problems into the relationship with the therapist who is used to test out all aspects of the child's pathogenic beliefs.

According to Control Mastery theory, there are two ways that patients "test" the therapist or reenact specific psychological dilemmas in the therapy: transference testing and passive into active testing. These are analogous to what the patient does outside of therapy by repeating the traumatic experience either in the role of passive recipient, or by reversing roles and taking the active traumatizing role. When the child repeats the situation where he acts the role of himself and he puts the therapist in the role of the traumatizing parent, that

is a transference test. When the child repeats the drama but reverses roles, taking the active traumatizing role and putting the therapist in the child's role, that is turning passive into active.

It is assumed that both of these strategies are adaptive in therapy because the child is hoping that the therapist has the understanding and skill to help him disconfirm his pathogenic beliefs. In a transference test, even if the patient invites the therapist to act a certain way, e.g., abusive, critical, or depressed like the parent was, he is hoping that the therapist won't act that way. If the therapist acts differently than the parent did, i.e. if he doesn't get abusive, critical, or depressed, it allows the child to disconfirm the distorted belief that he is really deserving of the abuse or criticism he received, or that he is powerful enough to ruin adults. This type of testing is often confusing to therapists who may come to believe the child wants to be maltreated, or wants to provoke the therapist to reject him. Therapists are sometimes drawn into the same webs of confusion that parents and teachers experience. But understanding the logic of the child's repetition to disconfirm pathogenic beliefs by these transference tests is very orienting and makes the therapy arena an opportune place for the child to finally step out of his pathological vicious cycle.

Passive into active testing can be similarly very confusing to the therapist. If a sexually abused girl starts acting lewdly seductive, the therapist might misinterpret this as an expression of the child's sexual wishes rather than a painful replaying of the seduction by her molester. If the physically abused child starts to threaten or attack the therapist, the therapist might misinterpret that behavior as an expression of the child's anger or aggression rather than as a specific display of the horrific abuse the child experienced.

The Case of The Sexually Abused Child: The Child's Strategy in Therapy

John and Amy were evaluated at a sexual abuse trauma center soon after being removed from the home and placed in foster care. During the evaluation, John described the molestation briefly and then never mentioned it again. Amy, who showed more signs of anxiety and sleep disturbance, described the molestation in greater detail. The children started in separate, individual weekly therapy after reunion with the grandmother. Amy was quite anxious and sexually provocative. She stood on her head, showing her panties, sang sexual songs, wrote "f-u-c-k" on the blackboard, and whispered inaudible secrets. She avoided direct discussion of the molestation and became quite anxious if it were mentioned by the therapist. She talked a lot about secrets and acted out the role of a judge who forced everyone to be silent. She then became increasingly agitated and destructive to the play equipment.

John's play was not sexualized. He played many games and developed a close connection with the therapist. John never initiated discussion of the molestation in his therapy other than to say, "That stupid Amy, if she hadn't opened her big mouth, everything would be alright now."

John's strategy in therapy was to engage the therapist in games like baseball. He enjoyed the physical interaction and the establishment of rules. He hoped the therapist would listen to him, like him, and respond to his specific needs and feelings. He was gratified to be able to develop a non-exploitative, non-traumatizing relationship with an adult and with a male. He worried when he was beating the therapist in games, and held back so he wouldn't win by more than one or two runs. Some times he let the therapist win.

At home, he suffered relative neglect in that he never got enough time from his grandmother and was outshone by his sister who seemed to be the grandmother's favorite. He developed the belief that he shouldn't get his needs met because they were inherently burdensome to others. For him to get more, he believed someone like his grandmother or sister had to get less. He felt that to expect more from his grandmother would be wrong because she was already so burdened by her health and the demands of her board and care clients. He worked on his ideas that his needs burdened others and his worry over impaired adults by competing with the therapist to see if the therapist could tolerate it.

He was also very worried about being precipitously taken away from his grandmother again, which he experienced as a major trauma in itself. He engaged the therapist with the simple goal of seeing whether there was predictability, stability, empathy, interest, and safety in the relationship.

Amy expressed tremendous anxiety, both about being taken away from the grandmother again but also related to the sexual abuse. Her anxiety was a signal to her and to the therapist of her internal distress about her feelings of vulnerability to further abuse as well as her feelings of responsibility and guilt. She turned

passive into active by acting lewdly sexual, demonstrating for the therapist the sexual seduction she experienced from her half brother. Her sexual behavior may also have been a transference test to see if the therapist would be seduced and molest her like her half-brother did. Control Mastery theory assumes that she really did not want the therapist to sexually abuse her again which would allow her to disconfirm her convictions that she was deserving of abuse and that she was a powerful corrupter and seducer of innocent men.

Her playing the role of the judge, telling everyone to be silent, was clearly turning passive into active, playing the role of her grandmother, exhorting the children to be silent or risk being taken away again. Both children complied with the grandmother by not discussing the abuse directly. John actually blamed Amy for causing the whole problem by "opening her big mouth." Amy complied with grandmother's pressure to keep secrets by not talking about the abuse in therapy. She indirectly expressed her feelings and her troubling pressures in the therapy by transference and passive into active reenactments with the therapist.

The Case of The Delinquent Adolescent: The Child's Strategy in Therapy

Sam presented to therapy wearing dark eye shadow, a shaved head, an earring in one ear, a studded leather jacket, and black leather boots with the words "criticize authority" written on the soles. In the first few minutes, he told the therapist he was there because his parents suggested counseling after he had been arrested for stealing a car. He also said he hadn't been attending school regularly since it was "a bother". He had just been fired from a job which he was getting sick of. He said he just hung out doing nothing. He got no allowance from his parents because "they're sick of me." His father and he didn't get along and "I tend to blame it on him more." His mother was upset that he didn't go to school but "there's nothing she can do." He said, "I want to leave home now. I don't enjoy it. It's like I've always done something wrong... They're not making things up. I do them. But it's all I hear."

He spoke of not sharing his parents beliefs or values. He said he'd have nothing to do with them if they weren't his parents. "You have to be the same or you're not O.K. It's the unspoken rule, mostly from Dad. My mom hides it more. My dad can't handle the differences. He stereotypes people by the way they look or dress. He stereotypes me... It's been going on for two years. It started with my earring. He bitched and yelled about it."

He said his mother got upset about the way he acted, in contrast to his father who got upset about the way he looked. He said, "I don't agree with her. She says I'm irresponsible. When I came home late (at 11 PM) she said I was irresponsible for coming home late. I didn't go to school the next day. That made it worse. That's irresponsible. When I don't go to school, it's because I'm tired and lazy."

In the first part of this first hour, Sam was cognitively laying out his pathogenic beliefs and some of his attempts to wrestle with them as well as testing the therapist in several ways. By coming in his bizarre "punk" habitus, he was testing whether the therapist would be rejecting of him like his father who couldn't tolerate any differences in appearance. By describing all his failures, i.e. his truancy, his job loss, and his police record, he was testing to see if the therapist would reject him like his mother who was ashamed of and overwhelmed by his behaviors. He was testing the therapist around a central issue in his therapy from the first moment of contact, whether he would be rejected because of how he looked and what he did. The corollary and central pathogenic belief he was testing was whether he deserved to be rejected.

In addition to testing, he also talked directly about the issues and began to address his pathogenic beliefs cognitively. He said he didn't agree with his mother's claim that he was irresponsible, but said that the real problem was that he was tired and lazy. Though consciously repudiating her view of himself as irresponsible, he unconsciously agreed with it by calling himself lazy. When the therapist challenged his use of the term "lazy", he said, "I've been called that by my teachers and parents."

He then went on to describe his interest in political science and his theories about government. He said the constitution and the bill of rights were excellent. But the law was too rigid and the country was becoming too much of a military police state. (His father was in active military duty.) He suggested that the government should start over with a new constitutional convention. He stated, "There should be more freedom. Now there's a lot of discrimination against adolescents. They took away probable cause for searches in school. I find that irritating. I think they're trying to make a slave class out of adolescents."

He talked about his parents being able to put a child in jail if they say their child is out of control. (In fact, he had been put in a detention center in their previous post for breaking curfew. The family had since moved to a larger city.) He noted, "I'm getting away with something here that I wouldn't in (our previous post). I'd be picked up there but not here. There's more violence here where they wouldn't bother with a kid who was 'out of parental control'."

In addition to the police and the government, he was complaining about his parents as inadequate authorities, both that his rights were not respected, but also that his behavior was not controlled. He earlier lamented that his mother was upset by his behavior but "there's nothing she can do." He saw his father as rigid, like in a military police state, resorting to infringements of his rights but not successfully setting limits. He accurately sensed his parents' failures, that they were unable to set limits while being overly harsh and rejecting. But he did not understand that he held pathogenic beliefs that he was a miserable failure who deserved to be rejected.

As the therapy progressed over the next year, he continued to discuss these themes with the therapist whom he seemed to like and appreciate. Early on he began to miss therapy sessions or come at the very end of the session with only one or two minutes left in the hour. The purpose of this missing was twofold. First, he was acting rejecting of the therapist by saying that he would prefer to be with his friends rather than come to therapy. This was turning passive into active, doing to the therapist what the parents had done to him. He had felt terribly rejected and unwanted by his parents. Acting rejecting of the therapist let the therapist know how he felt when the parents were rejecting and disregarding of him.

The second and possibly more important meaning of the missing was a transference test to see if the therapist would reject him. By missing therapy (in the same way he missed school, work, and other responsibilities), he was presenting himself as an irresponsible, ungrateful, hopeless degenerate who deserved to be rejected. He was unconsciously trying to see whether the therapist would view him in the same way everyone else did and reject him, thereby confirming his pathogenic beliefs. He was hoping the therapist would "see through" his appearance and his behavior, and continue to reach out to him, which would help him disconfirm his pathogenic belief that he was so worthless and deserving of rejection.

The Therapist's Strategy

The therapist's major goal, according to Control Mastery theory is to figure out what the patient's "plan" is, and become an ally to the child in attaining it. That means the therapist has to infer what the patient's healthy goals are and help the child achieve them. The therapist has to diagnose the patient's pathogenic beliefs and help disconfirm them. The therapist has to read how the patient is testing the therapist and figure out an appropriate attitude in response.

What makes treating children different from treating adults is that the therapist's work extends beyond that with the child patient to include the school, the pediatrician, the social worker, and the parents. The therapist acts as an advocate for the child and an ally in promoting the child's plan to get better.

Usually in the treatment of symptomatic children, the traumata that underlie their pathogenic beliefs are current and ongoing. A therapeutic strategy that disconfirms pathogenic beliefs and helps the child tolerate traumatic experiences is very helpful. But it is better if the therapist can intervene to stop the ongoing traumatic experiences in the family. Work with parents or caretakers, the school, and other external agencies therefore becomes a crucial and powerful tool to help the child.

This is nothing new to family therapists or to most clinicians who treat children. But work with parents and caretakers is often underemphasized in child therapy. Therapists often devote inadequate time or energy to helping the parents, teachers, and others understand the child and modify their strategies in their respective roles.

Most parents are completely invested in trying to do their best for their children. That doesn't mean that parents don't do horrible things. Parents can be terribly abusive and neglectful of their children. The reasons for this are complex and usually involve powerful pulls out of loyalty to the parents' own abusive and neglectful parents to repeat their horrible parenting styles. Parents who hurt their children, either inadvertently, or purposefully, feel terribly ashamed of themselves as parents. The dilemma of these parents

is if they abuse and neglect their children, they feel ashamed (for what they did to their children), and if they don't, they feel guilty (for doing better than their own parents).

The therapist strategy with all parents when possible includes the following elements: 1) Make an alliance with the parents to help them. The initial focus is usually to help them gain some success in understanding or handling their problematic child. 2) Use the parents to gain as much information about the child to diagnose the child's problem and monitor the child's progress in therapy. 3) Explain the child's problems, goals, strategies, and confusing presentation to the parents so they can be more helpful to the child and they can stop reinforcing the child's pathogenic beliefs. 4) Get the parents to stop doing hurtful things to the child (if that's happening) by allying with the part of the parent who wants to be a better parent. 5) Help the parents get appropriate help for themselves (if they need it) to relieve the child of his omnipotent responsibility to fix the family himself.

Work with the parents can be conjoint with the child in a family therapy model or can be separate in a couples or individual modality. Work with parents should be supportive and even respectfully directive. Confidentiality should be maintained where the child knows that what he says will not be communicated to the parents but both child and parents should know that the therapist will try to help the parents understand the child. Work with parents should occur as frequently as possible/necessary. Often the child is seen weekly and the parents are seen weekly. Financial constraints always play a role in what therapeutic frequency is agreed upon but should be independent of what ideal arrangements are recommended by the therapist after a careful initial evaluation.

The Case of The Sexually Abused Child: The Therapist's Strategy

The case of Amy and John illustrates the complexity of working with sexually abused children, their families, and external agencies. The therapy involved weekly therapy with each child individually, weekly collateral sessions with the custodial grandmother, and regular telephone discussions with the social worker. There was some contact with the school teachers and counselors to monitor the children's therapeutic progress.

The most important therapeutic intervention the therapist can make in a case of abuse is first to protect the child from further ongoing abuse. Second, the therapist should try to protect the child from potentially unwise interventions by other parties such as social services or the court. This involves the therapist making an alliance with social service workers, who may rotate on and off the case several times during the course of a therapy. In cases of sexual abuse, therapy is often court ordered as part of a temporary custody arrangement. The therapist can skillfully work with social services and make recommendations to the court which allows ongoing assessment of the custodial placement, monitors for ongoing abuse, and helps assess what is the optimal long term placement for the child, either with the original parents, with other family members, or foster placement.

(There are specific exceptions when the treating therapist should take a more narrow role and not have contact with the court, such as in certain custody battles. Because of space constraints, the subject cannot be adequately developed here other than to assert that the therapist many times can and should take an active role as the child's advocate with the court). At the same time, the therapist must make an alliance with the current custodial parent. The first step in this case was to help the grandmother to assess the multiple and confusing needs of the children and help strategize what she could do to help them. This initial strategy is both extremely helpful to the children and helps forge an alliance with the parents or caretakers who are relieved to see the child improve. They greatly appreciate the practical help and begin to experience the therapist as an indispensable ally.

Grandmother was worried about Amy's nightmares and anxiety in school. She blamed her granddaughter's anxiety symptoms on the Department of Social Services for taking the children away from her in the first place. The therapist supported when the grandmother was empathic and supportive to Amy, and agreed that a big part of Amy's anxiety was the fear of being taken away from her grandmother again. But the therapist firmly and gently underscored that Amy was also anxious about the abuse and needed to be protected from the half brother who had abused her. The grandmother never admitted that the abuse ever took place, but she gradually became more and more trusting of the therapist who took a consistent protective stance toward the children without condemning the grandmother.

In addition to actively working to help the grandmother understand and protect the children's needs, the therapist took a very supportive stance about grandmother's own life stresses, her health, and her distrust of the social services system by whom she felt disliked and victimized. The grandmother complained about her social worker whom she feared was racist and hostile to her. She missed therapy because she complained that she wasn't receiving promised travel vouchers from the social worker to pay for cab fare to the therapy appointments. The social worker confided in the therapist that he thought the grandmother was an inveterate liar and he was dragging his feet helping her get her travel vouchers. The therapist had to act as an intermediary between the two adults, reminding each of the needs of the children in order to resolve the logistical disputes so the children could come to therapy.

The children's mother, a drug addict who had recently been released from jail where she had been incarcerated for grand larceny, was now suing for custody of the children and trying to take them away from the grandmother. She had been unreliable and neglectful of the children during the course of their lifetimes. The court, which had previously rejected her pleas for custody, was evaluating her current petition. The therapist set up ongoing sessions with the mother to help her to improve her relationship with her children and to evaluate whether the mother's plan to take custody might have any merit. The mother continued to be quite unreliable and show poor judgment in relation to the children. The therapist became a central figure in evaluating potential custody resources and guiding the court's assessment based on a comprehensive view of the children's needs.

The therapy with the children was the most straightforward part of the therapist's job. The therapist attempted to raise the issue of the sexual abuse with both children. Amy got extremely anxious in response. John merely declined to talk about it. The therapist followed the material that was presented by each child.

Amy drew pictures of boats that were floating on uncertain seas. The therapist empathized with how rocky and uncertain it was for the people on the boat. She played many games and roles involving keeping secrets. When she played the judge telling everyone to be silent, the therapist played the corresponding role of the gagged defendant and lamented how hard it was to keep silent or face the judgment of such a harsh and critical judge. The therapist tried to be an ally to Amy by verbalizing feelings and thoughts in the roles she placed him in, giving Amy the sense that her painful and confusing experience could be pieced together while maintaining one's self esteem. There was little direct interpretation of her experience of abuse because she didn't tolerate trial interpretations which only made her extremely anxious.

Her anxiety symptoms, nightmares, and hyperactivity in school improved over the two year course of the therapy. Through a predictable, safe relationship with the therapist, and because the therapist was able to help engineer a more predictable, safe environment at home, she began to feel safer from attack and exploitation. She was also able to feel safer from the tremendous omnipotent responsibility to keep her family intact by keeping secrets to protect them. Because the abuse had stopped and because the therapist was able to help her get a handle on her traumatic experiences by allowing her to safely reenact them in the playroom, she was able to undermine her pathogenic beliefs that she deserved the abuse. She was able to feel some support and empathy in her distress which she did not get from anyone else prior to her therapy. In fact she was blamed by her grandmother and brother for telling the truth and trying to protect herself.

Similarly, John improved over the course of the therapy. He became less sad and withdrawn, more interactive with peers and more academically successful. His therapy was also characterized by very little direct interpretation. He didn't like to talk much about his family members or the abuse. Instead, he got intensely involved in the rules of the games he played and who won. He was initially very hesitant to let himself win at baseball, cards, or board games. The therapist commented that John held himself back from beating the therapist because John was a little worried about him. The therapist enthusiastically played games with John, had fun with him, and tolerated losing. John became more comfortable winning and let himself enjoy competing more and more intensely in the playroom.

The issues he was working on had to do with competing with his little sister, who seemed to be favored by his grandmother at his expense. He was also working on his worry about his grandmother (and authorities in general) who didn't adequately meet his needs and who were strapped themselves. Without any direct verbalizations about these issues on his part, or by the therapist, he worked on them behaviorally in relation to the therapist. He was extremely pleased that the therapist was interested in him, could tolerate him winning, could enjoy him, and could maintain a predictable, safe relationship with him over time.

The sexual abuse was not the only major trauma in John's life. In addition he suffered neglect, instability, parental (and grandparental) dysfunction and empathic failures. The therapy offered a safe haven to work on all of these issues directly in relation to the therapist. The therapeutic work helped disconfirm John's beliefs that his needs were inherently burdensome to others, that he deserved to be neglected, that he deserved to be abused without protection, that he had to meet the needs of others by keeping silent and ignoring his own needs.

The Case of The Delinquent Teenager: The Therapist's Strategy

The therapist took a very supportive stance with Sam who presented himself as an apparition from hell. Despite the invitation to be repulsed by Sam's eye shadow and trappings of demonism, the therapist maintained an affable attitude toward this boy who turned out to be quite articulate and thoughtful. The therapist showed great interest in Sam's theories but at the same time challenged his pathogenic beliefs. The therapist encouraged Sam's complaining about government or his parents. Sam took great pleasure in the therapist's ability to talk about Sam's father making parental mistakes.

Early in the therapy, the therapist forged an alliance with Sam by saying he would help him get what he wanted. This involved figuring out how much education Sam needed in order to get a decent paying job as an adult. Sam presented himself as irresponsible, saying, "What I really want to do is nothing and be rich. I don't like working. Jobs are boring." The therapist didn't bite at the invitation to put him down. Instead he concretely explored how Sam could best work towards his goals of going to college so he could eventually get a job that paid over minimum wage. In the planning for college, other practical issues came up such as what emotions currently got in Sam's way attending high school, how could he deal with living with his parents now, and what did his parents do which undermined his motivation.

When Sam started missing therapy, the therapist stayed in his office and kept his door open until the last minute of therapy when Sam would occasionally show up. Sam was concretely testing if and when the therapist would give up on him. If Sam was late, the therapist would call home within five minutes, and sometimes conducted therapy over the telephone. Frequently, the therapist called Sam at home the evening before an appointment to remind him of the next day's session.

As the pattern of missing sessions continued, since Sam wouldn't come into the office, the therapist laid out his entire theory of what Sam was doing over the phone. The therapist told Sam that his screwing up in school and at work was not rebelling but was really giving his father justification to criticize him which the father did all the time. Sam was actually complying with all of his father's put-downs by failing. The therapist told him if he wanted to rebel against his father, he should succeed and prove his father wrong! But Sam was afraid of doing that because he didn't want to make his father look bad. The therapist told Sam he was undermining himself to protect his father. He then strongly encouraged Sam to come into therapy and further work on this issue because he was in danger of continuing this pattern to protect his father at his own expense.

Sam missed the next four weeks. The therapist called and left messages before and during each session to encourage Sam to come in. He waited with his door open each time. In the fifth week, half way through the scheduled hour, Sam walked in the door and said, "You know, I've been thinking about what you said over the telephone last time about me undermining myself to protect my father." He picked up the discussion as if it had occurred the previous day and produced new memories to illustrate how he undermined himself as a compliance with his father's put-downs.

What the therapist said to Sam was very helpful in undermining his pathogenic beliefs. Equally or more important was how the therapist responded behaviorally to Sam's behavior. Sam acted uninterested, scornful, and dismissive of the therapy, in the same manner his parents treated him. He also acted irresponsible and hopeless, inviting the therapist to give up on him as the parents had. The therapist continued to be available, reaching out, not despairing, not shamed and shaming like his parents.

Sam's missing continued throughout the entire therapy. The therapist made a pitch that the therapy was very important to Sam and should continue. Sam said, "I can't believe you're saying that you're so important. That's pretty conceited, isn't it." Again Sam was turning passive into active, criticizing the therapist for being self important and conceited. The therapist stated that he was very important to Sam. Sam actually loved the

therapist's ability to deflect the attack. He also loved that the therapist thought the therapy was important because it meant that Sam was important. The therapist was fighting back in order to be Sam's advocate. Unlike the parents who were shamed and confused by Sam, the therapist was able to maintain his focus on what was in Sam's best interest.

While Sam was acting impossible, the parents were playing their typical roles. The father blamed Sam for being irresponsible, impossible, hopeless, etc. and the mother helplessly wrung her hands, half agreeing with the father and half-heartedly defending Sam. She felt her relationship with her husband was terribly strained by this conflict between the two men but she didn't want to lose her relationship with her husband. Since she too believed her son was hopeless, she vacillated between defending Sam and supporting her husband's condemnations and threats to cut Sam off and send him away from home.

The therapist was thrown into the fray of family dynamics. Everyone in the family was despairing just as they did outside of the therapy. The mother acted ineffective and confused with the therapist, just as she did with her husband and son. She got therapy sessions confused. She didn't follow through with setting limits with her son because she suffered worry and guilt. She was unconsciously inviting the therapist to be scornful and disrespectful of her as her husband and son were.

The father got easily disgusted with his son, showing little patience or compassion. The therapist tried to explain that the son was undermining himself for psychological reasons which could be rectified. The father politely listened and then went home and told his wife what an idiot the therapist was. The father told the therapist that his son was very much like a stock which a friend encouraged him to buy before the company went bankrupt. He explained he didn't want to get burned again by being invited to have faith in an investment which would turn sour. He scorned the therapist for advocating for Sam, just as he did to his wife, making the therapist feel like an incompetent investment counselor. He was unconsciously testing whether the therapist would be intimidated and paralyzed as his wife was, and as he himself was when his own father treated him in this way when he was a child.

The therapist maintained an active, encouraging, and reality based stance with the parents. He avoided the invitation to scorn the mother or be intimidated by the father. He continued to argue respectfully with the parents his formulation that Sam's strategy was to test the parents about giving up on him. Based on that formulation, he encouraged the parents not to give up on Sam and predicted that Sam would get better. The therapist was quite supportive and empathic to both parents about how difficult it was to be tested in this way. He strategized with the parents about what appropriate limits and consequences they could set in response to Sam's behavior. Much of the focus with the parents was spent working on how to get Sam to therapy. Strategies were developed which included reminders, physically bringing him, rewarding him with money, and punishing him with restrictions. A coherent series of escalating consequences, both positive and negative, was devised and enacted during the 13-month therapy, to deal with Sam's impossible behavior.

The content of the therapeutic work with the parents seemed very consistent with cognitive behavioral therapy, explaining what the child was doing and getting the parents to change their behavior to get the child to change his behavior. The process of the therapeutic work was more than that in that it included passing tests by both the parents and Sam. Standing up to father's intimidation modeled that capacity for both mother and Sam and reassured father that he couldn't ruin everyone. Tolerating mother's guilt and confusion and steadily working towards a coherent system of behavioral consequences modeled for father how to deal with mother and reassured Sam that he could be controlled. Not believing Sam's presentation of himself as an impossible monster relieved him tremendously and bolstered the parents against their feelings of shame in themselves as parents.

Therapy stopped when the father was transferred to another base. Six months later, Sam got a job at a grocery store where he did so well he was offered a job as manager. He made what his mother described as "nice, wholesome friends". He got another job for the summer where he was again asked to stay but he signed up for the army in the fall. Mother reported that the relationship between father and son improved dramatically, with the father learning to be more relaxed and less critical, and both developed the ability to enjoy each other's company.

Summary and Conclusions

Control Mastery theory does not suggest a radical departure from commonly practiced psychotherapy with children. It is consistent with a cognitive behavioral approach in its theoretical emphasis on pathogenic beliefs and its directive approach with parents (4). Like the interpersonal school (5) and the family therapy movement (6), it recognizes the importance of real pathological family interactions which need to be changed to unhook the child from his pathological role. It is consistent with the psychoanalytic tradition which discovered the importance of the unconscious and the tendency of patients to reproduce childhood dilemmas in the transference in therapy (7). It is also strongly rooted in the humanistic school which assumes that the patient is strongly motivated to grow, develop, and use therapy to get better (8, 9).

Control Mastery theory offers a coherent model which integrates these aspects of commonly practiced psychotherapy with children but contributes new insights which further help refine the clinical process. The contributions of the theory include recognizing the importance of: 1) the patient's plan, 2) the patient turning passive into active, 3) the child's worry about his or her family, 4) the therapist allying with the parents' plan to be better parents, and 5) the therapist having an active, enjoyable relationship with the child.

1. *Formulating the patient's plan* gives the clinician a more defined understanding of what the patient is doing in the therapy. The idea that the patient wants to get better may seem obvious to a clinician in the humanistic school but may seem quite controversial to many others. The plan concept states that not only does the patient want to get better but gives the therapist a framework to conceptualize how the patient is going about it. Based on inferring the patient's problem and diagnosing his "plan", the therapist can start to strategize how to best ally himself with the patient. Rather than relying on general techniques such being nice, setting limits, or exploring the unconscious, the therapist can start to guess how the patient is testing him and plan a helpful attitude in response. This doesn't mean the therapist isn't nice, or stops setting limits, or stops exploring unconscious motivation. But appreciating how the patient is testing the therapist helps refine the therapist's approach and helps the therapist follow the patient more accurately and successfully.

2. In addition to developing the concept of the patient's plan, Control Mastery theory also expanded on the role of the patient turning *passive into active in therapy* (1). Freud (10) was the first to discover passive into active but neglected it in his description of the therapeutic process, saying that all repetitions in therapy were transference repetitions. Control Mastery theory made a tremendous contribution to the field by recognizing that all repetitions in therapy were either transference or passive into active repetitions, and highlighted the distinction and its importance.

    - In the two clinical examples of the sexually abused child and the delinquent teenager, understanding passive into active behavior helps the therapist maintain a clearer and more compassionate view of the patient. Sexualized behavior on the part of sexually abused children is often seen by others, including therapists, as manifestations of the child's excessive sexuality rather than as a reenactment of what they passively experienced. Not understanding the passive into active function of the sexualized behavior might lead the therapist to share the patient's own pathogenic belief that he or she is a sexual monster.

    - Similarly, in the example of the delinquent child, not understanding the passive into active function of the teenager's rejecting behavior may mislead the therapist into thinking the child is angry or doesn't want help. What the rejected child wants is for the therapist to tolerate the rejection acted out in therapy, to understand what the child has passively suffered, and to reach out to the child anyway.

3. Dynamically, the importance of separation, loss, and rejection to causing pathology in children is a central feature of dynamic formulations in most psychodynamic schools (11, 12, 13). *The child's worry over impaired parents and omnipotent responsibility for them* has been frequently described but underemphasized in understanding pathogenicity in the child. Control Mastery theory places a much greater emphasis on the dynamic importance of the child's worry and responsibility over the parents and consequent feelings of guilt (14).

- The child's guilt over feelings of responsibility for parental dysfunction is understood by Control Mastery theory to have powerful pathogenic repercussions. It is seen as the reason for children identifying with impaired parents and repeating their dysfunctional behaviors first as children and later as adults. It is understood also as the motivation for children complying with parental abuse and neglect, viewing the parent as correct, rather than rejecting or dismissing the parent as impaired.

- In the case examples described, the children were willing to sacrifice themselves rather than put their parents or caretakers at risk. John and Amy bent over backwards to keep silent about their abuse to avoid burdening their grandmother. They assumed they had done something wrong which got them sent to a foster home, assuming responsibility for the abuse as well as for being a disruption to their grandmother. Sam, the delinquent teenager, was also crippled by his worry for his parents. He thought he was defiant of them but he actually complied with them to make them look legitimate as parents. He failed, acted badly, and felt miserable because he mostly accepted that the problems between him and his parents were his fault. It was very hard for him to accept what he consciously knew -- that his parents really were erring by being ineffective disciplinarians and too rejecting. He said he blamed his father but he really blamed himself. Only by feeling less guilty towards his parents could Sam view them more accurately and relieve himself of his damaging pathogenic beliefs.

4. *Work with parents* is crucially important in any child therapy. Some models restrict parent work to minimal information giving or getting. Control Mastery formulations recognize the importance of ongoing pathological interactions between family and child and suggest active, supportive interventions to change those interactions. Sometimes conjoint family work is necessary and sometimes couples or individual meetings with parents or caretakers is required to make the most salutary changes in the family.

    - It is assumed that parents, no matter how neglectful or abusive want to be good parents. Control Mastery theory implies that inadequate parenting (in the absence of neurobiological deficits) is usually the result of parents repeating their own parents' mistakes out of an unconscious sense of loyalty to those parents at their children's and their own expense. Work with parents is not just educative but also involves the therapist responding to the same sorts of passive into active and transference testing that occurs in the therapeutic work with the child. The therapist has to avoid the invitation to see the parents as impossible or crazy (the parents' own pathogenic beliefs) and needs to maintain a steady, supportive stance to help the parents be better parents.

5. Finally, *most child therapists maintain a pleasant supportive demeanor with child patients* because anything else doesn't tend to work. Even so, some models of psychotherapy require the therapist to be neutral (15) and others instruct the therapist to set limits all the time (16). Control Mastery theory doesn't prescribe any particular attitude with all patients. Based on the patient's plan, the therapist might set firm limits with one patient and take another to the store for cookies.

One generalization that could be made about psychotherapy with children is that it is not a problem and generally quite advisable for the therapist to be involved and emotionally warm. Whether the child is turning passive into active or transferring, whether the child has been neglected or inadequately disciplined, the warm interest and involvement of the therapist is helpful. The transference will develop no matter how the therapist treats the patient.

Control Mastery theory emphasizes how the therapy should help the patient modify his pathogenic beliefs. A neutral, passive therapist might arouse tremendous anxiety and arouse the transferencial experience of a scary or critical parent. But it only hurts the patient if the therapeutic experience confirms the patient's pathogenic beliefs and repeats the transference trauma. The patient needs a therapeutic experience to be different that his traumatic past, which can serve to undermine his beliefs about himself derived from a more grim and problematic family life. If the therapy repeats the trauma, the patient can't get better. If the therapy

can offer an experience where the child feels success, enjoys the admiration of an adult, and can experience fun and pleasure in relationship with another, it will be a more powerful agent for therapeutic change.

Many therapists have confessed guilt over being kind to their patients, or having fun, because it breaks certain rules about neutrality or gratifying the patient inappropriately. Control Mastery theory doesn't view gratification as a sin or a virtue except as it relates to a patient's plan. Some children thrive on gratification because they have been neglected. Others have not been appropriately limited by their parents and get anxious if the therapist is perceived as being unable to say "no". In the latter case, the children have suffered not because they were gratified too much but because they were not helped to develop an appropriate sense of internal controls.

Control Mastery theory implies the therapist should be free to enjoy the child, to be enthusiastic, to be involved, and to be an advocate for the child. Most of the children in therapy have few advocates and little optimism. Their parents and they are at war and few of the combatants are hopeful or having fun. The therapist's job is to maintain perspective when everyone else has lost theirs. The therapist serves as a crucial role model for moving forward even when everyone feels stuck. The family may attack the therapist's energy and creativity but they all secretly appreciate it. The therapist's tolerance of the family members' behavior and willingness to have compassion for them anyway is an experience that no one in the family may have ever had. The parents can take strength from the therapist's compassion in them and then be able to demonstrate that compassion to their children. Far from being a detriment, the therapist's advocacy, interest and energy is a necessary boon to the therapy.

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