In the Absence of Father: Theoretical and Clinical Perspectives

In memory of Dr Roy Muir: psychoanalyst, child psychiatrist and family therapist

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Abstract

This paper was written as a tribute to the work of Roy Muir, psychoanalyst, child psychiatrist and former Medical Director of Ashburn Clinic in Dunedin. It discusses Roy's theoretical and clinical contribution to his profession through a consideration of his thinking about the role of the 'father' in the family triad and discusses the psychotherapeutic challenges where, as a result of changing social patterns, 'fathers' are increasingly absent.

Introduction

I was a child psychotherapy trainee during the time that Roy Muir was in charge of child psychiatry services in Dunedin Hospital and Associate Professor in the Department of Psychological Medicine at the University of Otago in the early 1980s. The establishment of the Certificate Course in Child Psychotherapy was Roy and Elizabeth Muir's brainchild and was to some extent a consequence of their experiences in Montreal, where Roy did his analytic training. Prior to its inception there was no formal training for child mental health workers in New Zealand and no tertiary-level training course in any kind of psychotherapy.

Roy was the course director and, whilst we took part in the psychotherapy section of the registrar teaching, the core of the learning was a 'hands on' apprenticeship experience, supported by intensive individual and group supervision in which Roy and Liz played a major part. It was a demanding two-year period, which had a lasting impact on my professional and personal life. I am honoured and delighted to pay tribute to a man who ultimately became a family friend as well as a colleague.

Working with the child and the family

Within the course, three major theoretical schools of thought formed the basis

of our understanding of psychological development and our approach to diagnosis and treatment. They were the classical analytic intra-psychic model, with emphasis on the child analysts, Anna Freud, Melanie Klein and Donald Winnicott; the dyadic interpersonal model central to John Bowlby's attachment theory, but also including Margaret Mahler and Erik Erikson; and the group/systems models then being developed within the relatively new concept of family therapy. An adequate assessment involved a first meeting with the whole family, followed by individual interviews with the child as well as his/her parents. The resulting dynamic formulation was expected to provide a psychiatric diagnosis, an understanding of the child's intra-psychic development, his/her attachment and individuation status, as well as the family system.

At the time I was unaware that this consideration of multiple models - individual, interpersonal and group processes - was a methodological approach in any way unique. It was just very hard to grasp intellectually as a student. Later I came to understand that this approach to diagnosis and treatment was to dominate Roy's thinking about his patients throughout his working life, regardless of their age or developmental status, and was to become the distinguishing feature of his contribution to his profession, both as a child psychiatrist and a psychoanalyst.

Another noteworthy contribution was Roy's careful analysis of the role of the father. His sensitive observations about the changes to rigid cultural patterns of gender roles led him to consider the emotional roles fathers played. If parenting was to be a joint responsibility in the emancipated family, was there still a necessary and specific contribution to be made by the male parent, or was the father to be merely a substitute for mother? In a paper written in 1989 Roy described the father's unique contribution as follows:

1. the mothering dyad is 'held' by the father,
2. he provides an alternative and differently responding attachment figure/object,
3. having two parents ensures there is someone to love when the other parent is hated,
4. he is a stimulus for individuation,
5. he offers an oedipal challenge and thus the initiation into group relations,
6. he contributes to the group relational patterns of the family, which are internalised by the child. Out of these internalisations role functions will be recreated in adulthood.

Roy also identified the father's specific contribution to the affectomotor stimulus patterns of the developing child, i.e. being put to bed by dad is usually a different physical and emotional experience compared to being put to bed by mum. These differences broaden and extend the possibility for self-experience, self-expression and object relations. The same paper also contains a short case illustration entitled 'A Man Who Never Had a Father' (1989:55-58), which is an excellent example of his integrated thinking and analytic technique.

Four years ago, after ten years of working a with a mostly adult caseload, I returned to work in the public health system as a child psychotherapist, and found myself facing a social phenomenon of what appears to be epic proportions. I refer here to the major shift to the one-parent family. This category fits the majority of the children who present to the Child and Family Mental Health Service provided by the Otago District Health Board, where our treatment brief is to work with moderate to severe levels of disturbance in the age group 0-14 years. A quick analysis of my caseload last year shows that out of a total of 30 children, 6 lived with both parents, 6 lived with neither parent, and 18 were in sole parent families (14 with mother, 4 with father). The most recent census figures indicating that 27 per cent of children live in one-parent families, usually with mother, support my perception.

I have no desire to criticise or discuss this recent cultural change. I offer the information as part of the background to the current clinical situation in which many of us work, especially in the child and family treatment teams. It has particular relevance to the clinical material I will present later.

The sole parent family is, of course, a very sensitive issue, which Roy traversed with considerable tact and thoughtfulness in several of his papers, partly motivated I am sure by his own experience of childhood. He described the one-parent family as 'different' rather than 'worse' than the two-parent family, but in his 1989 paper Roy suggests that the lack of a father in childhood may produce parenting difficulties during adulthood, especially in males. I have assumed that he was thinking about less certainty in gender identity and role function, and perhaps difficulties with separation-individuation.

I wonder about the hidden stories of loss, absence or abandonment, which our assessment statistics so blandly record. What impact do they have on children's attachment status, on their capacity for affect regulation and self-experience, and on the family relational system?

Mothers interested Roy as well as fathers and he played an important role in the treatment of preschool families whilst in Dunedin. This work continued in

Toronto, where he came to be regarded primarily as an infant psychiatrist. His appreciation of the importance of the dyadic relationship with mother contributed to his sustained interest in attachment theory, which in turn stimulated his own theoretical ideas.

Over a period of twelve years Roy wrote and published a series of articles describing a model of mind in which attachment theory and object relations theory were essential components in an integrated psychology of individual, dyadic and group processes.

Theory of bimodal relationships

Roy was known to say that the infant was born 'prewired' to relate, and that the basic drive was object seeking, as evidenced in the psychobiological attachment system of infancy. He proposed a primary transpersonal relational mode analogous to Bowlby's concept of the inner working model, which we understand as an internalised representation of the self and attachment figure in a patterned interaction. Elaborating this concept, Roy proposed that all relational sets, including the family as a whole, become internalised and may include mother-child, father-child, mother-father, family system-child, family system-mother, family system-father.

This primitive start to mental processing (the transpersonal mode) is internalised in what Roy called the dynamic relational unconscious. From this transpersonal matrix (within a good enough environment) the infant develops the capacity for mature object relationships in what Roy called 'the individuated objective mode', in which self and object are discriminated (Mahler, Klein).

Inevitably the former is influential on the latter; affective/interactional patterns (relational systems) internalised in infancy remain active in the unconscious throughout life oscillating with the intra-psychic object relationships. Roy claimed that this transpersonal mode could be adaptive and flexible, facilitating our capacity for empathy, or rigid and defensive, as in many disturbed parent/child relationships.

Attachment-affect regulation and the self

Although attachment theory has been slow to influence psychiatry and psychotherapy in New Zealand, Roy has not been alone in his thinking. Other psychoanalysts have more recently recognized the significance of Bowlby's work and have sought to include it in their theoretical models.

Bernard Brandchaft, an eminent thinker amongst self-psychologists, describes 'systems of pathological accommodation' or 'traumatic attachment systems' which 'undergird inner working models' and form the core psychopathology in self disorders.

A British analyst, Peter Fonagy, and a group of his colleagues, have integrated attachment and object relations theory with cognitive psychology. They too hypothesise that complex mental life is brought into being by the biobehavioural attachment system. They propose that in the context of secure attachment relationships, the infant evolves an 'interpersonal interpretative capacity' as a part of the inner working model (Fonagy et al.:2002:129-130). This in turn facilitates the infant's capacity for a range of affective experiences and the development of affect regulation and sensitivity to self-states.

What has all this theory to do with the issue of absent fathers and children referred to our service? Firstly I think it is fair to say that Roy's insistence on the significance of attachment theory was not widely accepted by his colleagues and he was regarded as being rather 'out on a limb'. This is manifestly no longer the case, and looking back I think the treatment that preschoolers and their families received from him, and from the staff supervised by what we called the Development Centre, was far ahead of its time.

Secondly, we currently receive a large number of referrals of boys (and some girls) in the six to ten age-group whose presenting complaint is aggressive behaviour beyond adult control. Frequently father is absent or has never been present during the child's life, and his absence or influence is presented as a major reason for the problem. The expectation of mother and the referrer is that 'counselling' or 'anger management' will resolve this behaviour, the inference being that the problem is rooted in the child's inability to control his anger about the missing dad. Is this assumption reasonable? Can the absence of father be a serious consideration in the assessment, diagnosis and treatment of such presentations, and if so what can we do about it?

Case history

An eight year-old boy (J) was referred urgently by his school principal. The presenting complaints were his violent outbursts, in which the threat of damage to school property or injury to himself or other children was very real, and the triggers were often minor. Police involvement had been necessary in order to contain him.

Although the referral was made at the time of the violent dissolution of his mother's current relationship the symptoms were displayed mainly at school.

He had had a previous referral at age six for aggressive behaviour towards other children at school and the assessment at that time also suggested some separation anxiety. School regarded him as angry rather than defiant, and his mother thought that the anger was about 'having no dad'. Treatment was focused on the mother's management of J's oppositional behaviour. The symptoms settled quickly and the contact was ended at the mother's request.

Family and developmental history

J was the elder of two boys at the time of the second referral and his mother was about to deliver her third son. Mother and children lived with the maternal grandmother and had no extended family or close friends.

The developmental history notes that he had 'screamed incessantly' as a neonate and grandmother was the person best able to soothe him. However his subsequent development was unremarkable. Marital violence and alcohol abuse were a feature of his early life and his father left the family when J was still a toddler.

DSM1V diagnosis

Age: Eight

Axis I: Acute Stress Reaction, query Separation Anxiety Disorder; query Conduct Disorder.

Axis II

Axis III Asthma (mild)

Axis IV Severe; violent family break up, pregnant mother, isolated family.

Axis V GAF 42

Brief formulation

This sturdy eight-year old boy presented with a chronic history of loss and abandonment within a context of intermittent family violence. He appeared to have poor impulse control and was prone to violent and destructive behaviour towards self and others, most frequently at school. He demonstrated an intense and anxious attachment to his mother, with unresolved oedipal resonances, sharing her bath and bed at times. His mother appeared to have difficulty in completing her own individuation and the family was isolated and lacking in emotional and financial resources.

The family system appeared to be enmeshed, with poor boundaries between children and adults and an intergenerational pattern of absent fathers.

Treatment plan
As the mother was unable to participate in the treatment due to her imminent confinement, individual therapy was offered with the goal of containing the boy's anxiety and facilitating some working through of recent family trauma. A Strengthening Families Protocol was initiated to provide additional social support for the family and, if possible, a male 'buddy' for the child.

Course of therapy
This child was difficult to engage in therapy. He said little and the attachment was easily disrupted. At first, limit setting provoked a refusal to return, as did the summer break.

Play themes were initially violent and lacking in emotional content. A powerful Egyptian mummy figure had to be defeated over several weeks in a violent assault by a male figure. It was a struggle for me to concentrate on the play without wanting to make some interpretative comment but when I did it was dismissed.

In contrast, when playing board games J became extremely anxious and unable to tolerate the prospect of losing, preferring to stop the play instead.

As therapy progressed he began to show some pleasure in making things (fighting machines) and to seek my occasional involvement as a helper.

Indications of progress
At the time of writing reports indicate that J is less violent at school and able to be calmed by the principal when he does explode, without the involvement of his mother or the police service. However the school remains concerned that he will injure another child in one of his angry outbursts, which will result in his being expelled.

His mother has never really complained of his behaviour at home. Currently she reports that J is 'very responsible and loving towards the baby, able to feed and change him'. However, his aggressive behaviour towards his younger brother continues, and on one occasion J 'trashed his own bedroom' when his paternal grandmother was late to collect him for an outing. More recently he lit a fire whilst in the care of a babysitter for the day. This behaviour is seen by his mother as a response to others' failures of care, rather than as indicating J's emotional volatility.

Discussion

Children like J do not fit easily into the DSM IV system, and my initial diagnosis does not provide an accurate picture over time. Roy's wider view offers us an additional range of diagnostic possibilities.

The early history indicates that this child's primary attachment relationships were undermined by an unpredictable external environment and developed as insecure working models. In addition, other internalised transpersonal relational sets, and the family relational system, are likely to be rigid rather than flexible, working against individuation and the capacity for mature object relationships. We also need to consider the mother's internalisations, which may reflect intergenerational patterns of insecure attachment and rigid and inflexible transpersonal and family defensive modes.

Within this particular family system it appears that children remain symbiotically caught up with parents, and boys especially are in danger of being extruded when they reach adulthood. From this perspective, father may not be the only problem, but his absence and unavailability as an alternative attachment figure is an important consideration.

Fonagy et al. (2002) repeat the same formulation but in different words when they state that secure attachment relationships are crucial for the development of a capacity to regulate affect and recognise internal states of mind.

Both theoretical models point firmly to the significantly insecure or absent early dyadic relationships and the subsequent difficulty in developing what Brandchaft would call an authentic core self.

But can we treat the ailment? There is no Hogworts Academy with a benign Professor Dumbledore to fill the gap and J continues to live in a minimally supportive home environment. Pessimistically I wonder if pharmacology will be called upon to provide the answer. Child psychiatrists in North America, and maybe elsewhere, are debating the use of drugs to treat aggressive children. Optimistically I know that current neurobiological understanding supports the psychotherapeutic given, that it is relationships which facilitate development and support change. Roy's multiple treatment model is not out of date but is considered increasingly expensive to deliver.

Final thoughts

Roy concluded with some thoughts on the need for change in society. He wrote:

> I feel that cultural development toward a civilization in which empathic receptiveness and a child-centred parenting attitude are expected of fathers and fully supported by the culture is in its early stages. Even in Western society, the father role ranges from mere impregnator at one end of the spectrum, to primary caregiver, nurturer and provider at the other end. Given this variability and the wide cultural variations in father roles, it is obvious that no single father role pattern can be regarded as essential. The infant brings to the father a repertoire of relational needs that unfold as a series of relational modes, each with its phase-specific style of perceiving and responding to the object world. At each phase, there is an optimal response to the child, and in some of these the response of a father is crucial. (Muir:1989:59)

References

Bowlby, J. (1987). The nature of the child's tie to his mother. *International Journal of Psychoanalysis*. 39: 350-373.

Brandchaft, B. (1998). The Self and Its Objects in Developmental Trauma. Unpublished paper, presented at the 21st Annual Conference on the Psychology of the Self, San Diego, California, October 23, 1998.

Bowlby, J. (1970). *Attachment and Loss*. Vol. 1. London: Hogarth Press.

Fonagy, P., Gergely, G., Jurist, E.L., Target, M. (2002). *Affect Regulation, Mentalization, and the Development of the Self*. New York: Other Press.

Muir, R. C. (1989). Fatherhood from the Perspective of Object Relations Theory and Relational Systems Theory. In S. Cath, A. Gurwitt,and L. Gunsberg (eds). *Fathers and Their Families*. New Jersey: Analytic Press, pp.47-61

__________(1995) Transpersonal processes: A bridge between object relations and attachment theory in normal and psychopathological development. *British Journal of Medical Psychology*. 68: 243-257.

Perry, B.D. (1997), Incubated in Terror: Neurodevelopmental Factors in the 'Cycle of Violence'. In J. D. Osofsky (ed.). *Children in a Violent Society*. New York: The Guilford Press.

Siegal, D. J. (1999). *The Developing Mind*. New York: The Guilford Press