

## **The Issue of Custody in Psychotherapy: Its Changing Therapeutic and Legal Parameters**

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The growth in frequency and complexity of child custody as an issue within psychotherapy has been rapid. This growth reflects both the changing nature of the family and a growing divorce rate. This paper attempts to define some of the problem areas created by the issue of child custody which have been encountered in working psychotherapeutically with patients with particular reference to the role of the psychiatrist.

The traditional family role models included a "nurturing" mother and a "breadwinning" father. The major burden of the childcaring was presumed to be assumed by the mother. Thus, it is not surprising that courts have acted in general conformity with society's expectation and awarded the children to their mother's custody (in the absence of very gross pathology or nonconforming behavior) when divorce occurred. The mother, more or less willingly assumed this burden of child rearing. The father's expectations were likewise defined. Fathers did not seek custody, and if they did it was very rarely granted. The relationship between father and child post-divorce was assumed to entail some inevitable diminution or dilution of intensity with the fathers becoming a relatively distant presence in their children's lives.<sup>1</sup> This change was considered an inevitable if depressing by-product of divorce,<sup>4</sup> and, fathers, acquiesced in it while they continued to function as the family bread-winner — albeit under the direction of the courts.

The erosion of this traditional model of disposition has accelerated in recent years. In *Beyond the Best Interests of the Child*, Goldstein *et al* cogently argue for a disposition that provides the optimally nurturing environment for the child:

The traditional goal of such interventions is to serve "the best interests of the child." In giving meaning to this goal, decision-makers in law have recognized the necessity of protecting a child's physical well-being as a guide to placement. But they have been slow to understand and to acknowledge the necessity of safeguarding a child's psychological well-being. While they make the interests of a child paramount over all other claims when his physical well-being is in jeopardy, they subordinate, often intentionally, his psychological well-being to, for example, an adult's right to assert a biological tie.

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Yet both well-beings are equally important, and any sharp distinction between them is artificial.<sup>2</sup>

Their classic work emphasizes the need for individualization and careful examination of which parent will provide an appropriately nurturing environment, and against any presumption except that “the law must make the child’s needs paramount.”<sup>3</sup> Their questioning any automatic presumptions for awarding custody to the biological parents or to the biological mother parallels the changes within a broader society where it is no longer certain that either biological parent will seek custody of the children. Society has moved from a presumption of biological maternal excellence in child-rearing. And mothers, themselves, have re-examined their roles within the childrearing continuum. Now, as certain mothers opt for “liberation” from day-to-day child care responsibilities, men may opt for a greater degree of engagement in the day-to-day rearing of their children. In a society where the male role is being increasingly redefined, nurturance is seen in less sexually definitive terms. This paper attempts to deal with the impact of these changes on the role of the psychiatrist as a therapist working with patients whose orientation towards their role within the family is rapidly changing and who are involved in the resolution of the legal question of custody of their children.

The psychiatrist’s own personal responses to a patient and that patient’s problems are significant aspects of the doctor-patient interaction. As the psychiatrist attempts to work with a patient, it becomes increasingly difficult for him to function professionally or to deal with his counter-transference feelings with an appropriate degree of professional objectivity as the guidelines for appropriate roles are assigned by the broader society in an increasingly vague manner. As these guidelines increasingly appear to be “old fashioned” or are characterized within the media as “sexist” — simple reflections of male chauvinism — the individual patient’s confusion may well be matched by the psychiatrist’s. Thus, the psychiatrist must attempt to be aware of his feelings toward the parent-patient who is not acting out the role that might have been assigned to them in an earlier society. The initial *raison d’être* of this paper was a discussion with a highly trained and very thoroughly analyzed colleague concerning Robin C. (discussed at much greater length below) who simply said he could have only contempt towards a woman who even contemplated giving up the custody of her children — that he could not even conceive of working with a woman who contemplated, much less actually gave up the custody of her children — so intense were his feelings. Yet, on the other hand, the psychiatrist has the same need as do all other professionals to appear *with it*, and being *with it* may mean the psychiatrist’s bending over backwards to allow his patients to act out. Thus, in his zeal to appear flexible and *au courant*, the psychiatrist may not explore the patient’s decision to yield custody of her children in

sufficient detail — acquiescing in the patient's self-destructive maneuver. And finally, psychiatrists develop a variety of diffuse, intangible feelings that may never reach conscious awareness about their patients. A dependent woman who asks for a great deal of support — who is rather irritating in her demands — may be labelled an unfit mother despite her objective capability. After all, the mere fact that the psychiatrist would not have wanted that woman for a mother does not necessarily rule out that she may be a reasonably nurturing figure.

A significant area of concern in the psychiatrist's approach towards the patient who contemplates changing the terms of a custody arrangement is the degree and scope of the activity that the psychiatrist should be called upon to exercise — the degree to which his therapeutic activity should be guided by his presumptions as to how the children will be helped. In short, if the patient's child is the appropriate object of the private psychiatrist's concern — how directly should the psychiatrist intervene in directing his patient towards some particular resolution of the question of custody? The following two cases illustrate these issues:

Louise C., a 35-year-old woman, sought psychiatric assistance for anxiety and depression. At age 30, her husband had deserted her and her six month old daughter. The patient became extremely anxious and required two years' hospitalization at the local State Hospital. Her diagnosis was Schizophrenia, Paranoid Type. This had been her first (and only) hospitalization. She was discharged in good remission. Indeed, she was able to return to school and function with considerable effectiveness as a paraprofessional. Throughout this time, her daughter was in placement with one family who repeatedly emphasized their interest in adopting her. When Louise sought her daughter's return, she was informed that since the daughter had no memory of her, and in view of her history of severe illness, her daughter's return was not in her daughter's best interests. The patient countered this with her having been denied visitation rights with her daughter for extended periods of time after her discharge from the hospital. She said her recent lack of contact with her daughter was the product of agency policy and a bureaucratic decision, and did not reflect either her illness or any disinterest on her part.

The human dilemmas in this case are profound. The patient, Louise, had rehabilitated herself. She had become an actively functioning member of society. There was little question of the validity of the patient's complaint that the agency in question had done everything possible to discourage contact between the patient and her daughter in the best interests of the child. Ultimately, it appeared that even though the patient had made readjustment to society, the added stress of caring for a resentful six year old (with whom she had had virtually no contact) could

well be destructive to her. Through no fault of the patient-mother, the child had had virtually no contact with her for the past five and one-half years and had adjusted well to her new home. In these circumstances, the patient was advised that, although all the parties respected her desire for reunion with her daughter, it might well not be in her best interests to pursue this legally; and that she should strongly consider that, in any event, she would be viewed from her daughter's perspective not as a positive figure but rather as the selfish disturber of the *status quo*. The patient was incensed at this advice, left treatment, and pursued her legal recourse; to no final avail.

In retrospect, although the patient was encouraged to examine her situation objectively — to realistically assess the consequences of a variety of legal approaches available to her in the light of the near certainty that she would not be able to obtain legal custody, counter-transference feelings may have affected the character of the recommendations, though not their actual content. Experiencing Louise as an aggressive and suspicious woman (albeit with good reason), the psychiatrist may have too readily acquiesced in the agency's judgment that the daughter's home was idyllic, and he may not have paid sufficient attention to the depth of the patient's actual concern for her daughter. In effect, the patient's concern was seen too readily in narcissistic terms, and the psychiatrist may have played too passive a role in encouraging her to assert herself legally — though his desire to protect the patient from an anticipated failure was doubtless an important aspect of his passivity as well.

The ambiguities of the psychiatrist's role are well illustrated in this second case:

Lillian S. and Kevin S. were separated after some six years of marriage. The separation occurred during Lillian's hospitalization — a hospitalization precipitated in considerable measure by Kevin's increasing withdrawal. As Lillian was preparing to leave the hospital, Kevin announced that he was planning to leave her for another woman with whom he had been conducting a long term affair. Lillian's hospitalization had lasted three weeks, and it was felt that she was not Schizophrenic — rather that she had had a very severe Anxiety Reaction. Needless to say, Lillian was felt to be capable of assuming responsibility for their daughter, and she proceeded home. Lillian was referred for after-care. She was a histrionic, angry, dependent woman who was quite invested in caring for her daughter. Her husband was seen in consultation. His main preoccupation was financial. He discussed his wife's future primarily in financial terms. He did not talk about his daughter at all. The following week he made an unexpected visit to their old apartment. There he found his daughter in the care of a young babysitter. He immediately proclaimed that his wife was negligent and pulled his

daughter out of the home. My patient returned soon after to find her daughter gone. And she was required to bring a custody action in Court.

It is difficult to do justice to the complexities of the psychiatrist's role in this situation. What is the psychiatrist's responsibility to his patient? To the child? Is there a conflict between the two? And what should be the psychiatrist's role in a proceeding where both husband and wife — father and mother — might be legitimately held to have major pathology.

In resolving these issues, the psychiatrist took refuge in the rationalization that, where both parties are imperfect, one should not demand perfection from the mother. While Lillian had deficits in terms of ego structure, these deficits had not heretofore interfered with her treatment of her daughter. Indeed, no evidence of inadequate mothering was ever presented other than she had once left her daughter, in otherwise secure circumstances, with a youngish babysitter who was otherwise responsible.

Kevin had shown little interest in the child until the issue of child support had been raised. And his precipitous snatching of the child seemed to show little real regard for her needs. In short, the psychiatrist participated in the proceeding as an expert witness for the plaintiff, Lillian, because of his conviction that, in the absence of profound deficits in mothering, and in the presence of maternal concern, a young child should not be deprived of her biological mother. The father had claimed a redefinition of his rights, and, since he was in possession of the child, it was necessary for Lillian to start legal proceedings. The court case was an extraordinarily expensive action in which it often seemed that the burden of proof lay entirely upon the mother. This would be a burden of great difficulty for any mother to sustain. The problem was exacerbated by Lillian's own self-doubt and her constant self-recrimination that her defect in judgment had precipitated the entire problem. The psychiatrist was, thus, called upon to provide constant support and appropriate reassurance for a woman who was most dependent and whose ex-husband constantly reminded her of any real or fantasied inadequacies as a mother. This aspect of the therapeutic process will be discussed at greater length in the case of Robin C., but it is important to note this identification with the aggressor which may significantly affect the psychiatrist's therapeutic activity in questions of custody.

It is in this context that the decline of the automatic presumption in favor of the mother should be examined. Goldstein *et al.* emphasize their preference for "minimum state intervention and leaving well enough alone . . . and our recognition that law is incapable of effectively managing, except in a very gross sense, so delicate and complex a relationship as between parent and child."<sup>5</sup> Yet, since our legal system "rewards" the more aggressive party to an action (in many practical matters such as venue, burden of proof, etc.), it is in this context that the

decline of the automatic presumption in favor of the mother should be examined. Does the new approach not “reward” the more aggressive parent, encouraging those parties to undertake aggressive intervention since they can now act under the cover of the child’s “best interests” — resulting in an increase in state and legal intervention? . . . a result that Goldstein *et al.* do not seek.<sup>5</sup>

Similar practical and therapeutic issues are presented in a much more complex context when the mother already has given up custody of her children in a formal proceeding. What role should the psychiatrist play in working with this woman? A fundamental problem presented in working with such a patient psychotherapeutically is whether or not her earlier decision to give up custody was necessarily so pathological as to preclude any future efforts to regain custody. And to what extent will any attempt at an objective assessment of the patient be tainted by intense counter-transference feelings during either consultation or during the course of either individual or group psychotherapy? These issues can be discussed more relevantly in the context of a specific case:

Robin C., a 34-year-old woman, was referred for psychiatric treatment because of a history of depression and anxiety attacks. She was an attractive, neatly groomed, if drably dressed woman of obvious intelligence and with real anxiety. She immediately emphasized that her husband had been limiting her visitation, and their relationship had rapidly deteriorated since his remarriage. She stated that she had had custody of the children for a year after their separation, and that because of the strain of working and caring for the children she had allowed her children to stay with her husband for a year. She emphasized that her formalization of this custody arrangement had reflected her working and his apparent unemployment. And, since their relationship had been amicable at the time of divorce, she had allowed an initial temporary placement to be formalized.

During the course of her early sessions, Robin began to talk at great length about her need to placate male figures. She described her current relationship with a boy friend in placatory terms and re-emphasized her need to have his approval. In describing her ex-husband, Lionel, she said:

There’s something about Lionel — I feel really good when he’s nice to me. He can be nice to me. Lionel was so protective of me — that’s why I married him. I felt safe around him. I couldn’t sexually tolerate him. There’s something I need from him. He’s gone out of his way to be supportive of me. (But) the implication is always that I’m totally childlike and crazy. I miss that protection. I rejected him. He wanted to be with me. I know that I couldn’t be with him any more. I wanted to preserve that friendship. I couldn’t tell him that I found him

physically repulsive and always had. What is it that I want from him now?

In later sessions, the patient amplified this picture of her marriage. She described her husband as protective, but always in terms implying that without his approval and protection she could not possibly function. This came from a woman who was steadily employed and who, indeed, was more stable in her employment history than her ostensible protector.

As Robin began to discuss surrendering custody of her children, it became clear that her decision was a product involving many factors. Of primary importance were her devaluing herself and her tendency to portray herself as not living up to the unrealistically high expectations of motherhood she had created for herself.

Robin was the product of a home in which her father had been quite overtly seductive, and her mother was both critical and competitive. Developing within this inhospitable environment, she became a harshly self-critical woman torn by self-doubt. She saw any attempt at self-assertion as tabu and potentially subjecting her to her mother's retaliatory behavior. For example, Robin had given up a promising career as a singer when a major opportunity presented itself. When attractive and appropriate males courted her, she had allowed her mother to compete openly for their attention. Although she was critical of her performance as a wife, the actual breakup of her marriage was precipitated by her husband's homosexual liaison with a mutual friend. And, initially, the patient expressed little criticism of her husband's behavior both before and subsequent to the separation. She had been quite acquiescent in his lack of emotional and financial support during the period when she had custody of their two sons.

Robin's view of herself as a mother was harshly self-critical. She seemed genuinely frightened of having ever expressed any angry feelings towards her normally active and occasionally provocative young sons. She masochistically felt that appropriate maternal behavior entailed a total denial of any feelings other than those of uncritical love. Robin would cite her original decision to give up custody on a temporary basis as evidence of her incapacity to function on an appropriate level at any time. This self-critical attitude was re-enforced by her husband's remarriage. Robin rapidly assumed that his new wife could provide the mothering that Robin herself had been unable to provide. The maternal transference is obvious.

The psychiatrist must function on two levels in dealing with so masochistically self-critical an individual as either Robin or Lillian. On one level, he must carefully and continually attempt to evaluate the reality of the patient's protestations of inadequacy. The patient may, after all, be inadequate. But the self-deprecatory mother may allow herself to be exploited in contractual relationships by ex-partners, and the psychiatrist must develop particular alertness to the manner in which

these individuals open themselves up to manipulation through their own senses of inadequacy.

On the other level, the psychiatrist must function in a more conventionally therapeutic manner. Constant support was required to help Lillian and Robin assert themselves appropriately in order to obtain easy and regular visitation. Both patients frequently ruminated that perhaps their children would be better off without any contact with them. They both fantasied that their ex-partners' new wives (or girlfriends) would be better mothering figures, when in actuality, their children looked forward to their visits. The visits, themselves, passed without incident. Not surprisingly, their ex-husbands would encourage them to view themselves in this obsessively self-critical fashion.

In dynamic terms, both Lillian and Robin were encouraged to explore their self-deprecatory and competitive relationships with their own mothers. In a very real sense, both patients had acted out whatever competitive strivings they had by denying their adequacy and attempting to placate maternal figures by a show of inadequacy. Their work and social life began to improve as they, each in her own way, began to explore their behavior and to change it.

In this context, it must be noted that because of their continuously self-critical productions, group psychotherapy was of particular value. Both Robin and Lillian were encouraged to join psychotherapeutic groups. They regularly brought their self-critical assessment of their behavior (past and present) into their group sessions. Just as regularly they received a great deal of support from their respective groups, despite their outrageous and irresponsible characterizations of their behavior. The group provided a sense that their behavior was appropriate and constructive, and supported their efforts at assertion.

Obviously, this series of two is insufficient to justify hard and fast broad conclusions. But when women raise the issue of either surrendering custody or not aggressively pursuing custody when it has been temporarily lost (through child-snatching for example), the psychiatrist must alert himself to the possible presence of the issues of self-deprecation and self-denigration. The psychiatrist, in a supportive, non-judgmental fashion, encouraging the patient to explore the processes that are leading her to deny herself custody, can be of major benefit even if the mother does not re-obtain custody. Lillian was successful in her quest for her child. Robin eventually did not regain custody of her sons, but she was able, nonetheless, to re-establish a regular visitation relationship with them that allowed her to play a continuing active part in their lives.

Thus, it is not possible to answer in categorical terms whether or not the decision to give up custody is necessarily pathological or appropriate. It is most important for the psychiatrist to alert himself to the counter-transference problems that may arise whenever this question is raised. In consultation with colleagues of apparent sophistication and real competence, it became evident that their initial reactions to Robin were

that she would remain a therapeutic pariah. They would calmly discuss Robin's behavior as so outrageous that they could not even conceive of working with her in therapy. Their counter-transference feelings provided a categorical response which would have prevented Robin from obtaining the treatment she needed. Here, as elsewhere, unanalyzed and simplistic answers do not do justice to human dilemmas.

In a paper of this brief length, it is impossible to deal with the question of the father's motivation when he assumed the custody of the child. Nonetheless, certain aspects of the father's behavior may be legitimately examined. Obviously, if the mother is grossly inadequate or frequently absent for long periods of time, the father's assumption of custody represents an appropriate exercise of paternal responsibility. And, as children approach adolescence, living with a paternal figure who respects their autonomy is certainly preferable to their remaining with a mother who conceptualizes her maternal role in symbiotic terms.

The psychiatrist should be alerted, however, to the possibility that other, more pathological, dynamisms may be present. The father's changing role with the family and the emphasis on the father's playing a more nurturant role, give child custody an aura of machismo. This father acts out his competitive relationships with female siblings or with his mother in the arena of custody. The competitive father may become a figure of increasing importance with the increasing emphasis on the establishment of joint custodial relationships.<sup>6</sup> It would be unfortunate if a father, driven by his own competitive strivings — *vis-a-vis* the child's mother, were to seek unrealistic joint custody arrangements or even push for individual custody. It must be noted that the financial burden of child support payments may provide an additional motivation for this competitive and destructive behavior.

In this context, the psychiatrist can be of real help to the father, helping him explore the realistic dimensions of child care, and the responsibilities that minute-by-minute and day-to-day care of the child entail. Likewise, the psychiatrist can help the father explore whatever narcissistic injury is experienced as a result of custody provisions within the divorce settlement — an injury that may be expressed in the father's unrealistically aggressive approach to the issue of custody. And in those circumstances where the child's mother is inadequate, the psychiatrist can provide the needed support for the father who is seeking the appropriate reform of any custody arrangements.

### Summary

The changing roles of parents within families have led to an increasingly frequent re-examination of custody arrangements. Mothers are awarded custody only after more critical scrutiny and in a less summary fashion. Moreover, fathers may now seek custody of their children in circumstances which are either mundane or less indicative of a catastrophic degree of maternal inadequacy. Likewise, fathers are seeking

either joint or individual custody of children on a more routine basis. In this context, the psychiatrist is forced to re-examine his own biases regarding assumption of custody, and to help his patients work within these new social-legal frameworks. These issues are explored in the context of three cases where the individuals were seen in on-going psychotherapy, and both psychiatrist and patient were forced to confront these changing emotional, social and legal parameters.

### References

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