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Family therapy with unmarried African American mothers and their adolescents.

[Family Process](#), Winter, 2001, by [Dana Becker](#), [Howard A. Liddle](#)

Almost two-thirds of African American births are to unmarried mothers, and these single parents are among the most economically vulnerable in the United States. The effects of chronic stressors such as poverty can compromise the ability of these mothers to parent effectively, particularly during the developmental period of adolescence, typically a stressful phase of parenting. This article describes a multidimensional family therapy (MDFT) approach to working with African American adolescents who have drug and/or behavior problems. It is maintained that addressing the intrapersonal functioning of African American single mothers is vital if they are to re-establish the attachment bonds necessary for the maintenance of essential parental influence in the lives of their adolescents. Through systematic attention to the parent as an individual, leading to a balance between self-care and care for others, parental supervision is more easily achieved and relational impasses between parent and adolescent more equitably resolved.

Fam Proc 40:413-427, 2001

THE increase in the number of families headed by single mothers has led to a dramatic change in family structure in the United States over the past several decades, and the swift rise in the number of African American households headed by women since 1970 is an even more notable phenomenon (Darity & Myers, 1995; McAdoo, 1998). The growth in the number of never-married since 1970 (Bianchi, 1995; Demo & Acock, 1996; McLanahan & Casper, 1995), has been particularly high among African Americans as compared with whites. In 1990, almost two-thirds of African American births were to unmarried mothers (Bianchi, 1995). The dire economic situation of the growing population of single mothers accounts for the feminization of poverty (Sands & Nuccio, 1989). Currently, of all the largest demographic groups in the United States, African American single-parent families suffer the greatest financial hardship (Bennett, 1995; Franklin, 1997) and, among single parents, never-married women are the most economically vulnerable (Franklin, 1997;

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McLanahan & Casper, 1995). If current trends continue, it is possible that the majority of African American families will be headed by females within the next several years, and that these families will live in poverty, isolated from mainstream society (Darity and Myers, 1995).

Effects of Stressors on Parenting

In the not so distant past, causal inferences about the negative impact of the single-parent family structure on the development of children and adolescents were frequently made without regard for the role of mediating factors such as poverty (Blechman, 1982; McLanahan & Sandefur, 1994; McLoyd, 1990). Although the parenting system seems to be best protected when the psychological well-being of parents is sufficient to promote responsive involvement with children (Belsky, 1984), the effects of chronic stressors--financial stressors in particular--and the multiple negative events (e.g., assaults, evictions) experienced by many low-income parents in the course of daily life strongly affect their psychological functioning and may compromise their ability to parent effectively (Dix, 1991; Lindblad-Goldberg, 1989; McLoyd, 1990). Although social support is believed to offset the socioeconomic disadvantages posed by single motherhood, not only do a significant number of single parents not receive much help from their families (Jayakody & Chatters, 1997), but in some instances the help received may be offset by later demands for repayment of money or favors (Belle, 1982). Also, when mothers have little for themselves, both materially and emotionally, there are inherent costs in giving, even when doing so may provide the insurance of help in return at some future date.

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The adolescent period of the family life cycle can be particularly stressful for parents, and those parents who are already experiencing high levels of stress will respond less well in the face of its demands (Holmbeck, Paikoff, & Brooks-Gunn, 1995). Parenting adolescents requires a shift away from power- and authority-based practices. It also requires a parental responsiveness that involves greater flexibility, support, and reciprocity in communication; changes in the degree and nature of supervision when monitoring the adolescent's whereabouts and activities; and firm and consistent disciplinary practices (Belsky, 1984; Holmbeck, et al., 1995). These practices are characteristic of an authoritative parenting style (Baumrind, 1967) that has been shown to benefit adolescents from diverse socioeconomic, ethnic, and racial groups (Avenevoli, Sessa, & Steinberg, 1999; Baumrind, 1991).

Single Mothers in Family Therapy

African Americans have been making more use of mental health services than ever before (Hines & Boyd-Franklin, 1996), and unmarried single mothers and their children are currently, and will be increasingly, in need of a variety of supportive services, including family therapy. Since low socioeconomic status, parental psychopathology, and stress have been associated with the risk of early dropout from treatment and poor outcomes (Kazdin, Stolar, & Marciano, 1995; Patterson & Chamberlain, 1994), therapists working with low-income single mothers must address those negative perceptions and experiences that arise within the context of therapy itself. These can include: a poor relationship between parent and therapist, a sense that the treatment will be too demanding, and the idea that parental involvement in treatment is not very relevant to the child's problem (Kazdin, 2000; Kazdin & Wassell, 1999). For mothers of adolescents involved in drug use and/or antisocial activity, treatment must be acceptable, accessible, and understandable. Not all family therapy models serve this population equally well.

Many discussions of work with single-parent families focus on the

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need to help single mothers solve problems effectively, to shore up their parental authority (i.e., "executive function"), and tighten generational boundaries (Fishman, 1988; Jung, 1996; Weltner, 1982). In this era of brief therapy, it has been suggested that discussing how a single parent feels in order to deal with her sense of insecurity, feelings of incompetence, and helplessness is not as effective as working on improved self-efficacy, focusing on the accomplishment of goals, teaching specific skills, and mobilizing resources, among other activities (Gutierrez, 1990; Jung, 1996). The implication here is that the therapist is forced to choose between two incompatible alternatives when, in fact, making such a Hobson's choice may be dangerous to the health of the therapeutic alliance with the single parent and, consequently, to prospects for change itself.

Adoption of a systems perspective has long been advocated for use in work with single-parent families since it is thought that such a framework helps the clinician avoid pathologizing the parent (Jung, 1996). As feminist scholars have pointed out, however, systems thinking alone will not fully protect women entering family therapy from being assigned both the blame for family problems and the bulk of the responsibility for devising solutions to those problems (Goldner, 1985; Luepnitz, 1988; Walters, 1994; Walters, Carter, Papp, & Silverstein, 1988). Many single parents, accepting the societal message that the burden of attending, unassisted, to the multiple practical and emotional needs of their families is their responsibility and theirs alone, are depleting themselves and their resources.

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Difficulties with respect to supervision, monitoring, or parental limit-setting that exist in many referred single-mother families need to be addressed with particular care if they are to be resolved successfully. There are several pitfalls that await the naive practitioner. The first relates to the possibility that the therapist (particularly the male therapist) will "support" the mother by taking on the role of the absent father as disciplinarian, thereby giving credence to the myth endorsed by some single mothers that it takes a man to raise sons (Carter, in Walters et al., 1988).

For some single mothers, a means for relieving the stress of having to parent a difficult adolescent is to invoke their sons' fathers' names in times of difficulty, sometimes threatening to send them off to fathers who may not even be willing or able to take them. This, for some adolescents, is a threat tantamount to total abandonment. In this first session with a mother and her 16-year-old son, it is clear under what conditions the boy's father is invoked:

Mom: What really makes me angry
 ... when we go through what
 we go through, I think
 about ... his father should be
 here ... and it irks me.

Ther: Ah.

Mom: I think, you know, his father
 should with him, not with me-spending
 more time with his
 son.

Adol: You told me if that if he come to
 the house you gonna shoot
 him ... or ... ain't I supposed
 to say it?

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Mom: [interrupts] I don't want him at my house at all.

Ther: Umhmm.

Adol: But she want him to be there just when we have arguments.

In this family, father was not a reliable presence, and the therapist, mother, and son agreed that when mother and son raised the specter of father, the purpose was generally to hurt each other. The therapists frequent reminders about "That's frustration talking," moved mother and son back to the challenging discussion that had led one or the other to pull open this particular escape-hatch.

Another potential problem relates to the therapist's setting up a disciplinary standoff between mother and child(ren) before mother feels comfortable taking charge of an out-of-control child or children (Carter, in Walters et al., 1988). Obstacles to a sense of empowerment may range from the practical to the psychological, and parents who have a diminished sense of power may be less open to changing their views of the parent-child relationship (Bugental, Brown, & Reiss, 1996). Therefore, it is imperative for therapists both to acknowledge a parent's lack of belief in the possibility of change and simultaneously reinforce the critical nature of the situation and the availability of therapeutic support (Liddle et al., 1998).

Yet another dilemma in clinical work with single mothers is the tension that may exist for some single mothers between the need to care for others and the need to care for self, which is expressed in their approaches to monitoring and supervising their adolescents.

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Ther: It just sounded like your mom was upset with her; she was sad 'cause she didn't come [to celebrate Christmas with the family]. I was wondering, maybe, were you sad also? Were you sad that your mom was upset with your sister ...

Taisha: I was sad 'cause she took it out on me.

Mom: Yeah ... How? [Taisha giggles]. You can say, go ahead.... Maybe I didn't realize I was taking it out on y'all.

Taisha: [unclear] ... your attitude.

Mom: Well, what'd I say?

Taisha: I don't know. I forgot [unintelligible] But you was just ... [unintelligible]. You was just hollerin stuff ... not all like that, but every time someone said something you disapproved of, you just started hollering.

Ther: So that probably made it hard for you, then.

In another session, a different mother is able to observe the effects of her own upbringing on her parenting: "That's true. I always been hot-headed. I always been ... Let's put it this-a-way: I've always been

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hot-headed because I always had to fend and do for myself."
 Therapists can expand upon this theme later in treatment in order to help this mother alter her parenting behavior.

PARENT-ADOLESCENT RELATIONSHIP

Parental Supervision

Awareness and supervision of adolescent activities has long been a predictor of adolescent outcomes (Dishion & McMahon, 1998), and never-married mothers appear to be at the lower end of the scale with respect to parental monitoring, particularly with their sons (Chilcoat, Breslau, & Anthony, 1996). In single-parent families, time pressures and a lack of social supports may predispose parents toward premature autonomy-granting (Dornbusch, Carlsmith, Bushwall, et al., 1985; Dornbusch & Gray, 1988). The higher level of permissive parenting that appears to exist in many single-parent families, as well as the lower level of participation in school-related activities, has been shown to have negative consequences for adolescents' school performance (Dornbusch & Gray, 1988; Dornbusch, Ritter, Leiderman, et al., 1987).

In the relationship between deviance and decision-making, it is not clear whether some mothers reduce their attempts to influence their teenagers in response to adolescent recalcitrance, or whether deviance results from a paucity of attempts on the mother's part to influence the adolescent (Dornbusch et al., 1985). In any case, negative feelings about the adolescent may well contribute to a parent's reluctance to stay involved in her child's life (Dishion & McMahon, 1998).

The type of effective monitoring that can prevent problem behavior does not imply a tracking of the adolescent's every move by the single parent or constant intrusion into his or her life, but rather a consistent expression of interest in the child's life by the parent as well as a willingness to set limits and to raise issues of concern (Small & Eastman, 1991). Monitoring, then, has a significant relational component.

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The reluctance of many single parents to discuss themselves and their problems may discourage exploration of the self of the parent, and therapists may feel encouraged to move quickly to a focus on changing parenting behaviors. However, colluding in a mother's reluctance to discuss herself and her life may stand in the way, ultimately, of understanding what is preventing her from feeling or acting competent with her troublesome adolescent, and it may hinder the establishment of trust in the therapeutic alliance. Such collusion is not only encouraged, as previously mentioned, in some systemic formulations, but may be supported by a managed care industry in a hurry to resolve the child's presenting behavioral problem.

In many cases, even when family therapists do discuss a mother's personal concerns, they may do so only in order to avoid having the parent sabotage the problem-solving agenda. However, when therapists view attention to the parent as a digression from the more "important" goals of therapy, this outlook may be reflected in the nature of their questions and in the unquestioning acceptance of a parent's perfunctory replies. In MDFT, discussing the self of the parent, often in relation to self-care, is seen to address a central need of the parent to receive attention and nurturance, and thus is not considered a digression from the central goals of treatment. Here, the medium is the message: "This therapy is about you--not just your child, because the relationship includes both of you, separately and together." Self-care and care of others are inextricably intertwined in a framework within which the parent's dual status as both African American and female is recognized (Taylor, 1999).

In the case mentioned earlier, the therapist could easily have accepted mother's explanation that she had missed her appointments because she had the flu, and attributed her irritability to it. However, he persisted in asking about her experience of his coming to the house. It was only following this inquiry that mother mentioned feeling "down." As it turned out, the therapist spent considerable time, during that session and others to come, speaking with mother alone about her depression, her sense of social isolation, and her

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alienation from her family of origin, discussions that yielded plans for mother to rejoin her church in order to gain needed support. These discussions were pivotal, not only insuring the retention of the family in therapy and helping Ms. S to become aware of obstacles to accomplishing the personal goals that she had articulated to the therapist, but also in providing a shared understanding between mother and therapist of what might be responsible for some of the difficulties she was having with her children. The intention is to convey to mothers that their parenting can be affected not only by their external experience, but by their inner experience as well, and this understanding cannot be achieved if the self of the parent is marginalized in the therapy. Here, the therapist asks Ms. S's daughter, Taisha, for her perspective on an argument between her mother and older sister:

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For example, in the segment of a case transcript that follows, clinical work ground to a halt after a mother (Ms. S) and daughter who had attended three previous appointments did not call or come to the clinic for several weeks. The therapist, a young white male, had decided to stop by the home of Ms. S, an African American single mother. When he arrived, Ms. S's behavior at the door had been curt, and she had appeared angry. Back at the clinic the following week, the mother explained that they had missed their recent appointments because she had had the flu.

Ther: Yeah, that's why I stopped by yesterday. I didn't know how else to get a hold of you besides to stop by because the phone, I didn't know when the phone ...

Mom: Another couple of weeks

Ther: I don't want to be a pain in the neck or anything, or a pest. I'm just getting to know your guys. I mean, was it okay that I stopped by yesterday?

Mom: Well, I've just been depressed lately. If I came down the steps looking kinda angry, I've just been depressed.

Ther: Okay.

Mom: It didn't have nothing to do with you.

Ther: Okay. `Cause I'm just gettin' to know you, and I couldn't tell

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Mom: Well, you didn't have nothing to do with it. It was just me. Just feelin' down lately I guess [sighs heavily].

In addressing the issue of whether his presence at the house was acceptable to Ms. S, the therapist exhibits a respect that is not always shown low-income women within the culture of service delivery systems (Walters, 1994). He observes the boundaries that exist between him, as a young, white male service provider, and the family at this early stage of the relationship ("I'm just getting to know you"). He does not view Ms. S's failure to show up for her appointment as a client problem to be analyzed, but an artifact of her situation, both financial and emotional. He likewise expresses an interest in Ms. S as an individual who is in distress on more than one level.

The therapist must find a way to earn the trust of a woman who does not have much reason to believe that she can ask for or accept help from anyone, least of all a representative of the "system." Many African American women, having internalized the stereotype of the strong black matriarch, resist asking for help, feeling that they should be able to shoulder all burdens, no matter how heavy (Greene, 1994; Taylor, 1999), and this sense of responsibility may amplify broader social views and expectations about women's caregiving responsibilities. Mothers may feel that talking about problems is a waste of time and that coming to therapy is a sign of weakness (Greene, 1994). Many do not feel entitled to receive care, and some may not even feel entitled to care for themselves: they identify themselves primarily as caretakers (Boyd-Franklin, 1989; Boyd-Franklin & Garcia-Preto, 1994; Wortman, 1981).

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For some socioeconomically disadvantaged single mothers, it is critical to address the self of the parent prior to addressing her relationship with her child. For a single mother who may be an "undernurtured nurturer" (Westkott, 1986), overburdened in the present, and the recipient of little or poor parenting in her own childhood, the parenting tasks required to negotiate a child's adolescence may severely overtax her capacity to sustain an empathic connection with her adolescent. A strong therapeutic alliance must be forged if she is to tackle the parenting tasks before her, the foundation of which is the promise that the therapist will address her burden, stress, and needs, in addition to helping her become a more effective parent (Liddle, et al., 1998). Therapists meet with parents alone for portions of most sessions, creating a strong, collaborative working alliance within which parents are able to obtain practical and personal help for themselves as well as to discuss parenting dilemmas. The focus on the intrapersonal has the additional benefit of helping the parent prepare for the interpersonal (i.e., interactional) work between her and her adolescent that lies ahead.

Patterson and Chamberlain's (1994) antidote to early resistance by both parents and therapists to the tasks of parent training is to suggest that the therapist increase her efforts to intervene in the early to middle phases of treatment. Although resistance will increase during these phases, they maintain, it will presumably be reduced as parents see the positive effects of their changed parenting techniques. In MDFT, as differentiated from parent training, therapists assess the ability and readiness of parents at any given time to tackle given parenting tasks. The assessment includes judgments about: (a) the parent's level of psychological functioning and the quality of supportive resources; (b) the level of negative emotion experienced and expressed on a regular basis by parent and adolescent; and (c) the level of parent/adolescent disengagement. As is typical in our work with single parents, the therapist neither pushes relentlessly toward the stated goal of improving parenting techniques nor does she abandon that goal. It might be said that the ability of the therapist to enter the parent's world without fear of getting lost in it

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creates not only an improved therapeutic alliance, but an empathy for the parent that militates against the diminished caring and negative process (Binder & Strupp, 1997; Patterson & Chamberlain, 1994) that can contribute to treatment failures with this population.

Addressing the Self of the Parent

It is a fair assumption that single mothers will come to the therapeutic enterprise feeling "invalidated, blamed, and disapproved of," and it is critical to construct a context that counters societal messages and life experiences that negatively affect the single mother's self-esteem (Walters et al., 1988, p. 309). In MDFT, addressing the experience and the self of the parent is part of creating that context. One means to this end is through validation of the story of her hardships and acknowledgment of her love for her children as well as the efforts she has made to parent them in the face of such hardships (Liddle et al. 1998). This validating context must be constructed even when symptomatic change may be achieved in its absence (Walters et al., 1988), and there are instances in which failure to address the self of the parent may lead to premature termination or therapeutic stagnation.

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It is also the case that constructing a problem-solving agenda early in therapy may unduly burden a parent with the principal responsibility for change before it is clear she can or wishes to accept it, an action that may be experienced as a kind of taking without giving. Perhaps in today's society, we so fear returning to the era when assistance to the poor meant noblesse oblige--the days of Lady Bountiful--that we worry about "giving" too much to the client lest we weaken her. Paradoxically, however, there are situations in which our attempts to confer strength on clients have the appearance of unwelcome charitable giving. We might better deploy our energies to evaluate and address those factors that undermine a client's sense of competence. This focus is not to be confused with encouraging weakness or creating dependency, fears of which are deeply rooted in our Western ideology.

MULTIDIMENSIONAL FAMILY THERAPY

Multidimensional family therapy (MDFT) is an empirically supported, integrative, manualized treatment for adolescents (Liddle, 2001). Controlled studies have demonstrated MDFT's clinical and cost effectiveness with adolescents who have drug and/or behavior problems (Liddle, Dakof, Parker, et al., 2001; Liddle & Hogue, 2001). Additionally, process studies have confirmed MDFT's capacity to change parenting practices, and to link changes in this developmentally important therapeutic target to significant reductions in drug use and behavior problems (Schmidt, Liddle, & Dakof, 1996). Multidimensional family therapy addresses both the mother-adolescent relational system and the self of the teen and the parent in order to affect significantly the amount and kind of involvement between parent and adolescent (Diamond & Liddle, 1996; 1999). It is a strengths-based approach that supports parental competency in the areas of consistent and age-appropriate limit-setting and monitoring of the adolescent's activities while acknowledging barriers to the exercise of that competence that exist within the parent/adolescent relational system and the parent's self-system. As a multisystemic model, MDFT includes individual foci in its assessment and

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intervention agenda (Liddle, in press).

According to the epigenetic theory of enduring relational systems (Wynne, 1984), the developmental processes of attachment and caregiving optimally precede communicating, joint problem solving, and mutuality, in that order (Liddle, 1999). An erosion in attachment relations has profound effects on both adolescent (Allen, Hauser, & Borman-Spurrell, 1996) and parental functioning. Not only have recent studies detailed how parents continue to play an important part in their adolescent's development (Resnick, Bearman, Blum, et al., 1997), but there is evidence that, even when behavioral problems already exist, positive family bonds can also buffer the negative effects of peer influence (Steinberg, Fletcher, & Darling, 1994). MDFT aims to restore or strengthen attachment bonds between parent and adolescent as well as to address the single mother as an individual with needs and concerns separate from the parenting role (Dix, 1991; Liddle, Rowe, Dakof, & Lyke, 1998) and as a parent who may be questioning her ability to influence her child's life (Liddle, 1999; Liddle et al., 1998).

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Mom: But he came home late again,
Saturday.

Ther: Really late?

Mom: About four o'clock in the morning.
But I tell you, this time it
wasn't like the last time when I
was all upset.

Ther: Umhmm.

Mom: I said [unintelligible], I said me
a solid prayer, and I said the
hell with it and I lay down and
went to sleep. And I was just as
at ease and at peace.

Ther: Hmm. What made the difference,
do you think?

Mom: 'Cause I'm tired. I'm tired of gettin'
upset and gettin' worried.

Here, the therapist faces a problem: the mother (Ms. B) and the therapist have talked in the previous sessions about Ms. B's need to take care of herself. However, as with many of the single parents we have seen in treatment, Ms. B frequently views taking care of herself and taking care of certain parental responsibilities as mutually exclusive activities. This dichotomization is at the root of some of the abdication dynamics so prevalent in clinical single-parent families with teenagers. At times, for the overwhelmed, undernurtured mother, there seems no "cure" but to cease actively challenging an adolescent who is causing difficulties for her--acting out at school, engaging in delinquent behavior and/or drug use, or being defiant at home. Such challenges are, indeed, costly in terms of her time, energy, and

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patience, all of which may be in short supply. The following response is made by Ms. B after the therapist has made a strong attempt both to validate her need to take care of herself by worrying less and at the same time to encourage her to continue monitoring her son Carl's activities:

Mom: To be honest with you, if you can believe it, it don't seem like you believe it, I don't really care at times.... I don't care. And that's another way ... the only way I can get a peace of mind. 'Cause I'm tired of worrying. I been taking care of people all my life. I'm tired; I really am tired.

It may be tempting to the therapist at this point, sensing that mother is letting go prematurely of her supervisory and limit-setting functions, to move immediately into a problem-solving mode in order to establish her as the executive authority. If this were to occur, however, it would necessarily take place in the absence of a clear agreement by the mother on such a goal. In this session, Ms. B has clearly communicated to the therapist that she is satisfied with her new method of dealing with her son's lateness. She goes on to tell the therapist that she feels she has been overprotective in the past and is trying not to be; she is focusing more on taking care of herself. Further probing revealed Ms. B's reluctance to reengage around this particular problem. To continue forcefully to encourage Ms. B to take a stand with her son in relation to curfew would not only meet resistance, but would also put the collaborative relationship in jeopardy. In Ms. B's statement that, "it don't seem like you believe it," she is conveying to the therapist that she has not felt heard by her. On this day, she is trusting the therapist sufficiently to let the therapist in on this fact; if the therapist continues to ignore this information she may not receive another warning, and the alliance could be permanently ruptured. Because many clients who are single parents leave scant clues that they are feeling misunderstood or disrespected, it is especially important for the therapist to attend carefully to those that are given. In this session, as in many others, the furtherance of trust and the building of a collaborative relationship will take precedence over further exploration as well as any attempts to push the mother into the parental driver's seat. However, it will not permanently supplant support for changes in parenting practices.

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The parent-adolescent quid pro quo: Family conflict that does not occur within a context of relational cohesion is detrimental to adolescent development, and among a number of family process variables, mother-adolescent disagreement has been shown to have a particularly strong relationship to the overall adjustment, well-being, and academic performance of adolescents (Demo & Acock, 1996). In clinical work with parents and adolescents, adolescent disrespect is often seen as an outgrowth of past hurts, neglects, abandonments, or betrayals (Diamond & Liddle, 1999). In many cases, when therapists try to help single parents tighten the reins of their authority without helping them hear their adolescents' feelings about past events, it is unlikely that disrespectful talk and behavior will diminish. For example, when a single mother recovers from substance abuse and suddenly resumes the long-interrupted role of parent, presuming that all her problems now lie "in the past," her adolescent's angry resistance may be provoked.

Whatever the causes of the deterioration of their relationship, however, it is important for both parent and adolescent to recognize the fact of their disengagement in order both to decrease defensiveness (Alexander, 1973) and to make room for alternative behaviors during the therapy session (Diamond & Liddle, 1999; Friedlander, Hetherington, Johnson, & Skowron, 1994). One means of achieving improved communication is to have parents and adolescents share with each other their versions of past and present events, highlighting and elaborating the affective components of these stories (Liddle, 1994).

For adolescents in single-parent families, conflicts, struggles, and other types of negative events may be experienced with particular intensity when there are no emotionally sustaining relationships with supportive adults outside the mother/ adolescent dyad. An admixture of worry about and loyalty to mother may intensify the anger and sadness that adolescents experience, and some adolescents may experience this as a need to "give as good as they got." As one particular session with Ms. B and her son Carl progressed, it was clear

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that this was the case. Two years ago, Ms. B had had a heart attack. Prior to her health problems, she had had a serious drinking problem. In this portion of the conversation between Carl and his mother, Carl raises the issue of Ms. B's drunken behavior:

Carl: She talkin' about ... she don't want to take me out nowhere 'cause I'm embarrassing, and she don't remember when ... I think we was livin' on D-- [Street], and she used to come home and get me on Fridays, and we go down, urn, Southwest, and she used to be there on the train, she goin' to go sit on people laps and stuff, and laugh in people face. And she don't think that embarrassed me, no.

Ther: So you were embarrassed by her behavior.

Carl: What would you think if you were on the train with your mom and the train is crowded and your mom decides to sit on people laps and laugh in people face you don't know?

Ther: [softly] That was hard for you. How old were you then?

Carl: Thirteen, about.

Ther: [mumbles] ... hard ... so sometimes when your mom says those things to you, you think of those times. When she says, "Oh, you're embarrassing me."

Carl: Yeah, I think of them times and laugh. And she wonder why I laugh all the time. I don't sit on people laps and grin in people's face and grab people.

Mom: First of all, I know ... when I was drinkin' I had, like ... got to the point that I had to stop

because I would black out a lot.

Ther: Oh. So you wouldn't remember
a lot of the things that you did.

Mom: No, I don't.

Ther: Sure, because ...

Mom: So this is new to me. [Mother
talks about how she drank to
get drunk; to forget about a lot
of things.]

Ther: So you would try to forget about
the painful things, for you.
And then for Carl, I guess,
when....

Mom: His pain just begun. Where I
was trying to forget, his begun.

Mom: I just don't remember.

Carl: All right. Do you remember the
time when I ... was about
seven, and you had went out
and I didn't hear from you from
about a couple of days or a day
later ... Aunt R--, told me
that "your mother was in a bar
and a booth fell on her," do you
remember that?

Ther: So, for you, though, you felt like
you didn't know what was happening
with your mom, Carl.
Were you really scared?

Carl: Yeah. I'm ... six years, seven
years old.

Ther: You thought maybe she was
dead or something?

Carl: Yeah. Every night she used to
go out.

Ther: Every night you used to wonder
if she'd come back.

Carl: Yeah.

Ther: Yeah. Yeah.

Carl: But she don't care or nothing.

Mom: Why should you say I don't care? How you know I didn't care.

Carl: You don't care. You don't. All you feelings is ... against me. You don't care what my feelings is against you. Cause you don't ever don't let me talk.

Mom: First of all, I never in my life had anybody worry about me. I never even let my mother and them worry about me. I always felt that I could take care of myself.

Carl: But you don't feel like I came from you and.... [breaks off]

Ther: No, keep going ... keep going. Aw, come on now ... come on, now ... it's important that she hear what you're saying. You're saying ... Come on, Carl. Don't bail out. You said you came from her.... [Silence]

Ther: [Softly, turning to mother] Do you hear what he's saying now? What he was saying a minute ago?

Mom: That he came from me and he want to worry about me just as much as I worry....

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In this segment, Carl counters her worry about him with his for her. Within the session, the theme of mutual care, as expressed in worry, is highlighted by the therapist. As a result of encouraging Carl to articulate his feelings to his mother in a direct way, the therapist is able to open up adjacent content areas, with their attendant emotional intensity. The therapist also tracks the theme of payback--that is, the idea that Carl may be attempting to pay mother back for her neglect of him as well as for the embarrassment she has caused him. Now Carl is turning the tables on her by causing similar concern in the present. The issue of parental monitoring and supervision is thereby being indirectly addressed in this discussion, and Ms. B and Carl may, with assistance, be more capable of changing their positions in light of it. Of course, this conversation illustrates merely one piece of work in an overall therapeutic process and plan that includes the accomplishment of other, interconnected objectives within the extrafamilial realm (e.g., school, the juvenile justice system).

The ability to sustain this kind of emotionally challenging dialogue depends upon the work that has preceded it, and the discussion itself lays the foundation for work to come. Without prior validation of Ms. B's difficult history and her present burdens, without discussions about her right to self-care, and without explanations concerning the rationale behind the aim of helping her and her son improve their relationship in specific ways, it would not have been possible for Ms. B to hear Carl and to consider afresh what form her love for and responsibility to him will take during this critical developmental phase.

There is no unswerving course that marks the progress mothers like Ms. B and teenagers like Carl make in therapy. Therapists must be prepared to maintain many of the same types of responsiveness in family therapy with mothers and adolescents that they encourage between mothers and teenagers: flexibility, support, reciprocity in communication, and consistency of purpose. The mothers whom we have described here and the many thousands like them may more

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ably shoulder the burdens of parenting difficult adolescents if service providers understand the nature of those burdens and are prepared to help them reconcile the tensions implicit in their roles as women, African Americans, mothers, and members of communities within a society that offers them little in the way of support.

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