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PARENT-CHILD ROLE REVERSAL AND SUICIDAL STATES IN ADOLESCENCE

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Parent-child role reversal, as used in this paper, refers to the interchanging of traditional role behaviors between a parent and child, such that in the parent-child interaction the child adopts some parental-type behaviors (e.g., care-taking, supporting, nurturing, advising), and the parent acts more as a child would be expected to act (e.g., seeking support, acting helpless or unable to cope). Role reversal thus defined is typically a two-party interaction, although it is possible for more than two people to be involved. Such behavior usually is most obvious during the child's adolescence, since after the onset of puberty, a child who is physically approaching maturity is seen as being, and often is, more capable of assuming traditionally parental behaviors. Further, an adolescent in this culture is usually seen as "not old enough" to leave the family home and thus avoid a potential role reversal situation. This paper will demonstrate, using three clinical examples, that such parent-child role reversal is one of many situations that can generate suicidal behavior in adolescents.

As will be shown later, dependency needs in both parent and child are central to a parent-child role reversal situation. Resolution of dependency needs and growth to some measure of independence have long been recognized as essential steps in the maturational process. Unresolved dependency needs in the parent can lead to a parent-child role reversal, but those needs can conflict with the child's own dependency needs, and this conflict may result in suicidal behavior in the adolescent. While dependency needs and independent strivings have been subjects of extensive research and theoretical speculation, parent-child role reversal has not been reported on, at least in the literature of the past decade.

Role reversal is primarily due to the type of interaction a parent sets up with the child, in the same way that the parent structures the family interaction throughout the child's life. That is, the parent takes the initiative in encouraging and maintaining the reversal of traditional role behaviors. The child is hence burdened with the emotional reactions produced by this situation, especially feelings of hostility. This hostility tends to be acted out in one way or another. One form of such acting out is intropunitive behavior, which in its most destructive form is suicidal in nature.

The hostility that is present in the child results from the intense

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pain he experiences from several sources. First, he has been deprived of his position of nurturance. Second, he is restricted in the range of behaviors available to him. That is, certain expectations are placed upon him which mitigate against his acting with spontaneity, which at times would mean acting irresponsibly, carelessly, or frivolously. Third, he must to some degree carry a burden which has been placed upon him without his asking for it or wanting it. Fourth, he may experience severe anxiety because he senses his inability to fulfill the parental role adequately, and hence may feel subject to criticism or rejection. The hostility generated in these ways is often intensified by the adolescent's perception that his peers are not subject to the same stresses as he.

To cite an example, M.B. is a 16-year-old living with her divorced mother and 10-year-old brother. The mother appears to be an immature person, often acting in childish or attention-seeking ways. Most of this behavior is directed at her daughter, the demands for attention becoming more extreme after the mother developed an aneurysm. She then demanded that her daughter take care of many of her physical needs, as well as spend increased time with her and support her emotionally. It was apparent when the daughter was admitted to a psychiatric hospital six months later that the primary stress she was under was due to her role vis-á-vis her mother.

Another example of such stress is S.T., a 14-year-old girl living with her divorced mother. The mother often behaves in bizarre ways which puts extreme pressure on the daughter to be a "care-taker". Specifically, her mother occasionally runs nude from their hotel into the street, but not too fast for the daughter to catch her and take her back, which the daughter feels compelled to do.

We consider self-destructive behavior to result primarily from the hostility aroused in the child. Expressing this hostility directly to the parent might be precluded by the fact that the parent still provides a degree of nurturance which could be withdrawn as a result of such expression. Also, the parent indicates by the stance that he takes with the child that he needs some measure of support from the child, hence intropunitive aggressive behavior could be seen as more acceptable in the child's eyes than externalized aggression. Further, the child is likely to experience realistic difficulties in assuming the parental role which would lead to a lowering of his self-esteem, feelings of worthlessness and an acting-out of subsequent guilt feelings in self-harming ways. Finally, the child may hurt himself as a way of substituting an external physical pain for a deeper emotional pain.

As an example, S.T., when admitted to a psychiatric hospital, described arguments with her mother in which she became enraged. Rather than "lose control" of her rage (and hurt her mother), she felt compelled to hurt herself, and did so by slashing her own

forearms, thighs, and abdomen.

The child often wishes, at least to some extent, to escape from the parental role he's been put in, or from some aspects of that role. Self-harming behavior, particularly suicidal behavior, can be seen by him as serving that purpose, by 1) reclaiming the child's role in order to induce the parent to meet his dependent needs, 2) removal from the situation by others because of his drastic behavior, 3) placement of the child outside the situation by the parent(s), or 4) death.

In each of the clinical examples considered here, the child's suicidal behavior did in fact change the family situation and alleviate the stress involved therein. M.B. made two attempts by ingestion, and was hospitalized by her alarmed mother following each one. Eventually a placement out of the home was arranged by the psychiatric facility and reluctantly agreed to by the mother. S.T. made numerous suicide gestures in the presence of her mother and got a response from her on these occasions. The alarmed mother would intervene, soothe and comfort her daughter, try to smoothe over the argument which preceded the attempt, and care for her physically if necessary. On other occasions, this mother and daughter would even switch roles, the mother making a suicide gesture and the daughter responding with intervention and care-taking. The daughter described these interactions as "preventing each other" from suicide. The third case, G.Q., a 23-year-old boy, is included because his behavior in interaction with his mother is clearly exemplary of role reversal, even though he is older than the others. Perhaps his absence from the home because of his marriage from ages 15 to 21 postponed the appearance of the phenomenon. In periods of dependent frustration, both he and his mother have made suicide attempts, turning to each other for help during or after the attempts, even though there were others in the home. The responses each gives the other are usually expressions of concern and accompaniment to the emergency room of a hospital.

Of course, various forms of hostility expression occur in different children in different circumstances. Some children will not tend to be intropunitive, but will act out against others when stressed. We often see the hostility expressed directly to the parent, or expressed toward others through a displacement mechanism.

We also see different kinds of intropunitive behavior, some more destructive than others, such as drug and alcohol abuse, sexual promiscuity, conflict with authorities, poor school work and truancy, as well as suicidal behavior. Teicher and Jacobs (1) suggest that these are likely to be seen in an escalating fashion, and suicidal behavior, being the most serious form of self-destructive behavior, is the end state of the escalation. The final point reached would be a serious suicide attempt, assuming that prior behaviors had not been

responded to with support and nurturance, and the escalation thus interrupted. If the child's non-suicidal acting out is responded to in a way that meets his needs, we would not expect suicidal behavior to subsequently emerge.

Of the three clinical examples, only G.Q. demonstrated non-suicidal self-destructive behavior of the types mentioned above. Perhaps age and/or sex differences between him and the two girls are responsible for this discrepancy, and the inconsistency with Teicher and Jacobs' notion. On the other hand, none of the three had made any serious (or life-threatening) suicide attempts, probably because their suicide gestures were responded to by their parents with behavior appropriate to the dependency needs that were being expressed—they were given support, comfort and care.

Complete role reversal is quite rare, as evidenced by the clinical examples cited. Varying degrees, aspects and modes of role reversal occur in different families, and the pull to suicidal behavior on the part of the child is much less strong in some situations than in others. Hence, some parent-child dyads can exist where there is no suicidal behavior manifested. In fact, some relatively stable dyads exist. In such instances, this is at least partially true because role reversal can serve to provide a positive experience for the child (as well as for the parent), inducing feelings of being needed, worthy, etc. In other circumstances, and with role reversal manifested in other ways, it can be an intolerable stress on the child.

Little has been said to this point comparing the three families. All are white, lower-class families. Two mothers are getting welfare assistance, one mother is a maid. All the children lost their father through separation or divorce before the age of 3 years. While the mothers continued to see their ex-spouse, or had other suitors (in one case there was a 6 year remarriage), all the families were father-absent ones when the suicidal behavior emerged in the child.

All the mothers are seen by psychiatric hospital staff as having significant psychopathology, of which the common features are emotional lability and the consequent tendency to depression, and unresolved dependency needs. They are seen as attempting to satisfy their dependency needs through their children. For example, two of the mothers have made suicide gestures in the presence of their children to elicit care-taking, the third using complaints of illness for the same purpose.

The children also act out their dependency needs, and the multiple suicide gestures all 3 have made are seen as expressions of those needs, as well as attempts to change the stressful family environment. S.T. expresses more positive feelings toward her mother than the other two, although it is apparent that she too experiences anxiety in the reversed roles relationship.

Some differences in the three families also should be mentioned.

Both girls are ambivalent about accepting psychiatric help, while G.Q. is very accepting of help. In an attempt to understand this difference, however, we note that M.B. was placed in a residential treatment center for girls and did not attempt to run away. Also, while S.T. resisted out-patient psychiatric care, she did talk with her high school counselor frequently. The boy has been in individual therapy with one therapist for four years.

Similarly, the mothers of the two girls were very resistant to psychiatric help, but the mother of the boy was not. She had been in individual therapy for three years when she made her first suicidal gesture (over the failure of her son's marriage), and continued with the same therapist through at least two more years. However, the fact that she made several suicide gestures in a role-reversing way during that two years suggests that she was at least covertly resistant to the therapeutic attempts to change this interaction pattern.

Another difference is that the boy is the middle child of three, whereas one girl is an only child and the other is the older of two. The similarity in the girls' position is obvious. The mother of the boy may have centered her attention on him because of possible negative feelings about her other two children. Her 26-year-old son was conceived illegitimately when she was 17 and born into a marriage that lasted less than one year. Her 17-year-old daughter was fathered by a man she did not marry. The marriage that produced her 23-year-old son (G.Q.) lasted only three years, but we can postulate that it was more satisfying than the relationships she had with the fathers of her other two children.

Conclusions

On the basis of the cases reported here, parent-child role reversal is seen as occuring in one-parent homes between the parent and the favored child. Since no mother-absent families were found exhibiting role reversal, we can only assume that a similar role reversal pattern could occur in such cases. The primary ingredient in the role reversal appears to be marked unresolved and unsatisfied dependency needs in the parent, needs which the parent attempts to satisfy in interaction with the child. These attempts are at least partially successful because an adolescent child is on his way to maturity, and because they produce some positive feelings in him.

It is clear, however, that such situations also produce anxiety, pain, frustration, and hostility in the adolescent. One general reason for this is that he is just not ready to handle as much of a burden as has been placed on him. He may turn his negative feelings inward, blaming himself for his inabilities. He may seek to alter the family environment, or escape from it. He may simply collapse under the pressure. Suicidal behavior may result in any of these ways.

But as we have seen, a serious suicide attempt does not always occur, and it is very unlikely that such an attempt would be the

adolescent's first expression of his discomfort. Surely there are many verbal and non-verbal communications to that effect earlier. Also, suicidal behavior which is not life-threatening is likely to precede life-threatening acts, and in our sample, only the former were seen.

Recommendations

Several kinds of intervention are suggested by our observations. The unresolved dependency needs of the parent could be handled more constructively in order that the pressure be taken off the parent-child interaction. Since the mothers in our study are either overtly or covertly resistant to a psychiatric source of help, non-psychiatric (e.g., ministerial) sources might be best utilized in such cases. Apart from the immediate satisfaction of some of the mother's dependency needs outside the parent-child relationship, this non-psychiatric help could lead to constructive long-range changes in the mother's behavior. Further, using non-psychiatric sources of help can avoid the threat that psychiatry might imply to some people.

Help should be mobilized for the adolescent as soon as a role reversal pattern is recognized, lest the stress involved eventually lead to suicidal behavior. The earlier the adolescent's stress is relieved, the less the subsequent impulse would be to act out his discomfort. Suicidal behavior might be averted entirely by meeting the adolescent's own dependency needs.

Apart from dealing with dependency needs, the source of help (e.g., psychiatrist, minister) should attempt to clarify the adolescent's expectations and perceptions of himself and his family environment. He can be helped to learn that his age in some measure reflects his needs, as well as his capacities, and that these two qualities need not be in conflict, as they are in role reversal situations.

In short, the therapeutic approach first interrupts the role reversal pattern by providing non-family sources of dependency gratification for both parent and child, since they cannot adequately meet all their needs within the existing family structure. Subsequent efforts to reestablish a healthier parent-child relationship through insight and relearning will necessarily be guided by the capacities and motivations of both parent and child.

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