Introduction

This book is a guide for therapists working with families of adult-children who are dependent on their parents in highly dysfunctional ways. It is based on 10 years of our clinical work with hundreds of such families. It summarizes what we have learned about the use of Non-Violent Resistance (NVR) therapy in such cases, and shares what we learned about the processes of *entrenched dependence*, *accommodation* and *de-accommodation* and their roles in perpetuating or alleviating these families' sufferings.

Since 2009, we have been using the concept of *Adult Entrenched Dependence*[1] (AED) to refer to an interpersonal pattern that forms in certain families between young adults or adolescents and their parents. Most of these adult-children live in the parental home and are usually not in employment, education or training. At the core of AED lies the perception – shared by the adult-child and the parents – that the child is inadequate and incompetent. This perception leads the parents to feel obliged to protect and shelter the adult-child. The adult-child, in turn, feels they cannot live without the parents' services. Whenever parents try to break out of their role, the adult-child reacts harshly. Over time, both sides come to experience this condition as inescapable. AED can persist in families for decades.

Research into adult childhood is still in its infancy (Pozza et al., 2019), but there are many indicators that this is a wide and growing social phenomenon. It is estimated that a total of 40 million adolescents and young adults in Organisation for Economic Co-operation and Development (OECD) countries are not in education, employment or training (NEET), and almost two thirds of that population (28 million young people across the OECD) are not even looking for work (OECD, 2016; 2019). Psychiatrists and psychotherapists are increasingly concerned about adolescents and young adults who are socially withdrawn and live secluded in their home or their room (Li & Wong, 2015; Pozza et al., 2019; Uchida & Norasakkunkit, 2015). Studies of adolescents at high suicide risk have identified a large category of youngsters described as

[1] Originally we termed the condition "entitled dependence." We now prefer the term "entrenched dependence" because it is less judgmental.

being "at silent risk for psychopathology and suicidal behavior," who are characterized by a sedentary lifestyle, decreased sleep and high media usage (Carli et al., 2014). In our experience, most cases of AED fall into those categories. The fact that adult-children are often introverted and socially avoidant does not prevent many of them from voicing their demands in highly vocal, if not downright violent, ways. Although adult-children are mostly homebound, many of them show financial and social irresponsibility, as well as addictive behaviors.

At the very center of our understanding and treatment of AED lies the process of accommodation. Parents accommodate to their child's demands and expectations, when they persistently adapt their attitude, behavior and rules to prevent their child from suffering. Accommodation can be voluntary, when parents act out of compassion for their child, or forced, when they feel coerced into accommodating by the child's extreme reactions. Accommodation has been shown to perpetuate anxiety, avoidance and dysfunction in children and adults with a variety of disorders (Shimshoni et al., 2019). Parental accommodation also predicts failure of individual treatment for the child (Garcia et al., 2010).

Why NVR?

Our intervention for families with AED is based on the NVR approach. NVR is an approach to families, schools and communities that is inspired by the doctrine championed by Mahatma Gandhi and Martin Luther King. At first view, it may seem puzzling that an approach that was developed for resisting political oppression effectively and morally should be found relevant for helping parents of children with behavior problems, at any age. Parents are not usually in a position of weakness relative to their children, nor do they experience themselves as oppressed. Nevertheless, the moment we understood that the principles and methods of sociopolitical NVR could help in our therapeutic work with parents, enormous possibilities were opened. To understand this, we must recapitulate what, in our view, was missing (and still is) in psychotherapists' work with parents.

Many parents who come for help are confronted with highly stressful situations that require their response: a boy beats up his sister and humiliates her before her friends; a teen shuts himself up in his room after voicing dire threats; or the parents receive a call from the police that their daughter has been found totally drunk. These and other acute situations require a parental reaction. And the parents do react, for remaining helpless and in extreme worry is also a reaction, though probably not a very helpful one. Very often parents come for therapy with such a sense of urgency.

In such situations, the parents often feel they need a practical and simple solution, a clear sense of direction. The reason they need it to be simple is that

they are so stressed and confused that they cannot process very complex information. But we, psychotherapists, are not at our best with simple solutions. We are trained to search for complexity. We tend to be suspicious of simple explanations. Maybe this is one of the reasons that attracts us to the profession: the wish to search for what is not obvious, to trace richer and hidden processes. This disparity between the parents' immediate need and the counselor's tendency to focus on complexity may be a bad sign for the burgeoning therapeutic alliance.

This was the first challenge that we faced in developing an approach for helping parents of impulsive, violent or self-destructive children. We had to find a way to give the parents from the very outset a clear sense of direction, a kind of "parental-North" by which they could orient themselves. Something they could identify with, which would reduce their confusion and helplessness and make them feel they had a therapeutic partner who was mindful of their distress and sense of urgency. We wanted an initial guiding concept that would make the parents come out of the first encounter engaged and hopeful.

The concept of *parental presence* seemed to fulfil this role in a promising way. When helpless and worried parents came to us, we found that talking to them about increasing their presence in the life of the child and the family had an immediate engaging effect. We defined parental presence as the experience inherent in acts that convey the message, "I'm your parent. You can't fire me, divorce me or paralyze me. I'm here and I'll stay here." When we talked to parents in this vein, they became alert, responsive and motivated. The concept of parental presence seemed to galvanize them into a readiness to listen and act that was all but lacking in their previously defeated stance.

In the initial years of our work with parents, parental presence remained our major concept. We searched for ways in which parents could manifest their presence, how they could regain their voice, their place and their influence. We profited greatly from the work of Gerald Patterson, Salvador Minuchin, Jay Haley and Milton Erickson. But we always tried to subsume our borrowings from these various masters under the concept of parental presence. In this way, our work and message remained unified, although we borrowed eclectically from many sources. We gradually came to emphasize that not only the child should experience the parents as present, but also the parents themselves should feel that they had a voice, filled space, had weight and significance in the life of the family. This work culminated in the publication of *Parental presence: Reclaiming a leadership role in bringing up our children* (Omer, 1999).

When I (Haim Omer) was writing that book, I became aware of cases in which the idea of parental presence was misinterpreted. Some parents understood it as meaning they should achieve full control over the child. This interpretation might lead some parents to go home and set up barricades, conveying inappropriately dominant messages. Thus understood, parental

presence could lead to escalation. Those difficult cases led me to add a chapter to the book, proposing possible ways to reduce the escalation that might arise as a consequence of the parents' manifestation of decided presence. With the addition of this chapter, I was able to publish the book without worrying too much about the potential negative consequences of its message.

But this ad hoc solution was insufficient. The danger of escalation is not just a casual consequence of the parents' manifestation of presence but is intrinsically connected to it. It is almost the other side of the coin. Many parents lose their presence precisely because their attempts to manifest presence lead to sharp reactions by the child and to frightening escalation bouts. Considering escalation as a possible side effect that could be remedied by palliative measures would not do. Presence and escalation had to be considered in their intrinsic mutual connection. NVR provided an answer to this challenge.

NVR is probably the only model of social struggle that is carried out by and through the personal, emotional and moral presence of the activists. The fight is not conducted by throwing stones, arrows, spears and bullets from a distance, but by the determined presence of the activists, which conveys the message "We are here. We stay here. We won't budge." NVR is also the only kind of resistance in which the activists are rigorously trained to avoid all acts of violence, as well as all provocations, denigrations and offensive acts that might lead to escalation. The reason is both moral and strategic. The force of NVR is a function of its ability to stimulate positive voices in the adversary camp, voices that are opposed to the continuation of their own violent and oppressive acts. These positive voices say: "They are the moral side. We are the bad guys." These voices, however, can only be efficiently fostered if the resisting camp avoids violence and deliberate offensive acts, which would justify the dominant side in pursuing its oppression.

Sociopolitical NVR did far more to further our approach to parenting than showing that presence and escalation are two sides of the same coin. The reason is that leaders like Mahatma Gandhi and Martin Luther King were not only inspiring political figures but also master strategists. They created a detailed lore about how to translate those principles into day-to-day practice. They developed cadres of trainers and field leaders that helped transform a moral political philosophy into a highly effective resistance machine. Fortunately, the richness of NVR's principles, strategies and tactics found their ideal historian and codifier in the figure of Gene Sharp. His classic book, The politics of nonviolent action (1973), is like a Talmud of NVR, providing guidelines for every imaginable situation and detailing each tool of resistance in all contexts of implementation.

Thus, the work of translating sociopolitical NVR into the family context was rendered possible. With the help of a few dedicated students, each intervention,

strategic principle, tactical measure and training idea was examined in detail for its potential to the field of parenting. The combination of this work and our previous experience with parental presence led to the founding work of NVR (Omer, 2004b) and, more recently, a new edition: *Non-violent resistance: A new approach for violent and self-destructive children* (Omer, in press). Each and every principle, strategy and practical step in that book combines decided parental presence with the prevention of escalation. The book, and its treatment manual in the third chapter, became the basis of our treatment program and gave us a good starting point for our research program.

The next step that made NVR clearly relevant for cases of AED was the demonstration that adaptations of the NVR model for violent and self-destructive children were also effective for children with anxiety and other internalizing disorders. The first systematic adaptation of NVR to children with an internalizing rather than externalizing disorder was the Supportive Parenting for Anxious Childhood Emotions (SPACE) Program. The rationale for applying an NVR-based approach to those families was due to the parents' loss of their personal space (hence the acronym) on account of their child's anxiety disorder (Lebowitz & Omer, 2013). The loss of the parents' space is illustrated by the fact that many of them lose their ability to have a room that is really their own, to control their own time, to meet with friends, to go out as a couple or manage the house as they see fit, because of the requirements posed by the child's anxiety. These situations are also typical AED. A set of practical tools is included in SPACE to help parents identify the various forms of accommodation they provide, implement detailed plans for reducing accommodation and strategies for coping with the child's harsh responses. It is a quintessential model for how NVR can be translated for a condition with very different requirements than those of externalizing problems for which the approach was first formulated. In addition, SPACE and other adaptations of NVR for internalizing disorders showed themselves effective for children with various anxiety disorders, obsessive-compulsive disorder (OCD) (Lebowitz & Omer, 2013) and High Functioning Autistic Spectrum Disorder (HFASD) (Golan et al., 2018). It was not only as effective as Cognitive Behavioral Therapy (CBT) for the child (Lebowitz et al., 2020) but showed similar results with children who refused to accept treatment, thus making CBT not applicable (Lebowitz et al., 2014). Non-Violent Resistance (Omer, 2004a; 2004b, in press)[2] is well suited to help parents reduce accommodation and break out of the oppressive dysfunctional bond that keeps them and the adult-child chained to each other. The reasons are manifold:

[2] See www.haimomer-nvr.com/ for a fuller reference list of NVR-related publications.

(a) NVR sensitizes parents to situations where they are exploited and oppressed. In this respect NVR for parents follows in the footsteps of its sociopolitical model. The first step of NVR as a form of political struggle is to create awareness that the victims' submission is not preordained by God or nature. Similarly, the first step of parental NVR is to enhance the parents' awareness that their feeling of being obliged to service their adult-child is not a necessary consequence of the child's condition, but is often a result of habit, anxiety and coercion. When parents understand the destructive effects of accommodation on the adult-child, they are quick to perceive the damage it also inflicts on their life and on that of their other children.
(b) It helps parents to protect themselves, regain their agency and reclaim their personal space.
(c) It reduces the danger of escalation (Lavi-Levavi et al., 2013), which is usually what keeps parents in total fear of undertaking the necessary changes.
(d) It redeems parents and the family from isolation (van Holen, 2016; 2018). As will be seen, isolation is one of the important factors perpetuating AED. The passage from loneliness to support is key to empowering parents to liberate themselves and their child from their mutual trap.

On the conceptual side, this book offers a model for understanding the dependence bond that develops between parents and child in AED. When we first met families of adult-children, the literature describing the kind of family interactions we were witnessing was scarce. There were some references in the classical family therapy literature (e.g., Haley, 1980), mostly to a specific diagnosis, such as schizophrenia. Gradually, articles inspired by Dialectical Behavior Therapy (e.g., Ben-Porath, 2010; Zalewski et al., 2018) appeared, describing the mutual problems in emotional regulation between parents and very unstable young adults, as well as attempts to improve the child's condition by better parental emotional regulation. There is of course a lot of literature on various psychopathological conditions of young adults but very little on the special kind of dependence bond that we witnessed again and again. We therefore experienced AED as an uncharted territory and gained knowledge of it mainly by our own clinical observation. We now believe that the dependence bond typical of AED may not only be an important factor in mental health but also a growing social phenomenon deserving wide interdisciplinary research.

On the therapy side, this book offers a manual of NVR for AED. It is based on years of practice and refinement over hundreds of cases and is the latest in a series of manualized implementations of NVR for a variety of conditions, such as: conduct and oppositional-defiant disorders (Omer, 2004b), Attention Deficit Hyperactivity Disorder(ADHD) (Schorr-Sapir, 2018), anxiety disorders (Lebowitz & Omer, 2013), youth delinquency (Lothringer-Sagi, 2020),

unbalanced diabetes (Rothmann-Kabir, 2018), computer abuse (Sela, 2019), dangerous teen driving (Shimshoni et al., 2015) and avoidant/restrictive food eating disorder (Shimshoni & Lebowitz, 2020). Additional NVR manuals were developed not on the basis of diagnosis but in contexts of implementation, such as foster parents (Van Holen et al., 2016) and psychiatric wards (Goddard et al., 2009).

To date, one clinical study of 27 families that have undergone our intervention has been published (Lebowitz et al., 2012). Since then, we believe our approach to have become ripe for further research and hope that this book will inspire an expansion of its evidence base.

We noted earlier in this section that little scholarly work on families of adult-children was available to support our earlier clinical explorations. What we did find in abundance, however, was a supply of slang and derogatory terms to denote the adult-children we were studying. Terms like "entrenched dependence" and "adult-children" might perhaps be understood as adding to this stigmatic vogue. That is categorically not our intention. To us, entrenched dependence does not reflect any "bad attitude" or "negative motivation," but a systemic pattern that involves both the parents and the child. We do not view AED as a psychopathological entity residing within the adult-child's mind. On the contrary, we view it as subsisting because of the special kind of dependence bond that develops between parents and child. Our work strives to transform this systemic pattern. The fact that this effort can be successful illustrates how context-dependent AED is.

Similar considerations apply to our use of the term "adult-child." The paradoxical connotation here is intentional, as it reflects a social reality. Coming of age has never been more difficult than in our era of *extended* adolescence and *emerging* adulthood. Considering this difficulty, failures of emergence are to be expected, leaving millions of persons and their families outside normative discourses on childhood, adolescence and adulthood. The figures we quoted at the beginning of this chapter about the incidence of NEET persons in OECD countries speak for themselves. Stigmatizing or pathologizing these people is a way of disowning social responsibility for their condition.

This book comprises the following chapters: Chapter 1 (The Adult-Child: Functional and Dysfunctional Dependence) links AED to the labyrinth of emerging adulthood (Arnett, 2004), describing it as a failure to emerge. A child's dependence on parents can be characterized as functional or dysfunctional. We present ways to differentiate between the two. We clarify that the goal of our approach is not to pursue a mirage of "independence" (which we view as a rather problematic goal) but helping transform dysfunctional into functional dependence. The main changes we try to promote are: (a) developing a time perspective that allows parents to strive for better functioning; (b) helping parents to move from personal effacement into presence; (c) releasing

parents from their "sacrifice mentality"; (d) helping parents through a process of de-accommodation; and (e) identifying and resisting various forms of violence, blackmail and exploitation.

Chapter 2 (NVR and Accommodation) describes why parental NVR is well suited to treating AED. We describe why attempts at individual therapy for the adult-child or traditional parental counseling may fail. These failures have different forms, such as: (a) the adult-child refuses therapy; (b) the adult-child accepts therapy, but AED persists; (c) the parents are advised to show unconditional acceptance, but the dependence bond remains unaffected; or (d) the parents are advised to be tough but are daunted when they stumble on frightening escalation. We argue that parents are almost invariably the motivated partners, that they deserve to be viewed as clients in their own right, and that involving the adult-child would distract the parents and the therapist from their job. The chapter concludes with a description of treatment goals and of what changes can be realistically expected.

Chapter 3 (The Intervention) presents a detailed presentation of the NVR manual for AED. The intervention is not described session per session, as this would hinder adaptation to the special characteristics of each family. The manual specifies the essential treatment stages, the goals and tasks involved at each stage, and ways of dealing with typical parental concerns. This type of manual has been shown by previous research on NVR to guarantee satisfactory uniformity, as well as serving as a basis for the performance of treatment integrity checks (a central element in research). The treatment's *opening stage* is devoted to: building the therapeutic alliance, reframing the problem in ways that allow for new options, discussing parental accommodation, working on the parents' assumption of total responsibility, explaining the need for a support network, and training on how to prevent escalation. This stage concludes with the presentation of a therapy roadmap. The next therapeutic task is the formulation and delivery of *the announcement*. This is a semi-formal event, in which parents convey to their child, both by word of mouth and in writing, the changes they have decided to institute in their attitude and behavior. The announcement typifies NVR in its emphasis on resistance rather than control. Preparing for the announcement and its delivery introduces parents to the basic attitude of NVR, in which they: (a) learn to view their resistance as a function of their own readiness, and not of the child's reactions; (b) prepare to cope with the child's reactions without escalating; and (c) learn to focus on changes in their behavior, rather than on immediate improvements in the adult-child. The next task is the constitution of a *support group.* This task can take place parallel to preparation of the announcement. The therapist helps parents rally social support, conducts the meeting with the supporters, and guides the group after the meeting. The next therapeutic stage is the gradual process of *de-accommodation*. Coping with

violent, destructive and dangerous behaviors is the first priority all through this process. De-accommodation consists in a series of gradual exposures to diminishing services, infringement of prohibitions and, if necessary, change of living arrangements. The therapist helps the parents set goals, contain their child's reactions and maintain the relationship with the child. The *conclusion stage* is usually open-ended, offering parents the option of returning to therapy for a short period if crises arise.

Chapter 4 (Suicide Threats) presents the NVR approach to suicide threats that, tacitly or overtly, are highly present in families with adult-children. Although the literature on suicide is immense, little has been written on how parents can cope when the child voices a suicide threat. As we shall see, we focus especially on threats that are voiced or intimated as a reaction to the parents' de-accommodation. Parents are helped to cope with those situations by moving from helplessness to presence, from isolation to support, from submission to resistance, from escalation to self-control and from distance to supportive care.

Chapter 5 (Helping Parents of Children and Adolescents at Risk of Failure to Emerge) deals with the precursors of AED in childhood and adolescence. The major risk factors are digital abuse, school refusal, social withdrawal, "tyrannical behaviors" and irresponsible financial behavior. Non-Violent Resistance interventions are described that help parents deal with those conditions.

Chapter 6 (Addressing Entrenched Dependence in Special Contexts) describes how to deal with situations that require adaptations of the protocol described in Chapter 3. Some of these are: emergencies (e.g., psychotic breakdown, suicide attempt or trouble with the police), worrisome conditions that do not yet constitute full-fledged AED, very old parents and the implementation of NVR in a psychiatric ward.

Chapter 7 (Survival Mode: the Adult-Child's Experience), written by Ohad Nahum, describes AED from the adult-child's perspective, and how contact with them (either in the context of a parallel individual therapy or single meeting with the parents' therapist) may enhance the chances of improvement.

The Conclusion points out some of the many questions that require further exploration, such as the etiology and social impact of AED, as well as the efficacy of our intervention. It also expresses the need for courage as a major prerequisite for this process. Adult Entrenched Dependence can induce great fear in parents, adult-children and therapists alike. We see it as one of the virtues of NVR, both in the sociopolitical and family contexts, that it also inspires courage in the meek, the fearful and the oppressed.

AED, the Intervention and Global Diversity

Nonemergence into adulthood and Adult Entrenched Dependence are observed in many cultures. Much work is still needed to understand the interplay of

global trends and culture-specific factors in shaping these phenomena (Teo & Gaw, 2010). The same should apply to developing effective culture-specific interventions. Most of our development work was done in the context of our own culture. Although we are certain that members of many other cultures would find it useful, any application of the intervention model presented in this book to a given culture should involve consideration of that culture's specific coming-of-age connotations, symbols and crises.

A Word of Caution

This book is intended as a guide for mental health professionals interested in NVR interventions. Work on AED can be very rewarding but it requires a cautious attitude, as it destabilizes some very entrenched family patterns. We recommend against trying to implement our therapy manual without appropriate background in the mental health professions or without the support of a team.

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