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I. Introduction

There are substantial criteria for determining what relationships are adequate to assure children of a sound development. These criteria will be formulated in terms useful for understanding what defines and serves the aims of child advocacy. Since the substance of advocacy cannot be separated from its form of expression in any given time frame and cultural setting, these criteria will first be placed in historical perspective.

II. Historical Perspective

In medieval times, when the child was openly viewed as chattel, the family usually consisted of parents and children under the ages of seven or eight.[1] As soon as the child could control his sphincters, feed himself, dress and undress himself, and be responsible for avoiding obvious dangers, he became a working member of the household. As a worker, he was placed in the fields or in the shops, where he worked along with others and where his teacher was the boss or the master artisan to whom he was apprenticed. The teacher or master also could have been the child's advocate in those days, since the adult who instructed the child and demanded work from him or her was now in the parental role vis-a-vis authority and responsibility to govern the child's behavior, opportunities, and work.

In those days, many children were born of a mating, and a large percentage of them died from infection or pestilence. Those who survived left the immediate family at a young age to work. As Rousseau said in *Emile*, "The less one has lived the less one may expect to live. Of all the children, not more than one-half will reach youth."[2] The concept of adolescence in the family and normative conflicts between the generations did not then exist in their present form.

With the Industrial Revolution, the concept of parenthood changed. Children beyond the ages of six to eight stayed with

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1. P. Aries, Centuries of Childhood (1962).

2. Rousseau, *Emile*, in Poor Monkey—The Child in Literature (1957).

their families. Parents increasingly became the advocates for their children. These continuities in family living were associated with the advent of new institutions and customs, reflecting the impact of these changes on the community. Churches had youth groups, the concept of Sunday School arose, and there were organized places away from home in which children learned, socialized, and developed a sense of self and of group identity. The parents delegated their authority to other adults to instruct, guide, nurture, stimulate, and protect their children.

From these historical roots of the Scout movement, the Y.M.C.A.s and Y.W.C.A.s, the public schools, and other social institutions, it can be inferred that parents were seeking community assistance to supplement the shaping influence of the family. Following the Industrial Revolution, this trend was associated with parents being thrust into the role of caretakers and advocates for their children over longer periods of time.

Another change also had a complex and enduring influence on the family. With improved nutrition, infectious disease prevention, and medicine's increased capability of curing certain infectious and surgical diseases, infant mortality sharply decreased. The expectation of longevity for each human being more than doubled, and with it the psychological roots for advocacy began to be established. The child's fate was no longer decided by mysterious, nonvisible forces of illness, deprivation, and destruction, but was in the hands of the parents who could order the nutrition, immunization, sanitation, and medical care for their children to assure a longer life. As the child's dependency relationship was extended and intensified, the psychological meaning of parenthood was elaborated in functions and complexity. Parents were expected to become advocates for their children in the community in addition to providing them with nurturance in the home.

As parents attached themselves emotionally to their children as intimate members of their household for 16 or 18 years, rather than 7 or 8 years, not only the meaning of parenthood changed, but the sense of family changed. Each parent could now invest more in each child as a carrier of his aspirations and fears for the future. Children came to represent parents' replacements and hopes for immortality. These representations reflect powerful and ambivalent feelings ranging from the most intense love for children to the most fearful resentment of them. The notion of parents serving as advocates for their children is entangled in these complex and conflicting roots.

Thus, adults have deeply ingrained, irrational reservations

about the primacy of children's needs because they expect to be replaced by their children. Similarly, adults have a deep love and concern for children because parents hope their children's lives will fulfill their own values and aspirations. Unwittingly, in this way, parents express their wishes for immortality and reduce their fear of death.

In each culture, certain ethnic, political, and social patterns of a given historical period reflect the strengths of ambivalent parental attitudes in the priorities for assigning societal resources to meet the needs of children. However, the newborn's helplessness remains a crucial, unchanging force that presses parents or some other caring adults to become child advocates.

Since the parents' right to be advocates of their children was also associated at times with absolute power over their children,[3] starting in the early 1800's in this country, the state, acting in the role of *parens patriae*, began to limit parental power in certain areas in which the interests of children and society were believed to need protection or preference. As stated in a recent study at the Yale Child Study Center by Shelley Gaballe:[4]

> For example, the enactment of compulsory education laws limited the parents' previously boundless power to determine the manner of their child's education by eliminating the option "no education." "The child is not the mere creature of the State; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations."[5] The parents' right to the child's services and earnings was limited by the enactment of the child labor laws. [In *Prince v. Massachusetts*], [t]he Supreme Court stated: "But the family itself is not beyond regulation in the public interest . . . . Acting to guard the general interest in youth's well being, the state as *parens patriae* may restrict the parent's control by requiring school attendance, regulating or prohibiting the child's labor and in many other ways."[6] Child abuse legislation—designed to punish offending parents and protect victimized children—was enacted to try to curtail the more extreme methods of parental discipline [punishment].[7] Courts ordered life-saving medical treatments over the religious objections of parents despite the traditional parental preroga-

3. 1 F. POLLOCK & F. MAITLAND, THE HISTORY OF ENGLISH LAW (2d ed. 1898).

4. S. Gaballe, The Evolution of Children's Legal Rights (1976) (unpublished research paper, Yale Child Study Center).

5. Pierce v. Society of Sisters, 268 U.S. 510, 535 (1925).

6. 321 U.S. 158, 166 (1944).

7. *See, e.g.*, CONN. GEN. STAT. REV. §§ 17-38, -38a *et seq.* (1975).

tive to determine what type of medical care children shall receive.[8]

Thus, as the need for advocacy by parents was associated with children living in their families for longer periods of time, the autonomy of parents in regard to the care and control of children has been narrowed. Psychological roots for this are reflected not only in the parental ambivalence that has been described above, but also in the needs families have for support of community services to supplement the care and nurturance of their children.

III. Developmental Perspectives—Guidelines to Child-Rearing and Child Advocacy

Children are born helpless; the personal relationships that are optimal for their physical and social development are rooted in their biological immaturity at birth. This is underscored by the fact that the human child remains dependent on adult care for a longer period of time than any other species. If a newborn is not fed, kept warm and dry, protected from noxious environmental agents, stimulated and soothed emotionally—*i.e.*, taken care of totally—he or she[9] will die. As the child's biological stability is established and she progresses in development, the adults who care for her become a presence that can be known in increasingly specific ways: first, by association with predictable events, and later, in terms of the adult's guiding, protecting, stimulating, and limiting behavior in rearing a child. Associated with these specific functions of guidance, protection, stimulation, and limitation by the competent parent are the particular qualities and patterns of care that we refer to in terms of affection, continuity, dependability, consistency, and culturally transmitted styles of child-rearing. Value preferences of the parents can also have marked formative influence and can be formulated concretely as the sort of adult person the parents wish their child person to become.

Professionals concerned with the care of children usually presume the value preference that the child's interests and needs are paramount. They also assume that their professional code of ethics and the training that prepares them to maintain that code enables them to respect the rights of parents to develop their own style of child-rearing and family living no matter what the professional has inherited or selected as her own lifestyle. Thus, critical

8. *See* Annot., 30 A.L.R.2d 1138 (1953).

9. From now on in this paper, "she" refers to both male and female.

health factors should be distinguished from value preferences both in regard to child-rearing and in regard to what parents advocate for their children.

For example, the value preference of the primacy of the child's rights may run into conflict with the preference of a given family to put the parents' rights as primary. If this occurs, the value of privacy of the family as expressed in the preference of minimal state intervention would overbalance the preference that children's interests be paramount. Therefore, unless a child is physically or sexually abused or abandoned or medically neglected to the point of significant risk, the family's right to privacy will determine how a child will be raised. Advice should be couched in terms of health factors, not in terms of moral or personal value preference.

IV. CHILD-REARING

The following vignettes illustrate how parents function in their nurturing and advocacy roles. As adovocates, parents take their young children to physicians and nurses. In so doing, they seek to strengthen their capacity to nurture by seeking health professionals for diagnostic, therapeutic, and child-rearing advice. Thus, parents assume that they have delegated to these professionals part of the responsibility to help them also serve as effective advocates for their children. How children are raised, guided, and cared for in the family is largely a matter of nurturance, whereas advocacy refers generally to protecting children and assuring that their rights and priorities are safeguarded and supported. Thus child-rearing includes nurturance and advocacy by specific adults who live with the child on a permanent basis.

For example, a 2-½-year-old child was brought to a particular physician by her parents who are concerned about a sleep problem, *i.e.*, the child has difficulty sleeping at night. From a number of clinical experiences, three hypothetical cases will be outlined to illustrate the dilemma of defining optimal child-rearing relationships and to demonstrate differing ways in which the parents as advocates "borrow" advice from the physician of their choice in order to strengthen their nurturing activities while seeking to increase their satisfaction and confidence as parents.

In the first hypothetical case, the play interview with and developmental examination of the child and the account provided by the parents indicated the following:

1. The child was physically healthy and developing well.
2. The parents were fearful that they would spoil their child if

they stayed with her for 5 or 10 minutes each night until she quieted down.
3. The parents were inexperienced and living some distance from their families. They were unable to turn to family members for guidance.
4. The child's crying was upsetting the mother since she feared her daughter would feel rejected if she let her cry unattended for more than a few seconds.

In this case, the advice given by the doctor the parents consulted was:

1. Your child is healthy and is making good progress physically and developmentally.
2. Your daughter needs a few minutes to quiet down in your presence since going to sleep means giving up the fun of being awake and may mean a separation from you in terms of being asleep.
3. Your concerns and questions are understandable. I'm glad you've raised these questions. I want to increase your confidence in how you want to raise your daughter. If a 2-½-year-old child cries for a few moments, it is not harmful in itself. On the one hand her crying this way may be a prelude to knowing that frustration and crying are not pleasant but can be managed without help or support; on the other hand your daughter may be saying, "I'm not quite ready to manage on my own, please stand by until I can manage that dose of aloneness and frustration on my own."

In the second hypothetical case, the account given by the parents and the play interview and developmental examination of the child indicated the following:

1. The child was physically healthy and developing well.
2. The mother had been pregnant a few months earlier. She and her husband decided to have the pregnancy aborted since they weren't ready for a second child. The mother felt sad and was preoccupied with the abortion.
3. Although the mother found it upsetting to be away from her daughter, she also felt anxious about putting her to sleep, at which time she often thought of the child they had lost.
4. The mother feared that she would not be able to become pregnant again.
5. The child was afraid her mother would have to go away to the hospital again.

In this case, the explanation and advice given was:

1. Your child is healthy and making good progress physically and developmentally.

2. The abortion seems to have been upsetting to you, your husband, and your daughter. You are sad about the child you lost.
3. It will be helpful, when you feel ready, to practice short separations so you and your daughter can gradually get used to being apart. At first, your husband can take care of her; later, you should arrange to have a trusted babysitter take care of your daughter so you and your husband can go out together.
4. Have you discussed your birth control method with your gynecologist?
5. You seem to be anxious about when and how to plan for your next child.

In this instance, the health professional might have a personal preference against abortions being performed and against the use of artificial birth control measures. If these preferences interfered with his capacity to counsel, he could refer the family to another consultant. If he had attempted to impose his preferences on the family, he could not have provided effective support for the child or her parents.

In the third hypothetical case, the account given by the parents and the play interview with and developmental examination of the child indicated the following:

1. The child was physically healthy and developing well.
2. The parents had been quarreling about disciplining their daughter. The father felt she should be spanked when she was disobedient and that the mother overindulged the child. The mother was opposed to spankings. The father insisted on spanking the little girl if she cried for more than a few seconds when put to bed at night.
3. The child was fearful that the father would hurt the mother and herself and she talked of bad dreams at night.
4. The father wanted to discuss their disagreements with the parish priest and the mother didn't believe in religious affiliations.

In this case, the explanation and advice given was:

1. Your child has been healthy and has been making good progress physically and developmentally.
2. It is usually better to avoid spankings because your daughter may feel frightened by your strength. Also she may feel you are losing control when you spank her, which is very frightening and tends to make it harder for her to control her own feelings and behavior when she feels angry. More importantly, you should resolve your differences since your daughter will be unable to come to grips with the conflict between you and is fearful

and confused because of your disagreements.
3. Your daughter is too young to understand quarrels between parents. Could you talk out your disagreements privately or arrange to resolve them with my assistance or with some other person in whom you both have confidence?
4. No advice is given about the religious conflict since this is a matter of the parents' personal preferences that need not involve nurturance or guidance of the child.

In each of the above instances, parents were free to reject or to follow the advice offered. They felt able to ask an expert and free to decide whether and how to follow his suggestions. Child-rearing also can be viewed largely as a matter of parents' dosing the nurturance, the stimulation, and the frustration that their children receive. A closer consideration of the meaning of nurturance indicates its importance at every phase of development. The human child is born helpless and perishes if he or she is not nourished, protected, soothed, and stimulated by an older person capable of providing such care on a continuing basis. What begins as biological helplessness leads to social and psychological attachment as a result of the interaction of the infant and maternal person or persons. The infant progresses from biological dependency to psychological and social attachment in which the child craves affection, approval, and predictable, dependable responses from the caretaking adults. This craving, or "social addiction," is the "stuff" out of which social development emerges as a result of positive or negative identifications. Through these close relationships, the child acquires and internalizes parental attitudes and expectations. These identifications are the core of the unique personality of each child.

In a sense, we are endowed and plagued by this psychological and "social addiction" for the rest of our lives. The gradual transformation of the addiction leads to the need for social closeness, friendship, companionship, and eventually to the reestablishment of another family group. It also is the source of a need for privacy and independence. As with many of the lines of development, passive experiences, *e.g.*, being fed or bathed, become the basis for actively taking care of oneself and later of others. Many of our neurotic and developmental deviations stem from the failure to turn passive experiences into active, self-initiating capacities, unique to the individual, but influenced to a significant extent by how the child identifies with her parents and older siblings.

As we have already seen, these identificatory processes may entrap the child in conflict or may be her pathway to a unique

and well functioning personality. How the parents nurture and how they serve as advocates in regard to health care, schooling, and participation in the life of the community all are vital influences on the developing child's personality and sense of self. Probably the nurturance is more crucial for healthy development than the advocacy, although to separate them is somewhat artificial. The content and style of child-rearing usually reflects the substance and style of the parents' nurturing and advocacy functions.

When parents are depressed or suffer from the long-term effects of deprivation in their own childhood, they may lack the capacity to stimulate, nurture, protect, guide, and support their children. They transmit to their children what they themselves had suffered. In this way, certain deficits and deviations may be transmitted from one generation to the next through the dynamics of the family interactions.

On the other hand, in healthy development, these identifying processes proceed from imitative behavior to the internalization of parental attitudes and expectations. Gradually, this enables the child to separate and individuate as the attachment to the dependable, guiding parental persons matures. Now the child is prepared to have short separations from the parents because her mental and emotional capacity has enabled her to have the parents with her psychologically when the child and her parents are physically separated. Children can go to a nursery school or play group. With the psychological presence of the parents, they are able to form attachments to teachers, peers, and others as their progressive development enables them to socialize, learn, play and move along through the toddler, latency, and adolescent phases. The styles of child-rearing offer many options, so long as they are not the object of prejudice in the community. However, child-rearing starts with nurturance in the home and becomes child advocacy when the child has needs (*e.g.*, for education or health care) that the parent makes available to the child from sources outside the home.

Throughout development, the need for continuity with the same primary love objects is crucial as the child defines herself against parents, siblings, and later on peers, teachers, and others. Each young child attributes to the primary or psychological parents the omnipotence and omniscience that early on become the basis for feeling secure with and later awed by these parents in the family setting. As maturation and development proceed, these attitudes and expectations undergo gradual change. The child's sense of herself becomes more clear and confident as

she perceives reality more accurately and with the capacity to think logically.

Gradually, then, children undergo a disillusionment about their parents, who not only lose their mantel of omniscience and omnipotence but also "reveal" their human imperfections. Normatively, as the disillusionment is worked through, children perceive their parents more realistically. This enables children and parents to move toward greater closeness as friends and companions after the rebelliousness of adolescence. Throughout, the child and adolescent are storing up their future adult capacities to nurture, guide, rear, and be the advocates for their own children. If children lose their primary parents or have multiple and changing parents, there is the risk that these children will persist in relating to parental figures at an immature level. They may be fixated at the level of infantile magic thinking, in which adults in authority are viewed as omnipotent and omniscient. Often they are poorly equipped to become parents themselves.

Thus, knowledge about the developing child implies the relationship between and overlapping of the parental functions of child-rearing and child advocacy. Children's developmental needs that indicate why they should have advocates are the same needs that indicate why they must be nurtured. It is the psychological parents who are, by definition, the adults who can nurture and advocate for their children. In most societies, parents are responsible for the dependent needs of their children in two ways: they nurture them; and they assume the advocacy responsibilities for guiding and planning for them. The nurturing functions include affection, continuity of care and attachment, dosing of frustration and gratification, and being an adult with whom the child can identify and in relation to whom the child can be different and unique. The advocacy functions are those of planning and making decisions that regulate the child's involvement in his community and society. These functions include the choice of education, health care, disciplinary influences, religious beliefs and affiliation, and to some extent the mode of social and political expressiveness that is rooted in the parents' background and in their personal preferences. The latter include the decisions about who may visit, care for, and educate the child, including the role of siblings, grandparents, aunts, uncles, neighbors, and family friends in these activities. Advocacy by parents is exercised under certain circumstances when they select a lawyer to represent their child. In divorce cases when parents cannot agree, the courts may appoint a lawyer to be the child's advocate in regard to the custody conflicts.

Although they overlap, it is crucial to understand the differences between nurturance and advocacy. For example, expecting that school-aged children should decide which parent they will live with after the parents separate and divorce would place an unfair burden upon the 8- or 9-year-old child. This burdensome expectation would deprive the child of the nurturance and guidance that is provided when adults take responsibility for decisions about children that require adult judgment. Therefore, when divorcing parents cannot agree, some wise person, usually a judge, will provide the decision. Under such circumstances the parents may be able to continue their roles as advocates by agreeing that their children should have a lawyer to represent them. However, the child's advocate, hopefully the parents, will insist that the child's preferences as expressed in play, behavior, and words, as well as by the past history, be taken into account by the adults who have the authority and shoulder the responsibility for making the decision.

Certainly, advocacy is part of parenting, but not all of it. Advocacy is emphasized by the parental guidance and by the parents representing and defending the interests and agreed-upon priorities of children in a particular social cultural setting. For example, ordinary devoted advocacy is a daily function of parents in selecting their children's physician, dentist, schools, and babysitter and in all other ways that assure the child of the options, opportunities, and resources within his family and in his community and society.

Parents are crucial in providing nurturance and in being advocates for their children. Siblings, grandparents, aunts, and uncles are also vital sources of these shaping ingredients in optimal child-growing and child-rearing relationships.

Our knowledge about children's developmental needs converges with the judgment that the family unit should be supported and strengthened in a society where value preferences include the child's interests as paramount and state intrusion as minimal. This convergence is a substratum for optimal child-rearing in which parents are the most important hope that child advocacy can and will be effective.