# Should there be a right to effective psychotherapy? A child psychotherapy perspective

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In child and adolescent psychiatry, as in adult psychiatry, treatment selection is guided by the matching of the person's condition (symptom, syndrome, illness or disease) with the most effective available options chosen from biological, psychological and/or social therapy. The crucial clinical decision is the choice of the most effective treatment which often needs to be made in the absence of 'scientifically' proven data. Given the wide scope of clinical experiences, combined with the competing claims made about treatment efficacy, there is often heated debate about various treatment choices, for example the Klerman (1990, 1991) and Stone (1990, 1991) position on the Osheroff debate.

Some years ago Professor A. Solnit spoke on the subject of children with life-threatening conditions. He observed that for some children in severe distress a cuddle from a parent may be more effective than morphine. I have often recalled this simple observation especially when faced with clinical decisions about treatment for children in distress. This observation raises an essential problem faced by all clinicians.

A child and the family have a 'right' to effective treatment, and some argue a right to refuse treatment. The discussion of the different 'rights' of a patient, such as contractual or humanitarian is clearly relevant but beyond the scope of this presentation. The focus on the rights of the child to effective treatment in the absence of 'scientifically' proven data poses special clinical dilemmas. I will illustrate some of these dilemmas with a case highlighting three key points.

First, the process of decision making about an effective treatment where no consensus exists about the best treatment. Second, some issues surrounding informed consent in the absence of proven data about the effectiveness of treatment. Third, an outline of some assumptions that underlie the psychoanalytic psychotherapy and possible active components of the treatment in a distressed child.

## Case study

The child first presented with her concerned mother when she was 2 years old. Her parents at that time were separated and the mother was complaining about her little girl's partial baldness. Almost a quarter of her hair was missing due to constant hair pulling. This behaviour had persisted since she was less than one year old. Further history revealed a violent and alcoholic father who had repeatedly abused and abandoned mother and child. Mother thought that the tension in the parental relationship may have contributed to her child's behaviour. I agreed, but after two assessments the mother failed to return and contact was stopped.

Mother and daughter represented 2 years later, the girl was now 4 years old. Michelle (not her real name) was a friendly and initially compliant, attractive, ginger haired, blue eyed girl. There was no evidence of obvious growth or developmental retardation. She was neatly dressed and alternated between clinging to her mother, sitting near or on her, to solitary exploration of the room while being totally preoccupied with the doll's house in age-appropriate play. There was little observable relating to me, as a stranger, beyond the occasional glance.

Mother mentioned that she was finally separated from her partner who had moved in with another woman and they were expecting their first child.

The hair pulling had persisted during the last 3 years. Mother's reason for seeking further help was her concern about Michelle starting school the following year, and feeling that her daughter's baldness would become the object of teasing. She had seen her family doctor who reassured her that there were no physical causes for the baldness and suggested psychological treatment.

## Decision about choice of treatment

Hair pulling, or trichotillomania, is a condition with no consensus on the most effective treatment (Kaplan & Sadock 1988). This multidetermined condition may respond to drugs, hypnosis, behavioural modification, individual, group, or family therapy. Decision about the choice of treatment should be made after careful child centred and family focused assessment.

Based on the available developmental history and family context, I agreed with the mother's opinion that Michelle had lived in a very stressful family atmosphere, and that in every day terms, she was literally tearing her hair out in frustration. As a child she had used the hair pulling as a way to reduce her tension and cope with the stress in her unique way. The hair pulling could be regarded as a barometer of her level of distress. There were a number of treatment options available which were discussed with her.

My recommendation was for psychotherapy- a form of play therapy - as the treatment of choice, based on my understanding of the behaviour. I also suggested that mother may wish to seek a second opinion as there was no agreed 'best' treatment for her child's condition. I explained that some doctors preferred to give drugs, others, including myself, felt that the

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behaviour would be more responsive to psychological treatment. However there would need to be a 'trial of therapy' to see if psychotherapy would work.

## Informed consent

I explained to the mother my understanding of how the therapy - psychoanalytic psychotherapy with the use of play (Coppolillo 1991) - could work. The hair pulling behaviour was an outcome of the years of unexpressed tensions which Michelle had 'made her own' (internalised). The mother had previously indicated her capacity to accept that the family tensions were somehow involved in her daughter's difficulties. Further, I added that Michelle herself would not be aware of the reasons for her own behaviour. This was partly a reflection of the immature level of her mental functioning (cognitive and emotional levels of development, including the capacity for self-reflection and insight), but partly because such processes were not always available for conscious awareness even later in life.

The mother indicated her understanding explaining that she felt that there was more to this than met the eye. She had struggled with her daughter's behaviour by trying punishment, bribery, and even getting a crew-cut as a desperate attempt to stop the hair pulling behaviour. Nothing had worked. Mother's desperation was heightened by her noticing that Michelle didn't even feel pain when pulling her hair!

There were many aspects of the therapy that I did not detail but which clearly informed my decision making. These factors included the central importance of transference, which, although therapy is never predictable, I anticipated would eventually lead to a re-enactment of Michelle's traumatic life-events and experiences of conflict and (de)privation in therapy. Other factors that we did discuss related to the practical arrangements of frequency of sessions, fees and my own expectations of likely 'outcome'.

Getting started in psychotherapy is like setting off in uncharted waters with only a compass (the therapist's sense of direction) with a general map of the landscape (the psychodynamic formulation). The therapy itself provides the missing details. Predicting the outcome seemed a matter of clinical judgement but not scientific fact.

## The therapy

As the therapy progressed, both mother and Michelle related to the sessions as classes or lessons (as families often do). Therapy represented an overlap with the familiar everyday experiences in play-school, kindergarten or regular school. As Michelle became familiar with the ground rules of therapy, she gained in security, confidence, trust and increasingly accompanied her play with a running commentary.

She began to explore the limits of therapy, as her initial reserved, compliant behaviour gradually transformed at first to mild assertiveness and eventually fully expressed anger and rage. She began to throw the toys, her previous careful drawings gave way to ripping and shredding paper and throwing the bits all over the room. When drinking water, she began with swallowing while looking at me. Then the small spits followed. Later a full gushing mouthful was directed at me.

She had tested and found one of the limits of therapy. I explained that she could drink, but that when she spat at me I understood that she was very angry with me, but that she was not allowed to express her anger at me in that way as I felt very uncomfortable when I was wet. She cried, sulked and withdrew. After a week, with mother escorting her into the room, to protect her from what she perceived was the angry therapist, we gradually re-established a 'friendship' (the working alliance) again. of course there was much work around the oral aggression which her spitting represented.

During the months of open-ended therapy, we explored and acknowledged a wide range of Michelle's affects, behaviours and changes in relatedness. We explored the unique and fleeting movements of her inner world by tracking and containing her projections, both psychological and the physical equivalent that the spitting represented, healthy and destructive aggressions, using techniques of mirroring (reflecting) or verbalising and linking the swift revisions of her body-self images as related in the therapy.

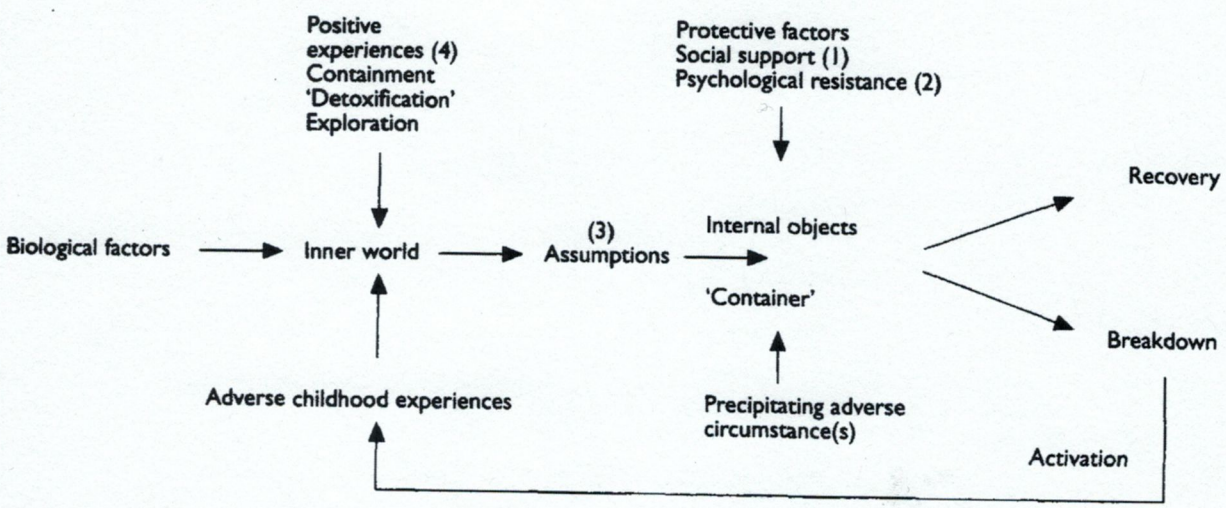
In this setting, with increasing trust, Michelle started to speak of her father and began to enact scenes of domestic violence (the trauma in the transference). She would suddenly run out of the consulting room, screaming and banging on the door. On her return she would explain how her daddy would yell 'fuck you' at her mummy. She described and showed her helplessness as she was shut in her bedroom during these violent scenes. These re-enactments, through the transference, were the reliving of the past conflicts.

At about this time, mother reported that the hair pulling was diminishing. She explained how Michelle was settling at kindergarten and generally improving. Yet there were complaints that she was now more testing and difficult with her mother. However, mother had more tolerance relating with her lively daughter. She felt that Michelle would stop her hair pulling because now she complained that 'it hurt'.

## Components of effective treatment

Holmes (1991) in his model of intervention in adult

**Figure One: Psychotherapeutic models of breakdown and intervention points**



psychotherapy proposes four impact points (Figure 1).

Psychotherapy may provide social support, improve the patient's psychological resistance, offer alternative thought patterns and/or provide a new experience to re-work and modify early adversities to assimilate them into a more integrated personality structure. These components, adapted to a child's specific developmental phases, could be used to conceptualise some of the therapeutic process in Michelle's case.

Winnicott's notion of a 'facilitating environment' providing a setting where a range of affects, behaviours and developmental issues of trust and security, containment of panic, rage and destructiveness could be 'held' through the techniques of play, drawing, story telling, verbalisation, interpretation and limit setting, also contributed important components to the therapy.

Theory might suggest that additional elements in Michelle's therapy included a 'regression to the basic fault' (Balint), a re-enactment in the transference and interpretation (Lewis), 'containment' of infantile splitting and projections (Bion), and the therapist surviving these processes in the therapeutic relationship. These components provided the developmental opportunity for Michelle to externalise and re-integrate primitive communications.

These and other processes allowed the presenting symptom to resolve as Michelle's body-ego differentiation resulted in a more adaptive ego. Her hair pulling behaviour, as a primitive communication, represented Feud's dictum that the ego is first and foremost a body ego. Through the effective components of therapy, Michelle's increased ego capacities resulted in more adaptive, age-appropriate behaviour.

Therapy facilitated normal processes of maturation. Michelle could now split, throw tantrums and yell, evidence of age-appropriate aggressive outlets. Her primitive aggression was mobilised and re-directed from self-destructiveness to 'other' directedness. She could relate the aggressive parts of her personality in new situations as she re-integrated missing parts of her unconscious aggression and the violent domestic scenes. The therapist was part of this facilitating environment.

## Conclusion

There are no simple answers to the question about the right to effective treatment in psychotherapy (Bloch & Brown 1991). There are indications, contraindications, side-effects and risks inherent in all treatments. Furthermore, all treatments are open to misuse and abuse. It has been suggested that for mere dissatisfactions, psychotherapy may even imprison.

The present state of knowledge about mental health is evolving rapidly. But the scientific knowledge base cannot yet provide definitive and unequivocal guide-lines about the choice of the most effective treatment in child psychiatry. Clinical decision making relies on clinical experience and judgement augmented by the emerging knowledge from research trials. The 'gold standard' evidence provided by a randomised controlled trial for the efficacy of child psychotherapy does not yet exist. However, a collective sense, a consensus view has accumulated decades of clinical evidence on the usefulness of child psychotherapy (Barrnett et al 1991).

In order to maintain the standards of clinical practice, adult and child psychotherapists have a duty to use their clinical skills, observation and judgement while accommodating new research findings to guide them in delivering an effective treatment. Until our knowledge base can provide us with the effective treatment, we can at least be reassured that properly conducted psychotherapy with the right patient is unlikely to do harm, and should certainly provide benefits. The same criteria should guide all therapies including psychopharmacological treatments. If these guide-lines were followed then we would be adhering to the old dictum primum non nocere, 'first of all, do no harm' (Halasz, 1991).

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