The Rights of the Child in Psychotherapy

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A brief history of the development of children's rights provides a context to discuss four areas the child psychotherapist needs to safeguard regarding these rights: informed consent; distinguishing between the child's withdrawal of consent and resistance in therapy; the distinction between "difficult to treat" and "unsuitable for treatment" cases; and empathic listening. Family dysfunction and "managed care" pose further challenges to preserving children's rights in therapy. Principles related to the well-being of the child in psychotherapy are offered.

AN HISTORICAL PERSPECTIVE

Relationships between parents and children enshrined in Roman law provided the father, in *patria potestas,* with "supreme authority in the family . . . even to the father having the power of life and death over his children and the right to sell them into slavery."[1] This absolute patriarchal power resulted in acceptance of systematic ill-treatment of children: abandonment, physical and sexual abuse, exploitation, neglect, and infanticide.

In the absence of any concept of children's rights, their status at the bottom of the social scale allowed for the continuation of infanticide until the 4th century.[2] Only then did parents begin to see the child as having a soul, ushering in a less drastic but still inhumane era of "child abandonment."[2] Socially sanctioned child abuse persisted for centuries. It was not until the eighteenth century that an empathic ethos began to pervade Western society, heralding a new attitude toward children. Interestingly, the function of empathy in psychological treatment has recently been highlighted as a potent therapeutic factor.[3]

Despite the Victorian motto "children should be seen but not heard," by the nineteenth century, the legal profession began to challenge the absolute rights of parents, (notwithstanding the recognition of the unique bonds between parents and children), and foreshadowed the modern concept of best-interest-of-the-child standards to determine care of children where parents violated or neglected their rights.

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At the same time, the medical profession began to study the basis of childhood mental disorders. Research into their causes was actively pursued by the latter part of the nineteenth century.[4] Freud's "analysis" of five-year-old Hans,[5] published in 1909, gave birth to the specialty that was to become child psychoanalysis and child psychotherapy. Mental health professionals finally came to appreciate the importance of family attitudes and relationships for children's psychological development. Anna Freud and Melanie Klein contributed further insights by unravelling unconscious layers of the child's mental life.[6] Those "revolutionary" ideas gained widespread acceptance within and beyond psychoanalysis.

Social reforms were given impetus with publication of Bowlby's influential WHO's commissioned report *Maternal Care and Mental Health*[7] and Kempe's[8] classic on child abuse. Increasing media attention paid to abuse and the "rights movements" of the sixties and seventies contributed further to the groundswell of public empathy for the plight of abused children and intensified social resolve to formalize better protection for children.

The next major development was Goldstein, Freud and Solnit's two publications, *Beyond the Best Interest of the Child*[9] and *Before the Best Interest of the Child,*[10] to which we now turn. Goldstein et al. made the developmental foundations of children's rights accessible to the medical profession as well as to the lay public, claiming, "that a child's need for continuity of care by autonomous parents requires acknowledging that parents should generally be entitled to raise their children as they think best, free of state interference," [and,] "that the child's well-being—not the parents', the family's, or the child care agency's—must be determinative once justification for state intervention has been established"[10] (pp. 4–5). Their message had a profound impact, prompting a fundamental shift in attitude to one of advocacy on behalf of children.

Provision of legal guidelines, based on children's developmental needs and rights, allowed legal decision-makers greater confidence to apply the best-interest-of-the-child standard in cases of competing rights between parents and children. Increasingly, child psychiatrists and psychotherapists, recognized as expert witnesses, were called to advise on disputes over what constituted the best interests of the child in cases of contest between parents over custody.

The most notable landmark in the last decade has been the UN Convention on the Rights of the Child, ratified in 1989. This has "achieved a remarkable degree of international acceptance"[11] (p. 6) by bringing

> together two of the most important twentieth-century developments in the history of ideas . . . acceptance of the idea that every individual, solely by virtue

> of being human, is entitled to enjoy a full range of human rights . . . [and] the recognition of the idea that children should be treated as people in their own right and not as mere appendages of, or chattels belonging to, the adults under whose responsibility they fall[12] (p. 1).

The UN Convention marks the culmination of a long struggle to achieve the rights of children internationally.

This overview offers us a backdrop from which to delve into children's rights in psychotherapy. I focus on four areas where the therapist is obligated to be mindful of these rights: (1) informed consent; (2) distinguishing between resistance and withdrawal of consent for treatment; (3) distinguishing "difficult to treat" from "unsuitable for treatment" cases; and (4) empathic listening. Let me use the case history of Michelle to illustrate these four aspects.

Therapists often have to treat their patients in the absence of solid guidelines about effectiveness. Intervention thus occurs in a matrix of ambiguity that Eisenberg has incisively observed arises from two sources: a "confession both of the insufficiency of information on which clinical decisions must be taken and of the frailty of the judgements we can, any of us, bring to bear on the human problems we face."[13] Trichotillomania is a good instance of this matrix of ambiguity in that it is a complex condition with no consensus on optimal treatment[14,15]: it may respond to drugs, hypnosis, behavioral modification, individual, group or family therapy, singly or in combination. The choice of treatment is usually decided through a child-centered and family-focused assessment. The inescapable tension created by ambiguity is a feature of all psychotherapy, including the case of Michelle.

CASE REPORT

Four-year-old Michelle was referred for therapy with a third of her hair missing. My initial assessment revealed a history of considerable family dysfunction in her earlier life. Key factors in the recommendation of individual psychotherapy as the treatment of choice were: mother's motivation for therapy for her daughter; her capacity to link past domestic violence with Michelle's present distress; the hard-to-define, but identifiable quality of mother's psychological-mindedness; and mother experiencing her own therapy as beneficial. After outlining the nature of psychoanalytically oriented therapy, its aims, methods and likely duration, we negotiated a contract based on mother's informed consent. A "trial" of three-times-weekly psychotherapy was thus launched.[16]

The first few weeks were unremarkable: initial cooperation, learning the

norms of therapy and, an emerging sense of trust and security. Then followed the inevitable testing of limits; initial reticence gave way to budding protest and aggressiveness. At first, the aggression was self-directed, consisting of anxious hair-twirling and pulling. Michelle's play gradually became increasingly violent; she ripped doll-house figures, shredded paper and scattered toys about the room. In one session, she insisted on a drink of water. I accompanied her to the kitchen and filled her glass. As she drank, she "eyed" me menacingly. My social reaction and my countertransference both signalled difficulties ahead. Michelle's gaze still fixed on me, she began to spit water onto the floor provocatively. I suggested that perhaps she had had enough to drink. Suddenly, she spat a mouthful at me. Spitting on the floor was the testing; the water on my clothes was the limit. I tried to explain I understood she was extremely angry with me, but added that I felt uncomfortable when wet and was sure she also would not like being wet. Finally, I indicated I would not allow her to spit water at me again. She sulked. This limit-setting turned out to be a critical moment, which I will discuss as part of Michelle's psychodynamic formulation.

Therapy continued for some months and eventually the hair pulling stopped. Mother believed that the practice had ceased definitively. When pressed to explain, she noted that Michelle now says "it hurts," when her hair is pulled. After months of intensive therapy, "working through" Michelle's unconscious conflicts led to resolution of the presenting symptom. At a two-year follow-up, she was still symptom free.

Let us reflect on the process involved in this therapy. A psychodynamic formulation permits a tripartite understanding of "the current difficulty, the transferential situation and the infantile or childhood constellation of conflict or deficit"[17] (p. 34). The setting—room, toys, therapist's mental space—contributes to the "facilitating environment," wherein patient and therapist create a unique relationship; the latter's capacity to listen "with the third ear"[3] promotes change.

In Michelle's therapy, her hair pulling was conceived of as an expression of internal conflicts; a symptom derived from traumas of early childhood. Listening, observing and "being with" her enabled me to hear her "from the inside." When she felt able to express her feelings freely, behave violently without fear of retaliation, secure in the therapeutic relationship, she could spit angrily at the "therapist-parent" figure.

Her long-standing conflicts were centered on mistrust of adults, insecurity, panic and chaos—a legacy of the violence she had witnessed at home in her infant years. The conflicts were expressed through her symptom—the

self-directed aggression that hair pulling represented. The conflicts were re-enacted in the "safety" of the therapeutic relationship.

Techniques of play, drawing, story telling, verbalization, interpretation and limit-setting combined to provide Michelle with the opportunity to externalize the unresolved conflicts, namely, her primitive aggression and hostility. As the family's dysfunction prevented dealing with these emotions with her parents, the aggression was directed at herself as hair pulling. Therapy provided an alternative outlet, directed at the therapist-parent figure. Subsequently, she was able to reinternalize and reintegrate her primitive impulses in the service of increasing ego maturation.

I now turn to the four ethical issues mentioned earlier, starting with informed consent.

Informed Consent

The general principle that informed consent is a precondition for intervention holds also in child psychotherapy. However, this is a vexing issue and two questions arise: first, the competence of a minor to give informed consent; second, whether "there is an age, or measurable cognitive capacity, at which the young patient's decision should be given more weight than that of the parental guardians or those of the treating physician."[18]

In considering children's and adolescents' consent to treatment, "the issue is not a simple one, and the arguments for and against children giving consent to treatment tend to be unhelpful polarized. Giving consent is often seen as an all or nothing ability, where a person is either able to give consent or is incompetent to consent. It makes little sense to have a magic age when children suddenly become competent,"[18] and for adolescents "firm guidelines for determining the competence of adolescents regarding consent to treatment have yet to be established although principles have been suggested by respected bodies"[19] (p. 418).

Even where intervention is clearly indicated and consent given by the parent, joint consent of child, parent and the professional is desirable. Conflicts of interest may, however, arise between parent and child related to the question of change. Daws[20] has noted that when barriers to therapy emerge, a therapist's task is to differentiate between lack of consent to therapy and resistance within it. A degree of resistance to change is universal; the distress inherent in changing exceeds that involved in maintaining marginal functioning. Resistance in treatment is a reflection of this distress; patients with an overall wish to live more adaptively use the resistance as an element of the struggle toward change.

Resistance or Withdrawal of Consent

A variant of consent arises when therapists are confronted with circumstances that lead them to question the advisability of continuing or terminating treatment; they have different thresholds of tolerance. The decision to terminate depends, in part, on the degree of rigor with which therapists conceptualize their responsibilities and their preparedness to examine criteria for "difficult to treat" and "unsuitable for treatment"[19] (p. 420). Ending treatment because of a child's irritating behavior exemplifies the withdrawal of a service when it is especially needed. Such a clinical scenario leads to the question of the child's right to treatment even without consent.

In Michelle's case, in the weeks following the showdown over her spitting, her mother reported that she was reluctant to return to therapy. I interpreted this not as the child's way to communicate withdrawal of consent, but rather the difficulty she had in confronting her (literally and psychologically) projected (spitting) rage and the dread of retaliation on returning to the scene of her "crime." This interpretation facilitated the continuation of therapy.

In the absence of a defined "age of consent," responsibility to determine continuing therapy against the child's will falls on parents and therapist. After consent has been granted to initiate therapy, the therapist has to realize that it is, as Daws[20] clearly submits:

> not a once-for-all interchange of a formal and legal nature; it is an ongoing agreement of mutual interest. The wish for therapy does not come one-sidedly from a therapist and be agreed to by the consumer. If the active wish to make use of therapy is not also in the patient, at some level, then therapeutic change is unlikely to occur (p. 105).

The Child's Right to Empathic Understanding

A therapist's obligation is "to see beyond their patients' overtly alienating and non-compliant behaviors"[19] (p. 419). Empathic listening provides a mode of engagement that leads to an understanding beyond the patient's overt behavior. Sondheimer and Martucci[19] emphasize that empathic understanding thus challenges the

> right of the patient to treatment and of the physician's responsibility to provide care . . . [and] the maintenance of the patient-doctor relationship, despite the difficulties involved, in the context of debilitating backgrounds for which the child cannot be held fundamentally responsible (p. 419).

In Michelle's case, empathic listening paved the way to understand her aggressive behavior as a manifestation of early environmental failures due

to family dysfunction. Clearly, ending of therapy, based on this aggressive behavior, would have deprived her of her right to therapy. In that case, termination could have been interpreted as a way of evading the therapist's responsibility for patient care.

In complicated cases, the decision to end therapy should be based on consideration of both overt communication and empathic understanding of any alienating behavior and its unconscious meanings. As Carol Nadelson alerts us, the intricacies of the

> relationship between ethics and empathy is not often explicitly discussed in the medical ethics literature, although concerns about the absence of empathy in medical practice have become pervasive[21] (p. 1309).

This is usually resolved during a consultation, peer review or formal supervision.

To achieve the necessary level of empathic understanding, the therapist must first promote, and subsequently resolve, the transference[22]; only such an environment can facilitate the child to access and express deeper levels of conflict and subjective experiences giving rise to the presenting problem. In Michelle's case, her hair pulling could be linked to a deeper conflict only with the emergence of her hostile spitting.

This process depended on provision of certain conditions that will now be detailed. The therapist's obligation to respect the rights of the child as patient depends on a facilitating environment: the therapist's maintaining empathic contact; constantly monitoring countertransference; tracking and countering any defensive behavior that may lead to avoidance of further empathic contact whether due to confusion, aggression, grief or depression or, the opposite tendency, to overidentify with overwhelming affect; and, in the extreme, to collude with the patient's system of defenses. Excessive distance or overidentification both interfere with the capacity to listen empathically. The therapist's commitment to hear the child from the inside, combined with his/her capacity to sustain contact through the vicissitudes of empathic relating, determine the degree to which the child's right to effective psychotherapy treatment is fulfilled.

These more subtle dimensions of the relationship are relatively ignored in the preoccupation with objectivity, measurement, and an attitude of "scientism." What is urgently needed is a reconquest of the subjective,[23] where experiential resonances from pre- and non-verbal levels are accessed and recognized. At this level, the attuned "therapist-as-instrument" is able to monitor, and, if appropriate, objectify and articulate the child's internal world, thereby making the unknown known.[24] The contribution of child psychotherapy to the right of the child to be heard at this deep level is

based on a recognition of conflict otherwise remaining beyond the reach of consciousness, yet powerfully handicapping psychological development.

Two further factors impede the therapist attempting to maintain empathic contact with a child needing therapy but behaving oppositionally. The first relates to interlocking parent-child psychopathology and the second to the forces of managed care funding.

The Child's Rights within the Family

The parent-child relationship, based on a constantly shifting balance between levels of adaptation and dysfunction, is a major influence of the child's intrapsychic development. Combined with the child's temperament, the relationship contributes significantly to future vulnerability or resistance to mental disorder. Children of mentally ill parents, through increased vulnerability, stemming from both genetic and interactional factors, are at special risk. Despite the mounting scientific evidence, many advanced countries still lack policies to provide adequate care for this "at risk" population. As these children are isolated from both formal and informal sources of support, one group has been prompted to call this a failure "to provide for their basic human rights."[25]

In families with a mentally ill parent, conflict-ridden patterns of development often persist despite the pain to both parent and child; the child internalizes these painful influences. In extreme cases, typified by a virtual absence of affectional bond where children lack an experience of a "good enough" parent to internalize, they tend to repeat maladaptive family patterns of relating in subsequent relationships. In this case, a diagnosis that locates the problem *within* the child is, at best, a clinical misjudgment, at worst, violates the child's rights. Sholevar et al.[26] have articulated the risk of ignoring the interlocking psychopathology of parents and children where the parent's psychopathology affects the parent-child bond: "In such situations, neurotic (*or other more profound*) conflict in the parent diminishes the child's therapeutic progress or renders the treatment ineffective. Simultaneous analysis of child and parent can elucidate their overlapping fantasies and regressive tendencies and help them progress beyond their positions of fixations." (p. 689) (my italics).

Sondheimer and Martucci[19] emphasize that the child's right not to be treated as the principal target must be considered in such circumstances: "Under what conditions, if any, should a child and adolescent psychiatrist limit treatment to the minor, when that child's symptoms appear largely to be a response to the parent's untreated pathology?" (p. 421). While concurrent treatment of parent and child is clearly not a universal need,

addressing such needs inadequately often constitutes a failure to distinguish between children psychiatrically "difficult to treat" and "unsuitable for treatment." The parental contribution must be fully recognized in such situations as "the points of contact between parent and child, keeping the two individuals wrapped in dependency with each other in a struggle to survive"[27] (p. 283).

Managed Care and the Rights of the Child

Finally, we turn to the impact of managed care on the rights of the child. In the last decade, managed care companies in the United States have become the primary gatekeepers of access to health care. This contractual model "represents a new shift in societal values. Society is declaring that there are limits to health care spending"[28] (p. 398). When the support for child psychotherapy is contrasted with allocation of scarce financial resources for life-saving machines, organ transplants or intensive-care beds—criteria managed care companies have adopted to decide on the priority of one treatment over another—these decisions must be carefully scrutinized. While the accountability for health costs is essential, the doctor is increasingly buffeted by the issue of cost impinging on clinical judgment. This ultimately must erode the right of the patient to receive appropriate medical care. One tragic outcome of our new societal values is the "significant blurring of boundaries between clinically driven and economically driven indications"[29] (p. 28) with the emergence of a new class of "unprofitable" patients. Patients like Michelle are still eligible to receive the intensive psychotherapy they need in the Australian health system. But it is doubtful if managed care would agree to such funding.

Who will provide answers to the following pressing questions on the deleterious effects of managed care on children's rights: Is the corporate health care system governed by a set of ethical principles? Are managed care companies in the US, a nation which ratified the UN Convention on the Rights for the Child, obligated to uphold the Convention's articles? To what extent is psychotherapy devoid of empathy ethical? Who safeguards therapists' mandate to act in the best interest of the child while they are contracted to a managed care system that is ethically insensitive?

It seems that Book's prophecy has come to pass:

> [the] corporate delivery system, with its focus on cost constraints, may inhibit our capacity to be empathic by stimulating self-serving concerns about the corporation's monetary welfare and our own financial well-being. This unempathic stance may result in treatment being driven by financial factors that override clinically driven needs of the patient."[29] (p. 29).

As any therapist will verify, ambiguity is inseparable from practicing the art and science of psychotherapy. But to forgo its empathic dimension, under the pressure of financial forces, and the pervasive need to objectify the subjective, is to negate, in Eisenberg's terms the "frailty of the judgements we can, any of us, bring to bear on the human problems we face."[13]

To state the obvious: managed care's impact on child psychotherapy has created a complex set of contractual obligations where the therapist is constrained by a three-way contract. Faced with a remitment from parents and children who provide informed consent expecting in return effective treatment, while contracted to a managed care system governed by the dictates of cost constraint, the therapist must choose between the right of the child to be empathically heard (but which can not be sustained since empathy is no longer cost effective[29]) or face breach of contract and the prospect of professional dismissal.

Sadly, managed care has only managed to erode the best-interests-of-the-child standard of care, to a level at which a "minimum-interest-of-the-child" contravenes the right of the child to adequate psychotherapeutic care. Looking to the future we must seek ways to arrest and reverse this unfortunate trend overtaking child psychotherapy.

CONCLUSION

In contrast to adult psychotherapy, where a central concern is the sense of the patient's "well-being," "handicaps in personal adjustments," and motives to lead a "happier, more fulfilled, less trammelled life,"[30] child psychotherapy, while implicitly guided by a similar concern, has neglected to explicate this inner dimension of experience. A notable exception is O'Rourke et al.[22] who incorporate "well-being" as a central construct in child psychiatry (see Table I).

Their compelling case to adopt the principle is noteworthy:

> Ethics seeks to define behavioral norms which, if observed, will lead to the well-being (i.e., happiness, well functioning) of persons. Psychiatry [*and I would add child psychotherapy*] as a science and as an art also aims at the well-being of people but in a different manner. Whereas ethics seeks to determine the behavioral qualities, objectives, and actions that enable people to strive for well-being, psychiatry seeks to alleviate or eliminate the emotional difficulties that inhibit people from achieving well-being. But if child and adolescent psychiatrists do not have some notion of human well-being and development as they enter the therapeutic relationship, they will be unable to apply their knowledge and technique productively[22] (p. 393).

An explicit adherence to the principles related to well-being brings into

sharp contrast the profit motive of managed care with the clinical and ethical needs of child psychotherapy. Failure to urgently confront this conflict of interest risks furthering the already considerable erosion of the rights of the child in psychotherapy.

Against the background of centuries of socially sanctioned ill-treatment of children, contemporary child psychotherapy should insist on the child's well-being as a basic right. Michelle's case highlights how the therapist's obligation to safeguard her rights depends on adherence to both subtle clinical and ethical dimensions in clinical care. The pursuit of objectivity, combined with cost constraints imposed by managed care, promote an anti-empathic ethos. Ultimately, such an attitude impoverishes patient, family, and therapist alike, as our culture reverts to a pre-eighteenth-century mentality. Must we "advance" in that direction?

Table I PRINCIPLES RELATED TO WELL-BEING IN CHILD PSYCHOTHERAPY PRACTICE—MODIFIED WITH TRANSLATION OF "PSYCHIATRY" TO "PSYCHOTHERAPY"[22]

Principle 1
Ethical child and adolescent psychotherapists will have some notion of human well-being and development for which they help patients strive (p. 393).
Principle 2
Ethical child and adolescent psychotherapists will be motivated not only by their desire to help the patient strive for well-being, but also by the desire to strive for the psychotherapists own well-being (p. 394).
Principle 3
Striving for ethical objectives for patients and psychotherapists requires constant interpretation and creativity by the child and adolescent psychotherapists in light of patient needs (p. 394).

SUMMARY

A brief historical perspective on the development of the concept of children's rights provides the background from which to delve into their rights when in psychotherapy. After centuries of the systematic ill-treatment of children, the emergence of an empathic ethos that pervaded Western society in the eighteenth century ushered in a new attitude of social reform. Social progress over the next two centuries culminated in the United Nations Convention on the Rights of the Child. The modern concept of the rights of the child and application of the best-interest-of-the-child standards in child care is evident in four areas of child psychotherapy: informed consent; recognition of the difference between the child's with-

drawal of consent to further therapy and resistance *in* therapy; the need to distinguish between "difficult to treat" and "unsuitable for treatment" cases; and empathic listening.

However, mounting evidence that dysfunctional families cause increasing vulnerability of the child to future mental disorder places an obligation on the therapist to recognize the interlocking psychopathology and needs of both parents and children for therapy. Finally, the effect on child psychotherapy of "managed care" in the United States, which threatens to transform a best-interest-of-the-child standard to a "minimum-interest-of-the-child" one as a socially regulated form of restrictive care, contravenes the child's right to optimal care. Principles relating to the well-being of the child in psychotherapy are offered to counter this trend.

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