Personal practice

Less orthodox psychological interventions

A BENTOVIM

Hospital for Sick Children, Great Ormond Street, London

A large number of children present to paediatricians with psychological problems caused by the ordinary vicissitudes of development and of modern day family life, with its high rate of family breakdown and divorce. The paediatrician needs ways of intervening that can unlock or undo hold ups in successful treatment and ensure that the patient with abdominal pain, food refusal, or constipation does not develop chronic illness behaviour and invalidism. The paediatrician also has to be able to distinguish between the child who is changing and moving out of a current difficult phase of development, and the one who is going to need a specific psychiatric referral.¹

We know that a number of agencies—educational, social work, community health, general practice, or paediatricians—see a great many of the disturbed children and their families in the community. It is essential to find a systematic approach to helping these families rapidly, effectively, and in such a way that we can determine which need specialist assistance.

Can we think about our ordinary practice in a more systematic way?

Once it has been ascertained that there is no continuing, organic disorder, or once it has been possible to sort out the physical elements of a problem, the paediatrician has to give an explanation for physical symptoms, which includes a psychological element. He has to give appropriate reassurance, putting the child and family's mind at rest, and has to provide advice and a view of the situation that will ensure that 'natural processes' of recovery will assert themselves, and that potential improvement will take place in the reasonably near future. Explanations for symptoms such as—

(a) a child seeking for response through complaint in the face of the strains of growing up,

(b) a parent over responding to a child because of not wanting to face the child's inevitable growing up and going away,

(c) concern that when there is severe illness in other members of the family, minor symptoms take on a very serious character and then become amplified through anxiety,

(d) tension and fear, for example about school or growing up, translating itself into body symptoms,

(e) tension triggering somatic syndromes such as asthma,

(f) perception of vulnerability based on 'unresolved' developmental antecedents, for example prematurity, previous serious illness,

(g) fear of loss when another child has died, or there has been still birth—

will, we hope, together with appropriate medication, relieve anxiety sufficiently for the symptom to resolve itself. Unfortunately, these explanations are already so commonly known, that their statement by the 'expert' may result in disappointment and irritation on the child's or the family's part. They may have heard all this before—from their health visitor, family doctor, friends and neighbours, and from their child's teachers—and inevitably, if there is irritation and anger, symptoms continue. Indeed, the picture of giving reassurance and then being greeted by a child with far worse symptoms, is all too common.

At this stage, attempts to refer the child to psychiatric colleagues may be greeted with demands for second opinions, demands for further investigations and tests, and an expectation that there must be some hidden covert physical illness causing the symptoms to recur. If the cause were simply worry or tension, these symptoms would, after all, have resolved. The child or family may feel threatened by psychological explanations: a diagnosis of physical illness represents a cure whereas a psychological explanation is perceived as a criticism. The paediatrician may find himself pushed into undertaking further investigations he knows are not helpful, yet still become enmeshed in an all too familiar battle situation, trying to prove the unprovable with increasing disappointment and anger until the family seeks help somewhere else. This is

particularly the case when the family's communication language is a 'physical' one, and there is limited ability to link feelings and emotions with physical responses.

In dealing with these symptomatic problems in psychiatry, we have been helped considerably by the introduction of 'systems' ideas.²⁻⁴ These ideas have helped us formulate problems differently, in particular in trying to understand the way the problem and the context—child, family, and social situation—are linked together and have a complimentary relation. Interesting and important ideas about 'systems' were developed by observing one of the great experts of hypnotic treatment—Milton Erickson.⁵ It was shown that the effect of hypnosis could be produced without the patient having to be hypnotised, as Freud had seen earlier. This improvement was due to the relationship with the therapist and the way in which this relationship was used.

Hypnotic relationship

In the traditional hypnotic intervention, the subject is told 'hypnotic influence is so powerful, you will find it will make your arm which you are now holding up in front of you feel so heavy that you will find it falling of its own accord—no matter how hard you resist the hypnotic challenges. Try to resist, try to make your arm stay up to overcome the hypnotic powers. Look your fingers are twitching, your hand will try to rise, but you cannot do it. Your arm will fall and when your arm falls to your lap you will find yourself going into a very deep hypnotic trance. When you get deep enough the influence will be so strong that it will help overcome your symptoms—the headaches, the tension in your chest which makes your asthmatic breathing so difficult, your abdominal pain etc.' The therapist invites the patient to fight the 'power' that will 'cure' him, but not to fight the therapist explicitly!

He therefore creates a 'complementary' relationship with the patient, in the sense that the patient, although invited to resist, finally seems to 'fit' into the therapist's suggestion using the notion of hypnotic influence, because it is on the side of 'improvement'. Finally there is no 'choice' but to respond 'gratefully' to the suggestion, and it has been shown that hypnotic interventions of various kinds are effective in a variety of problems.⁶ But is the hypnotic induction and the ascribing of power to hypnosis, a *necessary* part of the therapeutic intervention and its effectiveness? Are there aspects of the 'hypnotic' relationship that are used by us all as part of ordinary practice, and can these be adopted in a systematic way?

In a sense 'complementary relationships' whereby one individual seems to 'influence' or trigger states in the other, whether consciously or not, are an everyday part of family and social relationships, and we can observe these processes in families who show noticeably pathological interactions. For instance in families where there is an over close relationship, described⁷ as 'enmeshed', we observe the complementary relationship in action. We observe the 'hovering' protective mother or father and child, who, through interlocking feedback processes, are fixed into a pattern whereby the more worried mother is about her child's abdominal pains, the more anxious the child becomes because of his mother's concern. 'If mother is worried about me there must be something wrong.' As a result his stomach hurts more. At the same time the mother becomes more anxious, believing that he would not complain if there were not a real pain. She then fears the worst, and so the spiral of interaction continues until the child responds to his mother's belief in an illness state. If the child has the right sort of bronchus, or skin or gut muscle sensitivity, symptoms, signs, and states may be precipitated, only for the child to recover the moment he or she is admitted to hospital or is relieved of the pressure of having to attend school. At the same time we may well see the parents either confirming or amplifying each other's anxieties, or alternatively getting into what can be described as a 'symmetrical' relationship. The more anxious and involved mother gets with the child's state, the more distant the father becomes, the more angry he gets with his wife's concern; the more angry she gets with his disinterest, the more angry and distant he becomes; the more anxiously involved with the child the mother becomes—creating yet another spiral.

A change in the child may change the delicate balance in the family, and 'proof' that the symptom is psychological may be 'dangerous' to this balance!

We have to understand that family patterns, which may well arise as a response to an ordinary, developmental, symptomatic response in a child, may come to take on a secondary function. For instance, if there is some major problem within the family which could lead to disaster, such as an 'avoided' marital conflict or an illness state in one or the other of the parents' families, then by focusing on the child and his symptoms, the other problems may well seem to resolve. The focus on the child's symptoms then remains and becomes part of the family's avoidance processes. The family may experience a solution to previously unresolved conflicts and anxieties by trying to solve a different problem, for example the child's symptomatic behaviour, which is inherently unresolvable because

there is no inherent problem! The solution then becomes the problem.⁸ The harder the parent tries to find a solution to a child's pains, therefore, the more the aches and pains themselves become reinforced as a part of the family's way of life and reality.

Where these particularly deep rooted, dysfunctional interactional rules are seen within a family, a special intervention is required if the whole family is to be helped. Going back to our hypnotic model, successful interventions, say in an entrenched feeding battle, rely on the absolute sense of certainty with which the therapist tells the mother she should resist becoming involved in a feeding battle. The 'fight' is thus transferred from the mother and child, to the mother and the therapist. Rather in the way that the hypnotic therapist tells the patient that no matter how hard he tries his hand will drop to his lap, so in this intervention the therapist has to say with absolute conviction to the mother, that no matter how much she worries or becomes concerned, she will find that her child *will* eat if she stops trying so hard to feed him. It may even be necessary to say 'weigh him every day, keep weighing him for a fortnight, but you will find no matter how much you worry, if you stop yourself attempting to force feed him, you will find he will eat and his weight will go up.' The paediatrician may have to reinforce this with frequent visits.

There are many elements that help win this battle with the parent who feels drawn into the enmeshed struggle with his child. The mystique of the hospital, the expectation and desperation for help, and the careful authoritative examination may all be sufficient to allow change to occur. An expectation of change is therefore created, and there may be improvement. Anxieties must be respected, and a willingness to re-evaluate if progress proves the therapist wrong is necessary.

Less orthodox intervention

I feel, however, that although this form of intervention is often effective, some invitation of 'defiance' is necessary to ensure that the intervention holds. For instance, a child may feel himself in such a special role in the family, or the parental pattern may have become so institutionalised that change will not occur despite reassurance that there is no medical condition and that the parents can change their handling and stop seeing their child as ill but rather as showing illness behaviour. I often find it helpful to add that even though there is no present cause for the headaches, abdominal pains, feeding problems etc, these often take far longer to get better than one would think. I usually add, 'you

hope that it will be better tomorrow, now you know there is no present medical cause. But it will take very much longer than you think. In fact the healing processes are so variable that it may well get worse for a time, and you will all worry that the paediatric examination was not thorough enough, that we were wrong, that there is something else underlying the problem. You will even want to come and tell us that we got it wrong. But a time will come maybe days, weeks, or months hence when you will wake up and it will be very much less. You will try to examine your head or your tummy to see is the pain still there, and even though you try and twist and turn you will find that it will not come back and it will not be there no matter how hard you try to see if you can find it. The healing processes will have worked.' The question is then asked, 'Are you suggesting that he can make the pain come and go', to which it is important to add, 'Absolutely not—if he could make it come and go he would stop it now'. In this intervention we are, in a sense, following the hypnotic model by saying that with the healing process, aches and pains will gradually go, but it will take time.

I sometimes find it helpful to talk about how little we know about rehabilitation after illness. I am indebted to a colleague who talked about the 'foot prints' of an illness that was present but how little we understand of the processes by which they disappear. I may suggest that it is important to look very carefully for signs of improvement—they can be very slight indeed, the general brightening up of the child, the ability to do a little bit more—which will be seen little by little, not all at once. I would always be absolutely surprised, of course, if I were told about sudden improvements, and would say that this is very unusual and may revert rather than continuing at this rate of progress! I would try to convey that continuing pains and symptoms, looking unwell etc can be seen *not* as signs of illness but signs of the 'health process' taking its time, but inexorably working, even though there is a fear of the reverse—'*your hand will try to rise up, see it twitching, but it will fall.*'

What we are trying to do is to block the processes by which the parents and child find themselves in a spiral of anxiety by predicting and indicating all the usual perceptions of that anxiety.

A 'rehabilitation' programme may be helpful; for instance, using breathing exercises or periods of practising symptoms (particularly with the parent who is least involved) by making them *worse* for five minutes, then trying to make them better. At the same time it has to be emphasised that these interventions will not of themselves make the pain go away because the processes of recovery are not

understood fully. It might, however, help to overcome the pain process and gain a very small amount of control. We suspect that it will not effect the general course, which will take its own time.

I find it helpful to say, in a somewhat apologetic way, that even in very great hospitals there is so much that we do not know. Any process that allows the child to get 'off the hook' and give up his symptoms with honour, rather than exposing himself as being able to get rid of symptoms and therefore be openly attacked for causing so much anxiety, is extremely important. I find that some quite unusual suggestions can be very effective in the process of helping children get in control of themselves by inviting defiance. For instance, the soiling, non-constipated child is asked to make the smallest possible lump in his pants, and we then discuss whether it should be a five pence or 10 pence size. This may sound upside down, but it can be put forward as a way of getting control. Then, when the child is invited to create his symptom on purpose rather than suggesting it will resolve spontaneously as previously, he may find his only defiant solution is to give the symptom up!

Another way of achieving the same end is to change the family's view of the symptom as a nuisance. We might suggest that children sometimes get very confused about their families. If we are aware that there is a problem in the family, for instance a marital difficulty or concern about a parent's health, then we might say that children sometimes feel unconsciously that they are helping because they are distracting family members from other problems, and then without realising it their symptoms continue. I usually add that once children get such ideas in their heads, even though they are told that their help is not required, they do not accept it. Because once children (unlike adults) get an idea in their mind, nothing can be done to stop them, and the problems will continue until suddenly the child really understands his help is misplaced. In child abuse it is often helpful to say that you are very concerned about the child who seems to have it in his mind to behave in the sort of way that would make any parent extremely angry or cross. For instance, you may be very worried about his crying or oversensitivity because again the child seems to be in a muddle. Despite being very young he seems to feel that he has to distract his parents from other worries, financial difficulties, problems with grand-

parents etc, and you are very concerned that the child in his muddled thinking may go so far in his distress, whining, or oppositional negative behaviour that he makes his parents uncontrollably angry and gets himself hurt in consequence. Care may be necessary to protect him from himself.

Conclusion

I am suggesting that whenever there are long standing problems with no physical cause, ordinary interventions that ask families to do things differently—not to be so over anxious, or over involved, or worry so much about pains and aches—are not always effective in creating sufficient change to enable the child to improve appropriately. I am suggesting that in those situations where families are liable to go from one doctor to the other or remain disappointed with appropriate helpful treatments, less orthodox approaches may be helpful. There are a variety of approaches, including the covert hypnotic model, that can initiate improvement providing there is a reasonable appreciation of the problem in a family system that sometimes initiates and often perpetuates a 'benign' symptomatic response in a child. It is not difficult for the outsider to understand the way a particular family is creating problems for a child. The problem is to be able to change the situation without 'criticising' the family. If the approaches suggested here are not helpful, then the groundwork may be laid for more formal psychiatric consultation.

References

- ¹ Graham P. Paediatric referral to a child psychiatrist. *Arch Dis Child* 1984;**59**:1103–5.
- ² Watzlawick P, Beavin J, Jackson D. *Pragmatics of human communication*. New York: Norton, 1967.
- ³ Minuchin S. *Families and family therapy*. London: Tavistock, 1974.
- ⁴ Haley J. *Problem solving therapy*. New York: Josey-Bass, 1976.
- ⁵ Haley J. *Uncommon therapies: the psychiatric techniques of Milton Erickson*. New York: Norton, 1973.
- ⁶ Edwards SD, Van Der Spuy HH. Hypnotherapy as a treatment for enuresis. *J Child Psychol Psychiatry* 1985;**26**:161–70.
- ⁷ Minuchin S, Rosman BL, Baker L. *Psychosomatic families*. Cambridge, Mass: Harvard, 1978.
- ⁸ Watzlawick J, Weakland JH, Fisch R. *Change, principles of problem formation and problem resolution*. New York: Norton, 1974.

Correspondence to Dr A Bentovim, Hospital for Sick Children, Great Ormond Street, London WC1N 3JH.