Controversies in Children and Adolescents Psychoanalysis

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Do children demand analysis?

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Introduction

From our clinical experience, we know that the demand of a child or an adolescent for analysis, sometimes formulated as "I want to see a psychologist", it is more common in family environments where analysis is a personal experience of parents and where, usually, it is a valued space and offered to children when problems or situations that go beyond the family support appear. It is also known the relief felt by children that suffer from excessive anxiety and phobias that often feel already better at the beginning of the interviews. But after these promising beginnings, it often happens that questions and complaints, both from parents and patient, even analysis interruptions, sometimes in an unexpected way; this led me to think about the initial statement of the analytical work. If we are actually facing typical resistances of any analysis that should be worked on as part of the process or if these are issues that have to do with the unconscious unfolding, which is emerging as the analytical work progresses and is demanding a different space of the aforementioned resistential aspect.

The consultation for a child is always carried out by his parents. Hence the complexity of the field that the first consultation opens: we have to consider several fronts, the child and everything around him and what constitutes him. The psyche as an open system, i.e., adaptable in intersubjective terms, is crossed by several temporalities that coexist with the child's history, inserted in a family and in a social context.

A little history

To address the issue I will make a brief tour of theoretical developments that I have found significant and that pose prominent differences regarding how are thought

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the place of the child and of the analyst. I will take into account the developments of Melanie Klein, of D. Winnicott and of Cecil and Edmond Ortigues.

In the beginning of psychoanalysis addressed to children, the work was done with direct approach with them. We are located in the context of discovery and, from that place, the contributions that psychoanalysis of children provided -to the children's clinical work and to a research space of the psychic constitution and of the children´s transference ability and to the development of psychoanalysis in general- have been very rich. Children´s psychoanalysis helped to expand the boundaries of knowledge of child suffering and of serious diseases.

Melanie Klein applied the Freudian discovery without so much as the concern of an adult who made possible the child reached the office. Klein's premise was based on that analysis was the best a child could receive beyond the reasons that could decide him. In that inaugural time, the indication theme was not in the foreground. Based on the premise of sadistic fixations of the child, the analysis solves them by reducing the severity of the superego and allowing an expansion of the ego towards the requirements of reality.

M Klein says (The Psycho-Analysis of Children) 1932):

"Every child passes through a neurosis differing only in degree from one individual to another. Since psycho-analysis has been found to be the most efficacious means of removing the neuroses of adults, it seems logical to make use of psycho-analysis in combating the neuroses of children, and, moreover, seeing that every child goes through a neurosis, to apply it to all children."

Following the line of laying out a difference in this technique that we might call for everyone, a modification that introduces D.Winnicott arises. The spontaneous gesture, the constitutive aggressiveness, the infantile omnipotence, to allow the child to take the initiative, all this is what the mother must hold at the first moment so as the human baby reaches the basic sense of trust. Transferred to the clinical work, these theoretical concepts will change the approach in the analysis of children. It is no longer about applying a rigid frame but to generate the conditions for creation of the transitional space that contains the child's game and the analyst´s game. Thus, greater importance to the child is given when considering his wish.

With her contributions, the fact of taking emotional contact with the child was placed in the foreground. Her thesis: the analysis occurs in the intermediate zone between patient and analyst; it puts the analyst knowledge off-center and slides it to

produce, in that transitional zone, what is able to generate real changes in both, patient and analyst. The indication of classical analysis was left for neurosis. In other clinical symptoms, the technique was adapted to the needs of each situation. Thus, the long sessions and the sessions on demand arose. Here I notice an aspect in which I would stop because it is inherent to the issue of the analysis request/demand. If on demand sessions arise, it is the patient who regulates the frequency and his availability for psychoanalytic inquiry. This is a very controversial concept because one can argue how to play into the hands of the resistance or not properly interpret the negative transference. Moreover, this approach allows the patient to have autonomy and to feel respected in his time.

Later on, after a parents interview, the diagnosis began to install as a way of begin the analysis with children. The so-called child´s diagnosis, after interviews with the parents, has the function of detecting in what developmental stage the child is, if he has symptoms as an expression of an identifiable pathological condition or if he has a nonspecific disorder as product of subjectivity under construction. Diagnosis also tries to find out what place came to take up the child in the family. However, the most common way was to initiate the individual analysis of the child.

With the extension of the observation and intervention field, the unconscious components of the family group were included. This brought complexity since not always what was detected at the family level could be analyzed in the space of individual analysis with the child. This way, the clinical work was opening itself to include working with the family with analytical tools. Family interviews are conducted, dyadic, with siblings, and with all bonding cuts arising from clinical work.

Many times the theory has grown by its edges, turning analyzable what before it was not; advancing on the space gained to what resists the change. This way, childhood, psychosis, narcissistic neuroses were incorporated to the territory of the analyzable.

This made that more and more the subject of indication be taken into account. The individual analysis no longer appears as the only indication but it is a possible indication among others that take the symptom in a child as emerging from a dysfunction of the family group.

Is the field expanding? Is the clinical work improving? The specific of child analysis is fading? We are confronted with new spaces, perhaps more complex, which require from us, child analysts, reformulating our work. We do not renounce to the rule of abstinence, put in tension by the indications, which put the analyst in the place of the desiring subject.

Other models of intervention

M Cécile and Edmond Ortigues are in a position that gives priority to the installation conditions of psychotherapy for children.

They say:

Parents´ demand starts a situation that we do not know how it will evolve, if a psychotherapy will follow or not to the first interviews.

Any request mobilizes libidinal or identifying positions, the defenses of all parties as well as the typical dynamics of the family group. Do parents really want their child to change? Can they love him? What do they want? Do they know it?

It is helpful that the complexity of such mobilization have time to manifest. Coming to a decision too quickly, to make the decision instead of them, it could place them in an unbearable situation that would deprive them of their own resources.

Some clients demand the suppression of the symptom so that everything becomes to be as it was before. The quality of our listening and the beginning of a transference leave open to parents the possibility to modify their initial demand.

It is a shared experience the evolution of a symptom that initially distresses the parents, such as the depressed child, captured by the paralyzing defenses and who after a period of analysis becomes active and annoying for parents; or the inhibited child, for whom it is hard to study and that when he is able to leave the assigned place, asks and investigates about family secrets.

These authors postulate that the analyst should not be prescriber and whether he should open the way to disagreements that could not had been expressed.

If we are subject to want to guide in function of some ideal, we don´t analyze. It is the greatest difficulty that we have to sustain abstinence, the only way to gain access to any news of the unconscious.

I pose a clinical situation:

The parents of a 5 years old girl consult because they notice her daughter is in crisis; they say she was a happy child until the brother was born and she became surly, unmanageable, with oppositional behavior, and when someone speaks to her she does not answer.

They are also concerned because they see she is very demanding, that she criticizes her friends and that she takes offense very quickly. She is always waiting to be praised and to receive gifts. She masturbates herself. After some analysis time, the symptoms improve and, by parents, the questioning about continuity appears. They do not accept that her daughter enjoy so much the sessions and that she prefer going to session rather than to her uncles´ home.

This is a well-known course that, in general, is understood as the parents´ resistance to their child´s change, especially and paradoxically if he is getting better. This hypothesis has no way out since the interpretive tool cannot be applied to non-patients.

Following the Ortigues´ line: What would be the usefulness of committing to an analytical work of several weekly sessions, long term, if the child's development frankly improves with less frequent therapeutic consultations? We think that there is always time for the analysis opportunities to arise from these consultations, when this tangle of the child and parents symptoms is present. This is one of the many questions that it would be necessary to develop, to debate and to evaluate.

If after a series of therapeutic consultations the repetition perseveres and there is no evolution, the analysis or the psychotherapy becomes indispensable.

Thus, the classic technique is to include the parents as little as possible. It is based on the fact that in many interviews the parents transference can be unfolded, which the child analyst is prevented from analyzing because the parents are not his patients.

In this outline, the analytical work is done with the child, taking into account the reasons for consultation and the assumptions that arise after the initial interviews, i.e. the family context and the child’s place in the family but, basically the interpretive work is towards the child productions in the individual session.

The defections, the treatment interruptions, the sessions´ reduction are frequent destinations in the practice of child analysts.

How do we think the consultation made about a child?

The consultation is conveyed by parents who pose their concerns, their desire to help the child and, through that consultation, they place the difficulties in the child as a way of keeping themselves out of the problems.

Perhaps with the Kleinian theory as example, for a long time it was easy to indicate therapy for the child. All children can be analyzed and the analysis is the best for them, whether neurotic, psychotic or normal, i.e. not symptomatic. Within this outline, it will not be pertinent all what will be questioning the indication for children.

But taking into account the concept of projective identification of Melanie Klein it is often difficult to differentiate between what´s typical of the child and what´s projected on him.

There is also the fundament that says that the analysis is going to be good for him; it could be, but it would be skipping the unconscious causes that turns the indication into violence towards the child.

The compass that we have is the child's suffering, the anguish and his symptoms.

The analytical mechanism collects and transforms, via the transference, the unfoldment in the body and the bonds in transference neurosis. From that place, when the child expresses its opposition to the analysis it is easy to think of it as a resistance because it is hard for the libido to leave positions where it has settled with certain benefits. And with the analysis continuation, the child is improving.

It is not always that way. There are distressed children that are not installed in the transference or in whom the negative transference prevails. Are they unanalyzable? We modify the mechanism and we include interviews with parents. There are therapies that begin with a consultation for a child in which we do not work with the child. It is different when one thinks about bonds and the approach is always a working group and one does not work with the designated patient.

The 6-year-old child arrives crying to the interview because he did not want to come; he remains weeping beside the mother. A simple intervention "why are you so angry?" makes him answer and generating a back and forth that unfolds his anguish for the reprimands that he receives daily.

There are several transformations in the child analysis that must operate the analyst. From the interviews with parents, collecting the reason for consultation and

processing them on criteria so as to intervene and formulate an indication, from the game to the word, from the game to the game.

But I return to the subject of the demand for analysis and if it exists in children.

According to the classical theory we can infer a demand for analysis when there is an analytical process, i.e. a positive or negative transference, and the production of playful material.

According to the Ortigues, it is necessary the child´s agreement for an interview and to give him the required time for a decision before a possible beginning of treatment and also to be respectful for his decision. The child has the right to be asked in relation to what he thinks about what his parents say.

In severe cases it is more difficult to obtain a response from the child. When he refuses to the interviews, in general there is a family context that can be unbalanced because it was assembled pathologically. In such cases a careful but firm intervention is necessary; it must not leave the child exposed to the place of depositary of the disease.

Francisco of 14 years old agreed to the interview at the insistence of his mother. She tells that, as a kid, he was teased for being fat. A few months ago he had a gallbladder operation, almost of urgency; he did not want the surgery, he was very scared, and he asked the mother to take him away from the hospital. That was not possible as it was all prepared for surgery: all but Francisco, who was terrified. He was operated, everything went well, and the surgery was successful. In the post- operative period he has some discomfort and he vomits. Nothing significant, it is expected, doctors say. He is fully recovered from surgery, he is discharged and he goes home. But he does not eat. Or he eats and then he vomits: in that way, all the time. His physical condition worsens, he is malnourished. He stops going to school. He loses much weight. He is hungry, he eats and he vomits. Those are his main activities. His low weight (34kg) risks his life. In this condition, the psychological consultation arises. He will not talk about what happens. He does not accept another interview. The family is worried and angry with him.

In this case we can raise a homologation with what parents or professionals believe that can be good to someone, whether it is the analysis or the gallbladder surgery. This was decided by the mother and the surgeons. Theoretically it would be the best for him; it was what had been indicated. But obviously the conditions were not given; the boy did not want it. He had something to say but he was not listened, respected or heard about what he was going through. Even with the best intentions,

although we consider the indication is good, if we do not hear the subject to whom our therapeutic action is directed and he is not disposed for consultation, the desired effect does not occurs and, as in this case, the outcome can be very serious.

Conclusions

Based on all this, and as a first approach, I would say: I tend to think that there is demand when the child suffers; also when his symptoms and anguish compromise his development.

Suffering, distress, symptoms are expressions that constitute the first sign of analysis for a child. In these cases, by detecting distress, I tend to think that there is demand by the child, even if it is not explicitly formulated.

I do not tend to think that there is demand when the features of the consultation raised by parents do not necessarily coincide with the position of the child. In this case, I intend to investigate individual and family history, how it has come to consider the situation of the consultation and what anchoring it has on the child. I intend to clear the possible placement on the child of the problems of the others.

I do feel authorized to make an analytical intervention when I detect that there is suffering in the child, regardless the origin of the source.

It is clear that I do not think that a consultation for a child becomes necessarily an indication of analysis. I do not like, for the analyst, the place of prescriber or indicator when that role puts him in a position of authoritarian knowledge and does not come from the work process in transference.

I would not feel ethically satisfied if I were applying theories, or trying to respond to the parents´ demand, without investigating deeper if I feel that the child is the subject of consultation and he is truly needing and asking for my help.

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