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Does this Particular Child Need Psychotherapy?

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INTRODUCTION

Observant parents, potentially troubled by their own child's behavior, have increasingly turned to mental health professionals for advice. It is not uncommon for educated people to know a psychologist, a psychiatrist, possibly a social worker, a counselor, or a life coach whom they may consult under such circumstances. One such situation arose in my own clinical practice with children. A case that I will share with you involves a four-year-old girl whom I will call Tammy. At the time, she was an only child in a well-functioning two-parent family but with a sibling on the way. She was a happy and well-adjusted child until a red flag emerged at school. There was a single behavior that was of concern to her preschool teachers: Tammy refused to go to the bathroom. It seems that she resisted having a bowel movement, in particular.

Observant teachers noticed that at the designated school "potty time", Tammy did not line up with the other children. She hung back and did everything her clever four-year-old mind could conjure up to avoid the ritual; she would try to become invisible. Often she would surreptitiously hide out near her "cubby", pretending to search for a toy she had presumably brought from home. After a few days of this behavior, the teachers were sufficiently concerned that they alerted the parents. Was this just a problem at preschool or had parents also observed it at home?

The parents were not aware of the problem. Tammy had been easy to toilet train and since the age of three, she had been using the bathroom on her own. However, upon closer observation, the parents did notice the same behavior at home; she seemed to avoid having a bowel movement, in particular. Her mother also noted that recently she had become uninterested in food at mealtimes. However, up until now, she had always been a good eater. A bit defensively, the mother worried that her own preoccupation with being thin (she was drawn toward media images touting thinness as the prevailing route to attractiveness), might be impacting her observant daughter. Her mother was aware of the risk of anorexia for teenage girls. But surely, not at age four, she reasoned.

Tammy's mother had taken some psychology courses in college. Thus, she recalled that Freud had postulated that certain forms of psychopathology were linked to the anal stage of development which occurred around age two. In recent years the symptoms were primarily relegated to the metaphorical given that Freud's theorizing had fallen out of favor. Nevertheless, educated parents would speak of people who manifested an anal-retentive personality, with controlling and withholding features. However, as a four year old, Tammy had displaying none of the childhood precursors of such behaviors. In fact, the parents reported that Tammy showed no signs of any troublesome behaviors at home, she was happy and well-adjusted. The preschool teachers observed that her avoidance of the bathroom was only a very recent behavior for Tammy and recommended that they take her to their pediatrician as soon as possible since constipation could become a major medical problem if allowed to persist. Before returning to this case, I will share with you my own general perspective on normal and problem behavior in children. I view them both through the powerful lens of *development*. After applying this framework to Tammy, with whom I worked intensively for a short period of time, I will end the article with the following question: Does this particular child need psychotherapy?

A developmental perspective

What can we expect of a child given his or her particular age? One of the features of development in the preschool years is that their minds are very fertile and imaginative. In fact, at every age, children are by nature budding "theorists". I recently addressed this characteristic in a published article [1] entitled "*What were you thinking*"? I cited examples, in which parents naturally, but erroneously, assume that in the

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face of their child's apparent misbehavior, their child was *not* thinking. Nothing could be further from the truth. Children at every age are very cognitively active; they are constantly constructing vivid "theories" about their own behavior, different formulations consistent with their own immature level of development. They necessarily do so in the service of making meaning of their experiences [2].

During the preschool years, young children obstinately possess very clear "mini-theories", as it were, about their competencies and the many occurrences in their daily lives [3]. Be it their physical virtuosity ("I can run faster than my dad!") or monsters under their bed ("I'm sure because I hear them in the middle of the night"), their accounts provide a mix of fantasy and their own version of "fact" or "reality." At times, their stories can be quite endearing. However, they are not to be dismissed as mere humor or to be taken lightly, parents need to take their children's theories very seriously. Their perspective can also include descriptions of their *emotional* reactions to events in their lives. Often these involve fear, young children often feel genuinely scared. Rather than dismiss these thoughts and emotions as fanciful because they defy adult logic, we would do well to listen, to lend a supportive ear. Tammy, as it turned out, was extremely and legitimately scared.

THE EVOLVING CASE OF TAMMY

Her preschool teachers had recommended that the parents take Tammy to their pediatrician as soon as possible which the parents did. The doctor's first reaction was to prescribe a gentle laxative. Perhaps that would be an immediate, if only temporary, solution until further examination might reveal the cause of her avoidance of the bathroom. Tammy tried valiantly to resist the laxatives since they gave her diarrhea which was very distressing. However, the pediatrician could find no medical reason for her symptoms; constipation was not a common medical condition in childhood. Perhaps the problem was "psychological" but he offered no specific hypotheses given that his training did not include the psychological disorders of young children.

The pediatrician suggested to the parents that she be referred to the Yale Child Study Center, a highly recommended psychiatric clinic for children and families, where I was the Chief Psychologist at the time. I was asked to perform a psychological evaluation of Tammy. I first met with parents and teachers who were quite perplexed about Tammy's refusal to go to the bathroom. The teachers were experienced and generally quite perceptive. However, they could offer no obvious explanation for this isolated behavior. Tammy's behavior at school had been quite appropriate, she enjoyed the classroom activities and she played well with other children. Perhaps her refusal to use the bathroom was a manifestation of some deeper psychological problem but if so, "what"? And why?

As psychologists we are armed with a variety of tests and evaluative procedures [4]. We often begin with a standardized intelligence test in order to identify or to rule out any possible cognitive deficits. But in addition, in our armamentarium we have a variety of "projective tests" the most common of which are the Rorschach inkblot test and the Thematic Apperception Test where one tells their own stories to standardized pictures of people engaged in ambiguous activities or social interaction. However, in the case of Tammy, time was of the essence since constipation can be a serious and potentially life-threatening condition if not treated as soon as possible. At a first meeting with Tammy, it was obvious that she was a bright preschooler and I saw no need for an IQ exam. Nor did I feel that projective testing would be very fruitful; the tests were designed for adults and, at the time, clinicians had little experience in either administering them to children or in interpreting their meaning. Tammy was potentially very verbal, that was a positive sign. However, she could not really explain her unwillingness to use the bathroom, although she did admit to her refusal to do so. But then I did not expect a child of her age to have any direct understanding of the causes of this unusual behavior.

I felt that doll play might be revealing and our play rooms included a dollhouse fully equipped with all of the trappings of home. They also possessed a range of dolls which could be assigned a variety of roles. In observing the child's play, including dialogue that usually involves the adult clinician, it is hopeful that clues can be provided that may suggest reasons for the observed symptomatic behavior. In this case, I was also talking with the mother to determine if there was anything going on at home that might shed some light on her seemingly inexplicable behavior. I had noticed that the mother was quite pregnant.

The pregnancy was a new event in the life of this four year old, the first child in her family. Her mother, at the time, was eight-months pregnant with a boy and Tammy seemed quite excited about having a baby brother. The mother talked lovingly to Tammy about how the baby brother was currently in her mother's "tummy" but soon would be born. She encouraged her daughter to feel Mommy's tummy when the fetus started kicking, much to Tammy's delight. Wanting to be what she thought was a good, female role model, the mother also told her young daughter that "someday you may have a baby, too."

I spent concentrated sessions with Tammy in one of our clinic playrooms because time was critical, given the on-going constipation. I observed her dollhouse play behavior, where she first actively selected a girl doll and I chose one of the adult dolls and a boy doll. She had obviously engaged in doll-house play before, she had one at home and thus she began with relatively safe and mundane daily activities. Not at first, but I eventually tried to steer her play behavior toward the area of the dollhouse bathroom. However, this

produced play in which she had the child doll characters systematically avoid any attempts to go even near the bathroom. "They want to play outside" she insisted. While this was consistent with her actual behavior at school, her play gave few clues as to the causes of why.

In my own use of dollhouse play with children, I typically do two things, at first; I make interpretations about the child's *doll* behavior, *within the play*. It is only later that I make more direct interpretations about the child, herself, initially pointing out that she is a bit like the play doll, inviting the child to elaborate [4]. In this case, I had also taken the boy doll, asking Tammy to tell me what she wanted him to say and do although I took some control over the boy doll's behavior. Thus, after some time, during which I had observed certain patterns to the play, I would have my doll character point out that "...it seems to me that your girl doll really doesn't want to go near the bathroom, she would rather play outside. I am wondering why your girl doll doesn't want to use bathroom but that the boy doll is OK with the bathroom, what do you think?" Initially, this did not yield any productive comments from her; she simply said "...he thinks it's more fun to play outside." But then she added something that made me curious, she commented that "...and besides, he's a boy." So this suggested that in her thinking, gender played some role. Why wouldn't girls use the bathroom whereas this was no problem for boys? Frankly, I was pretty clueless, at this point in time.

Dollhouse play can often take an arduously long period of time to be productive. The child's defences carry over from their real life actions, in this case, avoidance of the bathroom. Plus, the direction that the play takes will in part depend upon the thoughtfulness of the hypotheses that the clinician holds with regard to the causes of the child's symptoms that are then spelled out in play. Novice child clinicians are sometimes eager to engage in dollhouse play with their child clients thinking it will be "fun". I tell my students that if you are having "fun" with dollhouse play, then you are not doing the hard "work" that is required! That is, our goal as child clinicians is to be constantly formulating hypotheses within the play and testing them out, observing the child client's reaction.

Where was I to go with the slim clue based on her comments about how the girl doll would avoid the bathroom but the boy doll would not be so concerned? Space and time do not permit me to describe the different hypotheses I attempted to put forth, within the play. Some were fruitless in that they did not advance the reasons for her avoidance of the bathroom. More progress was achieved when I had the boy *doll* enter the bathroom and say "See, nothing happened to me!" On this occasion, the girl doll, in Tammy's words, said with great agitation, "But you can't have a baby, you're a boy"! This had obviously struck a raw nerve for Tammy. Where did I go from here? What did having a baby have to do with being in the bathroom? I offered the general interpretation that I thought she was a little bit like the girl doll because *she too* was afraid to go into the bathroom but I could not advance a reason why. I had my adult doll ask her girl doll what would happen if she went into the bathroom, as I had my doll take her doll's hand and move toward the dreaded bathroom which the dolls observed but did not enter. At that point, quite unexpectedly, a major, although only partial, breakthrough occurred. She blurted out with emotion some of her personal four-year-old theory that I thought just might be related to her own bathroom behavior: "If I had a baby, I would burst in half, it would be too big! I'm really scared!" However, I did not yet understand the specific location for her obvious fear, notably why it occurred in the bathroom.

Moreover, her theory was incomplete. What did having a baby have to do with the bathroom and, more importantly, her constipation? My own interpretive wheels were churning as I tried to fill in the gaps of her thinking. From her perspective, I reasoned, she seemed to feel that a large baby might be growing in her own tummy, like her pregnant Mommy's. In point of fact, her stomach had become somewhat distended as a result of the constipation and she surely felt some different internal sensations such as fullness. I went back to the girl doll, asking "Does your doll think she is going to have a baby? " "Yes" she replied, "a *big baby*." Something prompted me to ask, "Is she going to have the baby sitting on the toilet?" "Yes", and she anxiously answered about herself, "...and it will break me in two, it will just be too big." And why, I had my doll ask, would she have the baby sitting on the toilet? She was choking back tears at this point but managed an interpretable reply: "Well, that's where babies get out of your stomach!"

She had come close to completing her own theory, at least enough for me to understand, if I had put the pieces together correctly. I surmised that her four-year-old logic took the only analogue to birth that she could imagine in her experience, namely, defecation. Something solid, coming out of your body as you sat on the toilet. But she was terrified because she knew the size of a baby in relation to the size of her own small body. She had every right to be terrified about how having a baby would literally tear her in two. But fortunately, in the short term, her body empathically responded by becoming constipated. This was the only way that her body could remarkably conspire with her mind and her emotions, in an attempt to prevent the dreaded outcome. This would explain why she never wanted to go potty again.

Yet there was more challenging work to be done. They key was to encourage her to change her very compelling and entrenched child theory. With further talk, eventually she accepted the fact that she was far too young to have a baby; her body would not be ready until she was much older. More importantly, with further explanation, she came to appreciate the fact that babies came out of a special place in her

mother's body, not where she herself had her bowel movements. We drew rather simple pictures that helped her to understand this fact. Soon thereafter, the constipation symptoms abated, as did her fears about giving birth, which had been based on the only theory that her four-year-old mind could construct. Tentatively, she was able, once again, to use the bathroom at school and at home. After a period during which she came to be further convinced that only her bowel movements passed through her body at her age, eventually her use of the bathroom was no longer a problem.

CONCLUSION

Two related observations are noteworthy. First, this case demonstrates the importance of appreciating the fact that children, beginning at a young age, automatically construct vivid theories about their behavior, consistent with their developmental level of understanding [1-3]. Even more importantly, these theories have a powerful impact upon children's actual behavior. Her own personal theory led directly to her constipation. This case clearly emphasizes the critical need for parents to encourage and be open to their children's theories of their own behavior, however immature they may appear on the surface.

Secondly, this article was entitled **Does this particular child need psychotherapy?** My own short answer would be "no". Professional intervention in the form of my clinical evaluation did appear to be helpful in allowing this child to come forth with her own theory of her symptoms that could then be addressed. But beyond that, this child was not in need of any extensive, therapeutic treatment. Her symptoms did not stem from any deep-seated pathology. Rather, this was an isolated problem that could be explained developmentally, by an age-appropriate theory that rested on a misunderstanding of bodily functions. With some effort, her misunderstanding was eventually amenable to correction. She was not, in my opinion, a candidate for longer term psychotherapy, per se. This is not to say that other children, with symptom stemming from a more serious history of pathology, cannot profit from therapy, many can and do. An evaluation, by a trained clinician, can aid in this decision and should be conducted, given a child's puzzling problem behaviors. Such an evaluation may or may not point to the need for therapy [4,5]. In the case of Tammy, fortunately no further intervention or therapy was indicated.

Post Script: Tammy and baby brother Lucas are doing just fine. She is a great big sister, which is the only role that for now she need be concerned about!

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