



Editorial

On therapist despair

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As part of my clinical duties with Brisbane North Child and Adolescent Mental Health Services (and like other psychiatrists in my service), I do a regular fortnightly videoconference (eCYMHS) to a rural area of Queensland. We have a very small full time resident staff of one clinical child and adolescent psychologist, and two part time Aboriginal health workers for an overall population of 30,000. There is an adult mental health team, with a full time psychiatrist who can provide some backup in emergencies, but in general our service has very limited capacity. We supplement the videoconference program with phone calls, emails and visits (although the best I personally can manage is a visit every 3-4 months). During the two days I usually see a number of current families or some new and/or urgent assessments, and provide some ongoing support and supervision. In the evening the 'team' and some other colleagues usually dine together, which allows ongoing clinical discussion, an improved understanding of local issues, and some strategic planning. On the second day we usually have a large-scale consultation with other services working with young people. I would like to share some of the cases from the most recent visit because there is something quite terrifying about their severity and complexity but, in addition, I think there are some important learnings that we need to consider in our quest to advance mental health in Australia.

The first child was a 7-year old boy who about three weeks before had tried to hang himself

with intent to die. Luckily he was discovered very quickly and transferred to the base hospital for immediate assessment, being discharged the next day with no obvious sequelae except the rope burns. He attended my interview with his grandmother and an aunt, having driven about 150 kilometres from his community. The precipitant appeared to be teasing by an older boy building up over some weeks, and this has now been dealt with successfully by the local school. The boy lives with his grandma and two younger siblings, another sibling living elsewhere with an aunt and her family. His natural mother seems to travel a great deal, and had been around with a new baby for some weeks, although she had moved on by the time of the most serious bullying incident, and was therefore not available to her son when he needed support. Grandma and another aunt with some professional training had been supportive, but had many other calls on their time.

During the interview, the boy sat quietly near me, personable, friendly, playing with some toys, but not offering comment. He did later on become animated and responsive during a shared drawing game that led to a symbolic intervention about confidence and self-esteem. Assessment suggested he is bright, managing his education and development well in the absence of the bullying; there were no current symptoms, no formal diagnosis, no immediate treatment, and very limited possibility for ongoing professional care. The best we could do was to ensure that the school issues were sorted, and that the family supports remain strong and vigilant.

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There are many issues here. How can the boy's self-esteem be maintained? Who will monitor his progress into the future? How can the boy be helped to reach his optimum? Do we review and, if so, when? How do we manage such a situation at a distance, with such limited capacity? But the key issue for me was the lack of primary attachment figures, leaving him vulnerable into the future, despite his kindly (but overwhelmed) grandma. Another issue for me was the general disappointment from the family and from professionals that I had not supplied a diagnosis, a label. There is no formal therapy, no quick fix, and no medication. Agreed, if we had the resources and could manage the distance, it might help to develop an ongoing relationship in which we could come to understand better how this very interesting and articulate boy thinks, and how we could help him to avoid such an impulsive gesture in the face of future challenge, and work on his relationships and the supports. But that is pie in the sky.

The second case had some similarities, if somewhat less drama. The parents reported they are increasingly troubled by their 7-year old son who has become angry, with some physical lashing out. All sorts of questions had been raised by the school, and others, as to whether he has ADHD or emerging conduct disorder, and whether medication would be helpful. Again, my assessment showed a boy of average ability, pleasant, polite, funny, easy to interact with, and with very few signs of any formal disorder. He did not seem to have any understanding of why he became so angry. The family context slowly emerged at my questioning, and was complex. Dad had been a binge drinker over many years and this was often accompanied by violence to his wife to the point where he had been convicted of domestic violence and stayed in gaol for six months some 18 months before. Somewhat reformed, he now worked hard for his family, had gained tolerance for complexity, had not been violent for the best part of a year, but claimed that Friday night was his to drink with his mates if he wanted to. His wife is Aboriginal, and over the last year or so had housed her extended family – which had become one focus of conflict. During the interview she said that this was just what you did, even if it led to overcrowding and conflict. She agreed that this

had been central to the marital discord, but explained that it was just about to change, and a date had at last been set. A further difficulty, central to the parenting, was that the father had ongoing doubts that he was in fact the father of the boy, and despite all evidence to the contrary, this had acted to alienate him from his son. This was a pivotal point in the interview, and the father became visibly upset and choked up. The boy moved over to hug him and eventually sat on his lap during a discussion of how his father parented him (poorly) and the importance of 'psychological parenting' and transmission of life skills. Our dad agreed (much to the delight of his son) that he could play a much clearer role in the parenting, would help his son to learn how to control anger and violence (given his expertise), and would seek out some shared 'mates' experiences. The mother looked alternately relieved and choked up herself, but both physically and emotionally appeared to move closer to her husband.

I am not sure what the long term outcome will be, but clearly we need for our psychologist (who played a part in the interview) to review and reinforce what was decided. This *is* possible given the family lives in town, and has agreed to follow up. Again, though, there are questions to be raised. Why this need (from all sorts of other services) for a label? And why does everyone leap to the idea that some sort of medication will be helpful? We seem to have lost our understanding of how young people develop psychologically, and how they respond to complex family dynamics, and the fact that they may not *be* the problem, but rather they are 'the symptom of the family problems'. Everyone wants what I call 'tick a box' child psychiatry – tick off the symptoms, make a quick diagnosis, based on how many criteria can be conjured up – however thinly they are described and however poorly corroborated by multiple sources. Then you can slap the kid on methylphenidate or resperidone, brush your hands, and move on the next case.

But then there is the other side of the story. Families seem to be under increasing pressures, but have not gained (or have lost) the ability to solve problems and keep their lives together and on track. Central to this again is the issue of

attachment; if the parents themselves have experienced limited attachment or shaky, anxious attachment (and can not get their own needs met), then they do not understand the need for (or perhaps do not have the capacity for) closeness, find it hard to focus on the child's developmental needs, and have no idea about the importance of shared mentalisation. It is striking how often there is a sense of relief when you begin to explore these issues, when you can draw parallels between how the parents were parented and how they are parenting, can gain agreement for the need for change, and then begin to discuss simple ways of managing the behaviours in a way that avoids repeated negativity, and the ongoing development of shame in the child. On this latter point, I have been re-reading a small, delightful and largely forgotten text by Haim Ginott (1965), *Between Parent and Child*. A delightful read, full of simple wisdoms to be shared with parents, this should be required reading for every professional dealing with children.

The third case was again very complex; a 12-year old girl with cerebral palsy and marked speech impediment who is at a special education centre and causing emotional and physical pain to the dedicated staff members. She had escalated her verbal abuse over the previous months, was well known to fight with other young people, and anyone else who tried to intervene. The staff were unsure they could contain her any longer, and begged for medication. I saw the mother and daughter together with our psychologist and then saw them with the two teachers. Once again no one had thought to explore the background family issues, which were severe. A single parent mother in a very depressed state, was struggling with our girl at home, but had four other children of her own at home. In addition she had her sister and *her* five children living with them. The whole system seemed overloaded, and Mum just had no time or emotional room for dealing with her daughter's problems, and no one else seemed to care. In the consulting room, after exploring some practical and financial options, as well as considering the mother's sister's options, we were able to (at least temporarily) re-engage Mum and daughter – with appropriate displays of affection. It seemed clear to all that the

(somewhat understandable) neglect had left the daughter feeling that no one cared, and so she acted out at school. An extensive examination of the management program at school discovered a range of behavioural options that the staff apparently had not tried and, for the time being, we have been able to avoid medication. The two staff members attended the second day professional discussions and seemed pleased with what they had gained and re-committed to the program of care. Again I was reminded of Haim Ginott's (1998) elegant and delightful book *Teacher and Child* – simple wisdom, without being simplistic.

Again there are the issues similar to those already discussed – the need for an additional label, and then medication, with little sense that family dynamics may play a role – and may be amenable to change. The rural issues, which I discussed in an AeJAMH editorial last year (Martin, 2007), in this case were lessened by having a service with dedicated staff available locally.

The last case was one I had originally assessed in Brisbane a month prior, and then referred on for extensive tests; a 4-year old girl with possible Autism. I say 'possible', because she has delays in several areas of development, and a marked expressive speech problem where she speaks in a very eloquent gobbledegook. However, she is friendly, plays well on her own and with her brother, makes good eye contact, and has few mannerisms. In this case we *have* to make a diagnosis; this child will need considerable help with education over her years of schooling, and the only way to get the extra resources from the Education Department is to provide a label – possibly 'pervasive developmental delay' would be sufficient.

There was something very different about this presentation compared to the others. This girl is the cutest little person, and everyone's heart melts when they see her. She has some engaging behaviours, and is rarely difficult or angry, though she can get cross if a routine is upset. But the engaging personality makes her very easy to like, and to want to help. The other issue is that her mother is absolutely bonded, has energy, personal resources and support in the home. The special kindergarten school has also engaged her

well and she finds their strategies helpful at home. Another point is that our client is fully attached to her mum. So, we have some hope for change. And finally, by chance, an excellent Brisbane service for Autism has an outreach to the country centre and is willing to provide ongoing and appropriate care after kindergarten.

When I review this set of experiences, I am struck by the sheer difficulty and complexity of the clinical problems, and the way in which living in a rural or remote situation can make life extra difficult – with the tyranny of distance, and the very limited capacity of local helping services. I am also struck by the difference that a caring, well-resourced, and child-focused family can make to either the outcome, or our sense of hope for the outcome. Central to this is the issue of attachment. When this does not exist for whatever reason, I feel despair. I felt despair for the young suicidal Aboriginal boy, cared for in an instrumental way, and with some love, but without that deep sense of knowing that he was cared about. Despite the small change visible in therapy, I despaired for the young boy with the Dad who was not committed because he wasn't sure of the paternity, and thought biological parenthood more important than psychological parenthood. Despite all of the resources provided to the young lady with cerebral palsy, with the quality of family emotional neglect, and despite the microscopic change in therapy, I despair for her future. There is a tide of poor parenting in Australia that is reaching proportions of a tsunami. I am not sure that we have been able to

get either State or Australian government to fully comprehend the devastation and the intergenerational legacy that will occur over the next generation if we cannot support families with children under 3 years to develop that close bond of caring attachment. All families and young people have challenges. Our job as therapists is to do our very best to help to set things back on track when overwhelming challenges occur. A 'tick a box' approach does not help – only a genuine therapeutic alliance and an attempt at deep understanding of the complexities can work. And if we don't spend the time to get it right, the need for resources will get greater, the demands for labels and spurious medication approaches will get louder, and service costs will skyrocket. Our job as Australians is to shout loudly about Social Exclusion, and the needs of an economy that is undermining good attachment, and sound family values. We must ensure that we provide the best opportunities for future Australians to gain the resilience they will need to overcome the adversities of a muddled and troubled world.

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