Types of psychiatric treatment: overview

Philip J Graham

The aim of this series is to provide paediatricians with information about therapeutic approaches used in departments of child and adolescent psychiatry. Such information can be seen not just as having general educational value. All paediatricians see a high proportion of children with behavioural and emotional disturbances. Only a small proportion are referred—many are not because the child psychiatric resources are inadequate, because parents are not motivated, or because the disturbances, although bothersome, are not serious enough. In all these cases the paediatrician may find it helpful to apply some of the ideas described in this series. This may sound like encouragement of dangerous dabbling. But paediatricians are inevitably forced into situations where they try and help families with disturbed children, and providing they proceed with caution, are appropriately self critical, and preferably have the opportunity to discuss what they are doing with a mental health professional from time to time, my observations suggest that they can indeed be extremely helpful.

Definitions

Psychiatric treatment covers all therapeutic approaches used for children with emotional and behavioural disturbances. Types of treatment can be divided into psychological therapies and physical therapies. Psychological therapies include those that primarily aim to uncover underlying conflicts, tensions, and drives of which the child and family members were previously unaware and which are thought to be the covert source of the problem. These insight promoting therapies are termed psychoanalytic if clearly derived from the work of early psychoanalysts, especially Sigmund and Anna Freud and Melanie Klein. The term psychoanalytic treatment is usually reserved for quite intensive (three to five times a week) individual treatment, and it is more likely to be termed psychotherapy or psychodynamic therapy if the underlying concepts are the same but treatment is provided on a less frequent basis. Psychological therapies are termed behavioural if they aim to alter what the child or family members do by methods that tackle the symptoms directly, or cognitive behavioural if they aim to produce behaviour change by altering patterns of thought. However psychological therapies can also be classified according to the unit (individual, family, group) to which the therapy is applied. Those engaged in family therapy may use psychodynamic or behavioural concepts or a mixture of the two. They may also use concepts special to family therapists. Thus ‘systems’ therapies are based on the notion that families can be viewed as homoeostatic entities—if you change one part of the system you change the rest. Physical therapies are less frequently used in children. They include medication, dietary approaches, and electroconvulsive therapy, the last of which is used either extremely rarely or not at all until late adolescence.

Child mental health professionals also provide indirect treatment through consultation without direct clinical contact. Consultation and liaison work is carried out especially with paediatricians, social workers, and teachers.

Finally, there is a variety of miscellaneous forms of psychiatric treatment which cannot readily be classified according to the above system. Hypnosis aims to allow the child greater control of his or her thoughts and behaviour through techniques employed while the child is in a state of altered awareness. ‘Holding therapy’, particularly used for children with autism, involves forcible physical contact to overcome the withdrawal such children show.

Not so long ago there was considerable antagonism between psychodynamic therapists and behaviour therapists. Psychodynamic therapists saw behaviourism as superficial tinkering that left the real problems untouched. Behaviourists saw psychodynamic therapists as misguidedly applying an unproved set of theories with little interest in or evidence for success. Such mutual dismissiveness has by no means totally disappeared, but there is distinctly more appreciation of the fact that different forms of treatment can be valuable in different circumstances. The indications and contraindications of different types of treatment will be discussed in later articles in this series.

Treatment settings and staff

There is a wide variety of settings in which psychiatric treatment is practised. Community child guidance clinics are now much more commonly termed child and family psychiatric clinics. Child and adolescent departments of child psychiatry may be sited in general hospitals or children’s hospitals. Inpatient units usually take either prepubertal children or adolescents, but a minority of larger units admit the entire age range. Some inpatient units also admit a proportion of day patients, and there is a relatively small number of child psychiatric day

Department of Child Psychiatry, Institute of Child Health, 30 Guilford Street, London WC1N 1EH

Correspondence to: Professor Graham.
centres exclusively given over to day patients. Many child mental health staff work in other settings, such as schools for children with emotional and behaviour disorders (EBD schools) and child development clinics. The professional staff working in any of these centres is likely to be multidisciplinary, and treatment may be delivered by any of the professionals involved. As well as child and adolescent psychiatrists who are medically trained, there are clinical psychologists, educational psychologists (nearly all with teaching experience) and, especially in London and the south east of England, but much less frequently elsewhere, there are analytically trained child psychotherapists. Although many local authority social workers remain in child and family psychiatric clinics and departments, some have been withdrawn and others are mainly taken up with work in child protection and have little or no time for therapy. Although child psychotherapists have a very specialised training in individual psychoanalytic techniques, they are increasingly becoming involved in liaison work and sometimes family therapy. Child psychiatrists and clinical psychologists are likely to be able to apply a range of therapeutic techniques, including most of those described above. In addition, child psychiatric nurses, although most likely to work in inpatient units or day centres, are now increasingly exercising their skills in the community.

Is child psychiatric treatment effective? This is nearly, but perhaps not quite as naive a question as 'Is paediatric treatment effective?' Although there is an increasing number of studies evaluating effectiveness, recently well summarised for individual psychotherapy, for family therapy, for behaviour modification, and for medication, the indications and contraindications for particular forms of treatment are still sometimes uncertain. There is however good evidence that certain forms of treatment are more suitable for certain conditions than others, as the ensuing articles in this series will reveal.

It must be admitted that some practitioners still enthusiastically apply the same form of treatment to virtually all children and families they see, and this is undesirable. For example, the application of individual psychotherapy to the treatment of autism or medication in the treatment of conduct disorders can be seriously questioned on the basis of existing evidence. Such relatively absolute contraindications can be matched by relatively absolute indications for certain types of treatment. For example, the uses of medication in the severer forms of the hyperkinetic and Tourette's syndrome, of a mixture of individual and family psychotherapy in anorexia nervosa, and of behavioural treatment in nocturnal enuresis and monosymptomatic phobias are well established. However for a variety of other common disorders such as anxiety and depressive states, and conduct disorders, it is likely that non-specific factors such as the enthusiasm of the therapist or therapeutic team are of greater importance than the specific type of treatment employed. Paediatricians in training who find themselves working with psychiatrists and psychologists with different therapeutic orientations may be confused, but should find that they can learn a great deal of value from observing the application of different approaches to similar problems.

As the classification systems employed in child psychiatry become more refined, it is likely that there will be increasing precision in our application of particular types of treatment. In the meantime, it would be highly desirable for evaluative studies to include not only scientifically valid controlled trials, but also measures of consumer satisfaction. With increasing dependence on their 'customers', among whom they must certainly count paediatricians, child mental health professionals will be increasingly sensitive to what their clients think of their interventions.

Indications for referral
Referral to a child psychiatrist or a child mental health service is not really a problematic issue for paediatricians who work closely with their psychiatric colleagues, see them at regular weekly psychosocial meetings and, at least occasionally, at lunch, and who have the opportunity to see which children and families seem to benefit and which do not. For those with less close contacts, some guidelines may be helpful. Children who are functionally significantly disabled by persistent problems that either have no organic basis or an insufficient organic explanation need referral, and the earlier they are referred the better. Some paediatricians have found it helpful to use a screening questionnaire routinely to identify children at risk for psychosocial problems. When from the outset, it is clear that children who present with difficult diagnostic problems probably have a non-organic explanation for symptoms, they should be referred early on, preferably while the investigatory stage is under way, so that when all investigations are proved negative, the child psychiatric department is not seen as a last resort or 'dustbin' department, but the child psychiatrist is seen as someone who has been involved from the start. In the occasional child who turns out to have a rare abdominal tumour or degenerative brain disorder to explain abdominal pains or headaches, the early involvement of a psychiatrist need not antagonise parents if it has been made clear at the outset that the diagnostic process may indeed reveal an organic cause for symptoms. Problematic child protection cases would also benefit from discussion with a psychiatrist, though in many cases direct clinical psychiatric contact will not be indicated.

Of course, probably only a minority of paediatricians are able to refer to psychiatrists as much as they would wish. Paediatricians who press energetically for an increase in their psychiatric service will usually obtain a better service within a reasonable period of time. One hopeful sign for the future is the gradual emergence of a stronger clinical child psychology service, sometimes, as occurs more frequently
in the US, working in close partnership with paediatricians. This will not only be increasingly helpful to paediatricians, but will allow child psychiatrists to concentrate more on hospital and community health work for which their medical training has specifically equipped them.

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