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TYPES OF PSYCHIATRIC TREATMENT

Individual psychotherapy

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This is the second of a series of articles on treatment of child psychiatric disorders.

Definition

Individual psychodynamic psychotherapy involves one to one treatment using verbal and play techniques. The treatment is based on working with the patient in the here and now—that is, on the relationship that develops between the patient and the therapist. Links are constantly made from this to past experiences and current external relationships. The patient is understood in terms of developmental pathways, unconscious process, defence mechanisms, and attachments.[1–4]

Which patients will benefit?

Individual psychotherapy can be used with children from about 18 months to 2 years of age and across the age range up to 21 years. Parent-child psychotherapy is used before 18 months with the therapist working with the parent and the child or with the child with the help of the parent.

One of the features of individual treatment is to try and provide a consistent regular reliable setting for the treatment. This means wherever possible making the treatment sessions on the same day at the same time in the same room and with the same play equipment and toys available. This may be in a child and family mental health clinic or in a department of child psychiatry or department of psychological medicine. Children can also be seen at school if a room can be made available, whether primary, secondary, or a special school. Children and young people can also be seen in hospital on a paediatric ward, a child psychiatry ward, an adolescent unit, or a day unit. The child or young person does need some privacy and if at all possible some physical space without too many intrusions such as telephone calls or people in and out.

Play materials provided vary with age and preschool children generally have crayons, paper, plasticine, plastic small farm and wild animals, simple plastic figures, cars, and pipe cleaner dolls. Primary schoolchildren are more inclined to use paper, scissors, glue, felt tip pens, cars, a ball, and string as well as plasticine, the animals, and figures. Secondary schoolchildren may prefer to talk, although many of them like to draw or write.

Which children and young people can benefit?

Children and young people can become distressed, confused, and depressed by life's adversities. Some of them may have particularly difficult circumstances and some may be vulnerable children. If a child or young person becomes stuck and unable to resolve the difficulties with the help of the usual resources—parents, teachers, family friends, their general practitioner, or a counsellor in school—they may benefit from treatment. Other children and young people may be much more floridly troubled with very worrying or disturbed behaviour dangerous to themselves or others. Very disturbed children with psychotic features can respond well to treatment, children with developmental delay can also improve considerably. I would like to suggest nine categories of problems where individual psychotherapy should be considered.[5]

(1) Family breakdown and reconstituted families. Some children may be caught between warring parents or in a very difficult new family situation. Individual treatment perhaps with family therapy can help the child sort out their own feelings and reactions to the emotional turmoil.[6]

(2) Life events such as bereavement loss of a parent or a sibling, physical or mental handicap in a sibling, or suicide of a parent or sibling can leave many children and young people confused and bewildered and they can benefit from individual treatment.[7 8]

(3) A child or young person with chronic physical or mental handicap may have serious emotional difficulties and conflicts that can prevent them from being able to use what mental or physical capacities they do have. Individual treatment can liberate them to enable them to develop in ways that they can and to enable them to find some satisfaction in the relationships they can develop. Adolescents may need particular help with their sexual feelings, needs, and wishes.[9 10]

(4) Paediatric liaison. Children and young people with acute or chronic conditions on the hospital ward may not be able to maximise their use of the skilled care they receive because of emotional difficulties and distress. Individual treatment can help them make sense of their experiences and their feelings so that they can respond more positively to those around, staff, and parents.[11]

(5) Many children who have been abused have emotional sequelae. Emotional abuse can profoundly traumatise the child. Physical abuse, neglect, and sexual abuse usually involve considerable emotional abuse. The child's sense of self, self esteem, awareness of boundaries, ability to think their own thoughts, have their own feelings, own their own bodies, have all been attacked. Some of these children need individual treatment urgently. Other abused children, once in a safe place, want to settle into

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a normal life and do not want at this time to talk about the abuse. Many of these children need help later, for example a sexually abused 7 year old girl may become very troubled at puberty, when she has a boyfriend, or when she marries or becomes pregnant and has the baby. She may need individual treatment at any or all of these transitions.[12–15]

(6) Children and young people with psychosomatic conditions where there may be emotional factors such as asthma, diabetes, or eczema can benefit from psychotherapy. There are also children and young people with quite severe problems such as abdominal pain to non-organic paralyses who have frequent hospital admissions and who can have considerable improvement with treatment.[16 17]

(7) Developmental delay can be generalised or specific. Children with overall delay often have emotional difficulties with autistic or psychotic features. Individual psychotherapy for these children is very specialised and the technique has needed modification, but some children can be helped to move forward.

Children with specific delays, language or numeracy delay, may have emotional factors which can be released. Children who are enuretic or encopretic can benefit, although many of them are difficult to help.[18–21]

(8) Children in transition in foster families or in adoptive families often have had very difficult experiences and are unable to use the new relationships because of the emotional pain, rage, and hurt confusion locked inside them. Individual psychotherapy can enable them to be freed up to engage appropriately with their new carers and can help avoid frequent breakdown of placements.[22 23]

(9) Adolescents have particular transitions and emotional turmoils. Becuase they are so volatile and fluctuating they can often make good use of a small number of sessions to make sense of their distress or confusion. Overdoses, anorexia nervosa, substance abuse, teenage pregnancy, leaving home, and moving to work or further education, can all lead to unresolvable difficulties. Some of the young people may respond to individual treatment but unlike young children they need to consent and bring themselves so the number taking advantage of this treatment is limited.[24 25]

Type of treatment

Individual psychotherapy is available from child and adolescent psychotherapists and child and adolescent psychiatrists if they have specialised in this therapeutic method. Child psychotherapists are generally psychologists, social workers, or teachers who have undertaken a postgraduate training.

Educational therapists are teachers who have undertaken further training in applying this treatment in the school setting with children with learning difficulties. Play therapists, nurses, and occupational therapists use some of the skills either with regular supervision by a therapist or after a postqualification course in therapeutic communication with children.

Treatment can be brief, for example five sessions offered to an adolsecent, or focused to work on a particular problem such as a bereavement or an inpatient admission. It can vary in frequency: generally it is once a week but for a very small number of children or adolescents who are very troubled it can be twice or three times a week. Very rarely indeed a child might be seen four or five times a week. Treatment may be time limited or may be open ended and reviewed at regular intervals and decisions on how to proceed then agreed.

Treatment is terminated when the child or young person ceases to be preoccupied with their conflicts or difficulties and better able to fulfil their potential and establish satisfying relationships. Improvement can continue for up to two years after treatment so the precise moment when to stop is still a matter of clinical judgment. Young people often vote with their feet and they decide when treatment will cease. Young children stop coming because the carer finds regular attendance difficult or continue coming for too long because the parents long to have their child 'transformed'. The work then has to shift into helping parents accept their child's condition. For treatment to be sustained most carers need regular contact with a worker to feel part of and involved in the treatment and to share their concerns. Children and adolescents recover more quickly and in general it is consolidated faster if the carers are actively involved with a worker exploring their part in the interactional problems and to help them think about how they can facilitate their child.

Prognosis

It used to be thought that children 'grow out' of emotional difficulties even if conduct disorders were predictors of problems in adult life. It is now recognised that children and young people with emotional disorders or mixed emotional and conduct disorders go on to have emotional and relationship problems in adult life. Therapeutic interventions can change this.[26]

Children and young people are generally resilient, many of them cope and can use resources available, for example a telephone help line, a professional, a teacher, their general practitioner or someone in the family, extended family, a friend, or a neighbour. But many pay a price in later life, children in divorcing families are more likely to divorce themselves, sexually abused children have relationship difficulties and mental health problems. Children unable to learn because of emotional problems do not achieve and can have frustrated and unsatisfying lives. It is not always the life events that are obvious which cause the problem, but whether the child has internal emotional strength, had good enough parenting, that is whether the current difficulty comes on top of pre-existing vulnerability. It does seem increasingly clear that without help troubled children become troubled adults in dysfunctional families. Of course, if a child is subject to a particular stress or a disaster then this may adversely affect the most robust of children and leave them with a post-traumatic stress disorder.[27]

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Evidence that treatment is beneficial

Outcome studies are sparse and more are currently being undertaken. Previous studies tended to be global and now that projects are looking at which treatment for which problem with which child and which therapist, the benefits are emerging, showing that therapeutic interventions do bring immediate and long term benefits.[28–30]

Can it be practised by paediatricians?

Many paediatricians are very effectively communicating with children about their feelings. Winnicott in his therapeutic consultations with children showed how effective these contacts can be.[31] Some paediatricians undertake a course on therapeutic communication with children, but to provide regular treatment for some of the very troubled children would not make sense. A non-medical therapist would more appropriately provide this intervention linking with the child and adolescent psychiatrist.

Specialised training is needed

Individual psychotherapy requires assessment skills and communication skills. But it also requires enormous reserves of understanding, compassion, firmness, resilience, humour, courage, perseverance, and awareness of oneself and one's own competence, authority, and appropriate professional behaviour. To achieve this a very thorough in depth training is required.

When children and young people expose themselves to the therapist they can be very vulnerable, their feelings and their pain make them easily open to exploitation, and a therapist who lacks personal awareness may all too easily use the child or young person to meet their own emotional needs. An essential aspect of any training is that therapists must be aware of their own experiences and how their own lives have affected them, so that they know when they might respond appropriately.

Inappropriate treatment

If a child or young person has a particular external reality—moving to another area, transferring to boarding school, about to take GCSE exams—it is not appropriate to embark on an intense piece of work. Opening up very painful, distressing areas when there is no time to work them through or when the child or young person must go outside and function can be damaging. A therapeutic consultation would be the right way to proceed in such a situation.

There are also dangers if therapists find themselves out of their depth and unable to cope with a child's rage, pain, distress, or desperate need for affection. The therapist needs to be very clear about what is treatment and what is parenting to avoid behaving inappropriately. Suicidal young people or children experiencing abuse all need to be placed somewhere safe and be adequately parented or cared for; therapy can never replace parenting or provide monitoring. In cases that involve physical illness, acute or chronic, it is important to work with the general practitioner or paediatrician.

Services across the UK

Skilled individual psychotherapy was restricted to the four Thames regions. However, in the last 10 years there have been attempts to move out of London and there has been a blossoming of interest around the country. Training centres now exist in Edinburgh, Leeds, and Birmingham and courses are run in Bristol, Cardiff, Manchester, Liverpool, Newcastle, Oxford, and Cambridge. Trainees are also travelling from other cities to centres so that there are more services available. However, there is still a long way to develop before it will be possible for there to be adequate cover of even one centre per region. Child and adolescent psychotherapists and child and adolescent psychiatrists with a special interest are committed to developing this specialty.[32]

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Chinese paralytic syndrome

Diseases which appear to be confined to a single country are important not only because of their significance within that country but also because they often pose tantalising questions about basic mechanisms of pathogenesis relevant to all countries (think of kuru). Every year in the summer months in northern China there occurs an outbreak of a Guillain-Barré-like syndrome which affects mainly children but also some young adults. At the Beijing Children's Hospital the neurology service occupies one ward but every summer it overflows into two or three wards. More than a thousand cases have been described in the last 12 years. In just two weeks in August 1990, 36 cases were identified in two centres, Beijing and Hebei, and they were studied with the help of neurologists from Johns Hopkins Hospital. The findings have been reported in the *Lancet* (Guy M McKhann and colleagues, 1991;**338**:593–7).

All patients were from northern China and over 90% were from rural areas. Their ages ranged from 15 months to 37 years with a median age of 7 years. All had been vaccinated previously against poliomyelitis. Almost half described a prodromal illness within four weeks of the start of the neurological illness. At the onset of paralysis they were afebrile. Weakness began in the legs and was symmetrical and ascending to affect upper limbs, swallowing, and breathing. Thirty percent needed respiratory assistance. Maximum paralysis occurred usually after about six days and recovery began on average at about 16 days. Marked weakness of the flexor muscles of the neck with resistance to passive neck flexion was characteristic. Sensory loss was not a feature and neither was muscle tenderness or pain but there was often pain in the neck and back. There was no pleocytosis but protein in the cerebrospinal fluid was raised (above 0·45 g/l) in 15 of 26 samples. Electrophysiological studies showed normal sensory action potentials and motor nerve conduction velocities but reduced compound muscle action potentials and denervation potentials in the five patients who had electromyography done. The site of the disease process is uncertain. The authors interpret their electrophysiological findings as indicating dysfunction at either distal motor nerve terminals or anterior horn cells but point to the raised cerebrospinal fluid protein as suggesting disease at the proximal parts of the motor nerves or at the anterior horn cells.

The main differences between this disease and Guillain-Barré syndrome are its seasonal predilection and epidemicity, its occurrence predominantly in rural areas, the absence of sensory loss or of neurophysiological disturbance in sensory nerves, and the absence of electrodiagnostic evidence of a demyelinating neuropathy. The disease lacks many of the clinical features of poliomyelitis, all the children had been immunised against that disease, and poliovirus has not been recovered from their stools.

So it's not Guillain-Barré syndrome and it's not polio. What is it? So far no infective or toxic cause has been found though neither can be excluded. A poliomyelitis-like illness with fever and haemorrhagic conjunctivitis has been described in children in India and linked with enterovirus 70. It's not that. Something similar to the Chinese syndrome was described in Mexican children in 1969 but whether it was the same is uncertain.

So it remains an unsolved medical detective story even after the Hercule Poirots of Johns Hopkins have been called in. Fortunately the prognosis seems quite good on the whole, although a 3 to 5% mortality is quoted.

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