





with children in mind

how child psychotherapy
contributes to services for
children and young people



The Child Psychotherapy Trust

*is dedicated to improving the lives of emotionally
damaged children by increasing their access to
effective child and adolescent psychotherapy services*

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1 introduction

It is often assumed that the difficulties children have are just a part of growing up and will pass. Sometimes, we do not recognise the depth of children's emotional pain. There is now substantial evidence of high levels of emotional distress and mental health problems amongst children and young people which may persist into adult life.



We cannot afford to ignore the emotional distress of children and young people. The importance of early help in promoting the psychological health and well being of children and young people is recognised by the Government in setting up the Social Exclusion Unit and in the Green Paper *Our Healthier Nation*.¹ Child psychotherapists help some of the most severely disturbed children who may have been traumatised by abuse, family breakdown or other problems. They also support and advise professionals who work with them – in primary care, education, social services, health services and the youth justice system.

This booklet provides an introduction to the principles of child psychotherapy and the way child psychotherapists work.

2 what child psychotherapists do

Mental health problems have many different causes. Disturbed and abused children may need help from several agencies, each of which may help with particular problems – whether emotional or physical and whether at home or at school. Therefore, services need to be child-centred with all professionals and agencies working closely together. Child psychotherapists are most effective when they provide a specialist service as part of a multi-disciplinary team. The contribution of child psychotherapists complements that of other professionals, but is distinctive.

- c Child psychotherapy is child-centred and attempts to understand the world as seen by the child – which is essential to help more severely disturbed children.
- c As well as language, child psychotherapy uses other ways of making contact with children and so can help children with communication difficulties and even those with severe learning difficulties. Therapists learn to be very sensitive to non-verbal clues and messages that are hidden in actions and play in order to make sense of what the child is trying to communicate.
- c Child psychotherapists have intensive training and experience in working with severely distressed or disturbed children.

Child psychotherapists provide consultation, support and advice to other professionals working with disturbed children and young people and their families.

Child psychotherapists also treat individual children with a wide variety of difficulties and disorders, ranging from problems arising from family breakdown, abuse, developmental and behavioural problems, bed wetting, refusal to go to school, eating or sleeping difficulties, autism and anorexia nervosa. Referrals come from GPs, teachers, social workers, paediatricians, from parents directly and from adolescents themselves. About a third of the referrals to child psychotherapists are made because other interventions have failed.

How child psychotherapists spend their time is summarised in Table 1.

TABLE 1 Work undertaken by child psychotherapists²

Type of work	% of time
Therapeutic work	43
Supervision and teaching	18
Assessment	13
Consultation to other professionals	12
Management	10
Other	4
	100

3 how child psychotherapists work

In order to help children, we need to understand how they perceive people and things around them. Psychoanalytic treatment can help children make sense of things that they do not understand, such as family breakdown, bereavement, fostering, child abuse or physical illness. Refugee children and children who have been victims of torture or victims of natural disasters can benefit from intensive psychotherapy. This can help children come to terms with their experiences, reduce their distress and help them change the way they act.

The child psychotherapist is concerned with understanding the inner world of the child. Child psychotherapy is based on psychoanalytic assumptions some of which are outlined below.³

- 1 *The events occurring in our early years affect the way we view the world throughout life.* This goes back to the way that our parents relate to us and how we in turn relate to our children. Figure 1 (see page 4) outlines some of the factors that may help or hinder the development of a child's mental health.⁴
- 2 *Children communicate with their parents and others through their behaviour.* The psychoanalytic approach explores the meaning of a child's behaviour and what children are trying to communicate about their thoughts and feelings.
- 3 *The 'unconscious' hopes, fears and wishes of children affect how they behave.* The child changes through the relationship he or she makes with the therapist on to whom he or she transfers the attitudes and feelings that impair relationships outside therapy.

FIGURE 1 Some factors that affect children's development and mental health⁵

	<i>Plus</i>	<i>Minus</i>
Conception	<ul style="list-style-type: none"> • Parents are healthy and secure and want a baby • Inherited intelligence 	<ul style="list-style-type: none"> • Parent(s) are insecure, living in poverty, chronic illness, drug abuse, violence, discord, do not want baby • Genetic disorder or loading
Pregnancy	<ul style="list-style-type: none"> • Pregnancy is uneventful (with no losses or disruptions) 	<ul style="list-style-type: none"> • Mother is ill during pregnancy • Parent(s) are unsupported • Parent(s) are homeless
Birth	<ul style="list-style-type: none"> • Full term, normal delivery 	<ul style="list-style-type: none"> • Born early, illness, brain damage, etc
Infancy	<ul style="list-style-type: none"> • Parent(s)/care givers are supported 	<ul style="list-style-type: none"> • Care-giver depressed or out of touch • Child has sleep and eating problems
Early years	<ul style="list-style-type: none"> • Child is confident and supported • Parent(s) have secure attachments 	<ul style="list-style-type: none"> • Child is neglected or abused • Child is insecure • Parent(s) have insecure attachments • There is family discord
Middle years	<ul style="list-style-type: none"> • Child makes good friendships • Child makes progress in learning 	<ul style="list-style-type: none"> • Child anxious or disruptive, falling behind at school, few friends. • Parent(s) are jobless
Adolescence	<ul style="list-style-type: none"> • Adolescent makes new friendships • Parent(s) are firm and tolerant 	<ul style="list-style-type: none"> • Adolescent gets into 'bad company' (perhaps self harm and delinquency) • Parent(s) are at a loss

The process of child psychotherapy

When a child is referred, the psychotherapist carries out an assessment of the child over about three sessions. This enables the therapist to understand the child's difficulties and gives the child experience of what therapy involves so that he or she can see if this will help. Individual treatment will vary. Some, particularly for adolescents and young people, may have a few sessions each lasting just under one hour. Children with severe problems may have regular sessions extending over one or two years. A study found that 59% of individual psychotherapy treatments were completed within 18 months and 76% within two years.⁶

It is important that sessions are regular. When they work with individual children, child psychotherapists have a continuing relationship with the child which is important to a child who may have experienced broken relationships, long periods of difficulty, distress or abuse. By acting out their feelings through the relationship with the therapist, children are able to understand their feelings and change their behaviour. While in therapy they may become upset or angry as they realise for the first time the extent of the loss or abuse they have experienced.



For young children, and even older children, it is mostly by playing rather than by talking that they are able to express their feeling about their experiences. Play is a crucial part of normal child development and is the way that a child learns and solves problems. Through play children can describe or enact painful emotions or situations. It is possible to work in this way with children with learning difficulties, even without speech, and help them cope and adjust to their disabilities. Each child has his or her own simple play materials. The materials, depending on the child's age, may include small figures of wild and domestic animals, fences, papers, crayons, scissors and glue, string, cars and trucks and bricks and building materials.

Therapy sessions will normally be separate from parents and carers so that the child can explore painful or hostile feelings without fearing that others will find out and react. Child psychotherapists usually meet with parents or carers each school term to share developments and concerns. This can be done without breaking the child's confidence. It may be important to address the needs of the family as a whole and for another worker to help the child's parents or foster parents. Where a child with difficulties is under five a limited number of sessions with the parents and child together can help the relationship.

4 where child psychotherapists work

Child psychotherapists are mostly employed in the NHS as part of child and family mental health services. They may be based in child and family treatment centres, child health clinics, special schools or young people's consultation centres. While child psychotherapists are mainly based in child and adolescent mental health teams, they also work in specialist mental health services, with educational psychologists, child and family social workers and family therapists providing psychotherapy for children with severe problems, such as eating disorders.⁷

Child psychotherapists' skills complement those of other professionals working with children, young people and their families. They can offer sessions in many settings and work with many professionals working with children and families. These are summarised in Figure 2 on page 6.

Primary care

- Behaviour disorders are the third most common reason that children are brought to see their GP.
- 3% of all children under 16 have a disability. Behavioural disabilities are the most common form of disability.
- Almost one in four children who were born in 1979 are estimated to have been affected by divorce by the time they were 16. In England and

Wales just over 160,000 children aged under 16 experienced divorce in their family in 1995.

- 4.2 million children live below the poverty line.⁸

It is very important that help is offered to children, young people and their families as early as possible when problems are beginning to develop. This is because interventions are more likely to be successful if help is offered before problems are entrenched. Primary care staff have an important role as they can provide services that parents and young people do not see as stigmatising. The general practice is the first place that many families with children and young people go for help.⁹

Child psychotherapists may be based in the surgery on a part time basis where they work with primary health care colleagues to:

- help the team develop awareness and skills in identifying problems in families at an early stage.
- support GPs in the assessment and treatment of children and young people with psychological problems.
- help health visitors develop their skills in relating to children and their families. By providing parents with support and practical help they develop better ways of dealing with their child's difficult behaviour.

The Child Psychotherapy Trust has produced a series of advice leaflets for both parents and front-line staff on coping with common problems, such as sleeping problems, tantrums and aggressive behaviour.

Some mothers need more intensive help than most health visitors or other front-line staff can provide. Some difficulties within families can be resolved in a few sessions with a child psychotherapist and this may prevent more serious problems developing. Some services, including the Tavistock Clinic and Anna Freud Centre in London, provide an infant

Primary care – case study

When Anna was three years old, her baby brother was born and her mother, Mrs W, started to worry about her. When Anna threw a tantrum she attacked herself by violently banging her head and scratching her arms and legs. She wanted help for Anna, but, as she told her GP: *'Nothing to do with psychiatry'*. Fortunately her GP was able to recommend an appointment with the child therapist, Ms B, who worked at the GP practice one afternoon each week. Mrs W was reassured that she would not have to be referred to another clinic. She was glad to accept an appointment to come with her family to meet Ms B.

During the meeting both parents shared their concerns about Anna and her jealousy of the baby. Anna said spontaneously *'I hate*

punishment'. Her parents described how when Anna was naughty, they shut her out in the hall where she would start to attack herself. Anna also expressed the fear that her parents would leave her in the hall when they moved house and Mr and Mrs W were concerned to recognise how insecure Anna must be feeling now that they had another child. After they went home the parents decided to punish Anna in future by holding her until the tantrum was over. Next time they came to see Ms B both Anna and her parents were happy that they had found a way of preventing Anna from hurting herself while showing her that she was wanted even if she was naughty. Meeting with Ms B had enabled the family to reflect on themselves and had facilitated a major change in the daily climate of family life.

FIGURE 2 Settings where child psychotherapists work

<i>Service and professionals</i>	<i>Work with</i>	<i>What child psychotherapists offer</i>
Child and adolescent mental health	<ul style="list-style-type: none"> • Child and adolescent psychiatrists • Clinical child psychologists • Community child psychiatric nurses 	<ul style="list-style-type: none"> • Assessment of individual children and young people • Brief psychotherapy for children and young people • Long-term psychotherapy for children and young people • Group work with children and young people • Supervision, advice and support to other professionals working with children • Work with parents and extended families
Primary health care teams	<ul style="list-style-type: none"> • GPs • Health visitors • Children's community nurses 	<ul style="list-style-type: none"> • Develop team skills in identifying problems early • Support GPs in the assessment and treatment of children and young people • Train health visitors to support mothers on child care • Brief psychotherapy with children and young people in the practice
Children's health services	<ul style="list-style-type: none"> • Intensive care • Oncology • Paediatric endocrinology • Orthopaedics • Burns units 	<ul style="list-style-type: none"> • Brief therapy with sick or dying children • Support for staff • Support for parents and siblings • Support for children with long term illnesses
Local authority social services	<ul style="list-style-type: none"> • Social workers • Child care workers • Fosters carers • Residential workers • Youth workers 	<p>For social workers, staff in residential homes and foster carers:</p> <ul style="list-style-type: none"> • Develop skills in identifying early problems (eg signs of abuse) • Support and supervision for staff on management of individual children • Assist in assessment of child protection cases • Psychotherapy for individual looked after children as part of a care package
Voluntary organisations	<ul style="list-style-type: none"> • Child care workers • Social workers • Youth workers 	<ul style="list-style-type: none"> • Develop team skills in identifying early problems in families • Support and supervision for staff • Training for staff • Direct access for young people in youth consultation centres
Education	<ul style="list-style-type: none"> • Teachers • Specialist teachers/educational therapists • Educational psychologists • School counsellors • Youth workers 	<ul style="list-style-type: none"> • Support and training for school counsellors • Support and supervision for teachers and special educational needs co-ordinators • Regular work with special schools • Work with children excluded from school
Youth justice	<ul style="list-style-type: none"> • Probation officers • Social workers • Youth justice workers 	<ul style="list-style-type: none"> • Advice on distinguishing between children who will 'grow out' of delinquency and those who need psychotherapeutic intervention • Intensive psychotherapy for some offenders • Advice and consultation to youth justice workers, residential care staff and probation officers in thinking about and managing the risks to children and young people

mental health service run by child psychotherapists, where the child and parents can be seen for up to five sessions at short notice. Courses for health visitors on therapeutic approaches to parents and infants have also been run by the Tavistock Clinic in London.

Local authority social services

- In 1996 there were 32,352 children on child protection registers in England, 8% were aged one to four and 30% aged five to nine.
- In 1996 there were 51,200 children and young people looked after by social services department in England. The average age of these children was 10 years, 11 months and the average length of time that children were looked after was 500 days.
- 65% of children who are looked after by local authorities are in foster placements.
- An in-depth study found that four in five children aged 6 to 16, who had disclosed that they had been abused 2 to 4 years ago, had found therapy helpful.
- More than 75% of care leavers have no educational qualifications.

- At least one in seven young women leaving care is pregnant or is already a mother.
- Studies have found that between a quarter and a third of young homeless people have been in care.¹⁰

Many of the children who are referred to child psychotherapists have been or are in residential or foster care or have been adopted. Children looked after by social services have often been victims of neglect, abuse or trauma. They need specialist help to come to terms with the experiences that have led to the local authority looking after them. Without support these children may have difficulties in school and problems in settling into home life. These difficulties, unless treated, will persist into adult life. Child psychotherapy can help children settle better with foster or adoptive families and lessen the likelihood that placements will fail.¹¹

In addition to individual psychotherapy, child psychotherapists offer support and consultation to staff looking after children. The stress of working closely with troubled children and young people is very great. For example, staff, who work in family centres and day care for families where children

Local authority social services – case study

Shaun's father had left home shortly after Shaun was born. His mother suffered from mental health problems which meant that her moods were unpredictable. Although she was capable of being affectionate and caring to Shaun she could also become violent, and on occasions had been physically abusive and sworn at him. Social services had tried to support Shaun at home but it had become increasingly clear that Shaun's mother was dangerous to him on a physical and emotional level. When he was aged five, he was placed in short term foster care with a view to a long term placement being found where he could live permanently and still retain some contact with his birth mother.

Shaun soon had to be moved from this first placement as he was very destructive to the possessions of the foster carers and attacked the carers themselves and their children. After Shaun had been moved to a second foster carer, similar behaviour began to occur and the social worker approached the local child and adolescent mental health service hoping psychotherapy could help.

Even though Shaun was in a temporary placement when she met him, the child psychotherapist felt that he could benefit from thinking about his experience of having lived with an ill mother and his current situation of being in transit.

During Shaun's sessions he would constantly re-arrange the furniture in the room leaving his

therapist with a feeling of disorientation about how different her room looked every time Shaun was in it. She was able to talk to Shaun about how he was showing her how he felt the world he was living in was uncertain and unstable and linked this to his experience of having moved twice already and continuing to feel uncertain about how he would end up. As she got to know Shaun better, his psychotherapist was also able to link Shaun's sense that things change unpredictably and his feelings about having lived with a mother who could suddenly change moods.

The child psychotherapist felt it was important, in this case, to meet regularly with the other professionals who worked with Shaun to help them think clearly about the issues Shaun was struggling with and to work out what type of permanent placement would suit him.

After a year and a half of psychotherapy, Shaun's destructive and aggressive behaviour had diminished considerably and this happily coincided with an adoptive placement being found. This meant Shaun moved away and consequently his therapy ended. Shaun's psychotherapist felt that, even though ideally there needed to be more time to work on the difficulties that remained, this period of psychotherapy did allow Shaun to settle in family life and opened the way to a permanent placement for him.

may be at risk, may need advice and to talk over problems with someone outside the organisation who has specialist knowledge of the complex dilemmas and feelings aroused in the work. This can help to reduce staff 'burn-out'.

Child psychotherapists use their specialist training to provide:

- consultations for staff on particular cases or discussion groups for staff teams, team managers, field and residential social workers and family centre workers.
- foster carers with support to help to make a placement succeed.
- managers and staff in residential establishments with help in thinking about the complicated dynamics that arise in organisations looking after disturbed children.

Working with social services, child psychotherapists provide the child-centred care and long term support promoted by the Children Act 1989.

In the case described above, the child psychotherapist helped to stabilise a child in a temporary foster placement so that a permanent placement could be planned for him. This was especially important for this young child who had recently been placed in foster care for the first time.

Education

- One in five school children is believed to have an identifiable mental health problem. In 1995 over 211,000 children in English schools had a statement of special educational needs.
- In 1996 there were 11,084 children permanently excluded from schools. 15% of those permanently excluded had statements of special educational needs.
- Black African and Caribbean pupils are four times more likely to be excluded than other school children.
- In one survey around 10% of primary school pupils reported being bullied at least once a week, as did 4% of secondary school pupils. If these patterns are repeated across the country as many as 350,000 school children aged 8 to 12 and over 100,000 secondary school children are being bullied at least once a week.
- Parents who were themselves bullied are more than twice as likely to have children who are bullied. 20% of parents, who had themselves been bullied as a child, reported that they had suffered long term effects from this. Some experienced problems in forming friendships and relationships in later life.¹²

Children's problems often become apparent when they go to school. Some children find it difficult to settle at school and may disrupt classes and other

Education – case study

Dean, 12, is one of a large family of mainly boys. He is the youngest child of his mother's first husband, though there are two younger brothers by his step father. One or two of his brothers have difficulties, one with cerebral palsy and one with attention deficit and hyperactivity disorder. Dean is in severe trouble at school because he disrupts lessons and is often violent if he is thwarted – raising his fists to teachers and pupils alike. In sessions with the psychotherapist who sees him in school he oscillates between playing with cars on the car mat and drawing. When he is playing with cars, it is noticeable how law-abiding the play is. There is never a crash, the cars wait at intersections and zebra crossings. The psychotherapist comments on this to him.

When he draws, he draws scenes of the uttermost violence as if his head is full of killings, torture and sadism between grown up and smaller people. It seems as if there was an absolute division between a violent, terrifying and murderous world of his drawings and the compliant virtuous play of the car mat. Gradually as he played on the car mat, Dean began to talk about the 'tornado' he experiences sometimes when he gets angry. He began to talk about his

fear of his brothers, the fights he has with them and with other boys and young men on the estate. He talked of beating them up, of people put in hospital and his ambition to put someone in hospital, then everyone would be afraid of him.

As he talked about what he felt while he played calmly with the cars, the therapist was able to comment on his compliant behaviour, which seemed to be based to some extent on fear, and its contrast with his wild and violent inner feelings. They talked a little about his fear both of his violent response to others and his lack of confidence in those around him. Did this lack of trust spring, at least partly, from his lack of trust in himself?

Dean has not yet conquered his disruptive and aggressive behaviour, but staff in the school report that, for increasing periods after his session, Dean is calmer and more able to learn. His violent feelings have been aired, accepted and put into words in this therapy so he can begin to do the same for himself. Dean is grappling with a difficult problem, but regular thought about it seems to be bearing fruit and helping to move him from behaving on impulse to being able to think before acting.

children. Their behaviour may isolate them from other children and teachers and lead to poor performance, absences and eventually exclusion from school. Learning difficulties may result from or be worsened by a child's emotional preoccupations.

Child psychotherapists are often involved in:

- assessing children with special educational needs to see how far problems in their emotional development are affecting their life at school and creating difficulties with their relationships to teachers and other pupils.
- advising parents and those in contact with families, such as special educational needs co-ordinators, teachers and child care workers, on how best to respond to a child who is having difficulties.
- helping teachers and school staff to understand and cope with disturbed behaviour among children in their care in a way that helps them to contain their own anxieties and as well as those of the child.
- regular work with staff and pupils in special schools for children with emotional and behavioural problems (day and residential).

Some children with Attention Deficit Hyperactivity Disorder (ADHD) experience difficulties at school and at home and may be given drugs to help control their behaviour. However it is very important that children and families receive support and advice alongside drug treatment.

Hospital and specialist services

- In 1995 the General Household survey found that 13% of children under 4 and 19% of children aged 5 to 15 years reported a long-standing illness
- More than one million children visit an A&E department each year following an accident in the home.¹³

Child psychotherapists help severely ill and dying children and their families in hospital departments of oncology, paediatric endocrinology, orthopaedics and burns units. Most psychotherapeutic work may not be long term, but helping children and parents express how they feel may aid their recovery and ability to cope with the illness. However long term work may be essential in the treatment of serious and life threatening conditions.^{14, 15, 16}

When someone is ill or injured, everyone in the family is affected. Children may have strong and frightening feelings that they do not know how to deal with. They often try and protect or spare their family and friends from knowing the true extent of their distress and so have no one to tell how frightened, angry or helpless they feel. Other children in the family may feel guilty that they are healthy, while also feel envious of the attention given to the sick child.

Hospital and specialist services – case study

Lennox was a young person whose diabetes was seriously out of control; he had up to 17 hospital admissions in the two-year period prior to his referral to a psychotherapist. Each admission was a medical emergency and there were real fears that he would die before too long. In addition, he had missed virtually two and a half years of school, and there were fears about long-term damage to his eyes and kidneys.

In the course of psychotherapy, an important theme emerged. Lennox felt he could not trust his body to do as he wished it to do, and so he gave up trying to control his diabetes, feeling it was all hopeless anyway. This was a severe blow to his developing manhood. He felt he could not live up to the image of his healthy active father. In addition, changes with puberty made him feel even more out of control of himself, and tipped him into despair and hopelessness. He experienced the treatment for diabetes (frequent finger-pricking and injections) as a further assault on him. He felt attacked by unseen and mysterious internal physiological forces and by the very treatment meant to cure him.

He also experienced psychotherapy as an attack and tried to defend himself by obsessively

counting every minute of every second of the therapy sessions. Gradually, therapy allowed him a space in which to think and he started to draw. A turning point was a graphic cartoon-like drawing in which a man was literally shot-through with holes. Lennox then talked of his fear of going swimming – that the water would wash straight through him and wash his insides away.

As he became more able to think and explore these terrors he suddenly became a keen sportsman – and did very well. He was then able to express his relief at being able to test his body, and to find that it did, after all, obey him and serve him well. Within six months the emergency diabetic hospital admissions ceased, and within a year his long-term blood sugar levels (HBA1) reduced to acceptable levels. He returned to full time school and was proud of his football ability. Two and a half years later his diabetic control remains good.

It is clear from this example that this was a very good investment in treatment, both in personal and financial terms. Medical treatment of the complications of diabetes is complex and expensive often involving later eye treatment, kidney dialysis or amputation.

In neonatal intensive care units child psychotherapists support parents and staff. Bonding can be difficult to establish where babies are ill at birth, often in incubators. When a baby is in intensive care parents are often torn between their loyalty to the new baby and to their other children at home. Child psychotherapists advise and support parents and staff to help them to deal with these conflicts.

Chronic illness in childhood can have life-long repercussions, both emotional and physical. Diabetes is one such illness that causes great difficulties for children and their families. It is a very serious condition which until relatively recently would inevitably lead to death within a few months. Nowadays thanks to insulin and a sophisticated understanding of physiology, well-controlled diabetics can expect to live full lives. However, very many children – particularly adolescents do not have well-controlled diabetes. Monitoring of exercise and food intake and balancing this with insulin injections is central to diabetic control – little wonder that there is a strong association between eating disorders and unstable diabetes in adolescence.

It is now accepted that psychological treatment is a vital adjunct to medical intervention in order to optimise diabetic control. Without this the long-term consequences are tragic. Young people may die in a diabetic emergency or, more commonly suffer terribly with deterioration of the eyes (and

possible blindness as an adult) or serious damage to internal organs such as the kidneys.

Most young people with unstable diabetes are adolescent girls, but younger children and boys are also at risk.

Older children and young people

- During the winter of 1995/96 281,000 16 to 19 year olds were unemployed. Young men aged between 16 and 19 are twice as likely to be unemployed as the rest of the male workforce.
- 2 to 4% of adolescents have attempted suicide.
- In 1994, 77 young people in England and Wales died by suicide, self inflicted injury and other undetermined causes. The suicide rate among young men has almost doubled since 1979.
- 16% of 16 year olds are involved in the regular use of solvents and illicit drugs.¹⁷

Older children often experience a conflict between their need to identify with their parents and also to separate from them. They may also be in turmoil and anxious about entering the wider world and struggling to establish their sexual and personal identity. At puberty and through adolescence young people with disabilities or chronic illness face particular problems and may need help to understand and come to terms with their disability.

Often older children or young people do not want long term treatment but sometimes brief work can help them deal with particular moments of crisis.

Older children and young people – case study

Jane is a 16 year old who approached a young person's open door inner city advice centre for help in finding somewhere to live. During the first appointment with the advice worker she explained that she was living temporarily at a friend's home. She had left home after a violent argument between her mother and step-father.

The situation at home had gradually deteriorated and this was confirmed by Jane's school. The advice worker helped Jane prepare an application for re-housing. During further appointments Jane told the advice worker that she had periods of depression and self-destructive episodes. The advice worker realised that Jane was beginning to talk about her feelings and so she suggested that Jane should see the child and adolescent psychotherapist who worked one day a week at the advice centre.

Jane took up this suggestion. In the first meeting the therapist explored Jane's self-destructive behaviour and Jane disclosed that she had recently presented herself at hospital having taken an overdose of painkillers, but had not attended follow-up psychiatric appointments.

Jane's suicidal thoughts and feelings were still present. The therapist was able to help Jane acknowledge her anger and disappointment about her poor relationship with her mother and step-father.

Jane accepted the offer of further appointments and gradually spoke about her own difficult behaviour at home, recognising that this had contributed to her problems. She began to make links between her current feelings and her feelings when she was a child during the breakdown of her parents' marriage. Being able to talk about her feeling of being unwanted, lonely and confused was an important step. The therapist could then think with Jane about how her self-destructive thoughts and suicide attempt expressed these feelings.

Jane continued her psychotherapy appointments and was able to meet with her mother and step-father and re-established a relationship with them. She decided to apply for a place in a supportive hostel for young women which would provide her with support and prepare her for independent living.

Self referrals often have the best outcome where adolescents or young people want to focus and work on the problem that they are facing.

Youth justice system

- c In 1995 there were 142,000 known male and 37,300 female offenders aged between 10 and 17.
- c About 3% of offenders are responsible for about a quarter of all offences.
- c In 1989 Home Office statistics showed that of all offenders cautioned or found guilty of sexual offences, 32% were under 21 and 17% were under 16.
- c In 1995 35% of all people convicted of drug offences were under 21. (5,452 males and 466 females under 17 were convicted for drug offences).
- c In 1996 an estimated 1650 children and young people were subject to full supervision orders made under the Children Act 1989, 56% were boys and 57% were under the age of ten.¹⁸

Tackling youth crime requires an understanding of why children and young people offend. Many young offenders grow out of it, but some do not.

Where children have experienced early trauma and poor attachments, they may become delinquent, violent or sexually abusive, especially if there is a family history of violence.

In order to prevent youth crime it is important to identify those who need specialist help. Child and adolescent psychotherapists work with children whose behaviour distresses them or others. This may be in clinics or in specialist forensic units, such as the Portman Clinic in London. In addition they give advice and consultation to other professionals, social workers, youth justice workers, residential care staff and probation officers working with young people.



Youth justice system – case study

Ben was the youngest of four children, the only boy. His father had died of a heart attack when Ben was four years old. Ben had found him and phoned for an ambulance. Ben's mother was depressed and could not control him. She was reluctant to talk about it to anyone in authority, school or the police. Ben felt that he should have saved his father. He became silent and angry.

At his primary school, teachers tried to engage him but became frustrated by his restlessness and his sudden flashes of aggression. He behaved in such a way that he would be sent to the head teacher, a large, kindly, firm man who liked children. In the head's office he would sit peacefully drawing while the head went about his business. One of his paintings was on the wall.

At secondary school Ben's routine fell apart. His mother's depression and drinking became worse; his youngest sister left home. He began to truant and by 12 was regularly in trouble for shoplifting and minor vandalism. One day he created a scene

in school and slowly walked out. 'No one bothered. I sat on the steps for ages, but no one came'. One night he set fire to his primary school after he heard about the retirement of his old head and the planned closure of the school. 'I was so angry, so upset and no one wanted to listen'. His search for parenting was misconstrued everywhere.

After referral Ben's therapy initially progressed slowly. He was very afraid of trusting a new person. As Ben became more secure in the routine of therapy, he was able to get in touch with earlier emotions. Ben can now separate infantile emotions from adolescent ones and has begun to learn at school.

Ben found a good foster home where contact with his mother was maintained and supported. Therapy is regular, weekly and provides the supportive environment that Ben had been seeking.

5 is child psychotherapy effective?

There is little systematic research on the outcome of psychoanalytic therapy, particularly with children.¹⁹ Though there are a number of methodological difficulties in undertaking systematic outcome studies, meta-analysis of child psychotherapy outcome studies have shown that psychotherapeutic treatments for children are associated with significant improvements.²⁰ This is important since many children who are referred to child psychotherapists have failed to respond to other forms of treatment.²¹

- Overall children and young people who have received psychotherapy show more trust and confidence, more age-appropriate behaviour and a greater awareness and concern for other people.
- Children who have received psychotherapy are subsequently less likely to need expensive institutional placements later²² and the breakdown of foster placements may be avoided.
- Younger children (those under 12) are likely to show larger changes than older ones and are more likely to be well at the end of treatment.
- Longer treatment is generally associated with a good outcome for children.
- Intensive treatment (that is the number of treatment sessions a week) is important for certain diagnoses (generalised anxiety, depression or mixed emotional and disruptive disorder).

There is a need for more research and audit on effective treatments for children with mental health

problems which take into account the complexity of the processes involved in child psychotherapy. Objective research methods need to be combined with intuitive and qualitative approaches that can reflect the complexity of the theory and practice of child psychotherapy. These approaches are now developing. They have shown that clinical audit can be integrated with clinical work and at the same time improve the planning and direction of the services to ensure that they are of high standard and meeting the needs of children and young people (see box below).²³

Is child psychotherapy cost effective?

If child psychotherapy services can help prevent the breakdown of foster care or adoption, this is clearly cost effective. If early intervention with children and their families can prevent later problems in adolescence and in adult life, this is clearly cost effective.

Intervention at an early stage may prevent further deterioration and avoid the costs to the NHS, local authorities as well as the juvenile legal system of inpatient or residential care for people with mental health problems. Psychotherapy may prevent some very disturbed children from deteriorating to a point where their carers give up in despair and where residential care may become the only option. The cost of a single referral to a residential home by a local authority may cost in the range of £1,000 a week to the local authority or a health authority when a child is referred for inpatient care. This compared to the salary of employing a full time child psychotherapist at £20-30,000 a year.

At present research has not been undertaken to demonstrate the cost effectiveness of intensive psychotherapy. However, studies do indicate that child psychotherapy can prevent children deteriorating and help them cope.²⁴

Clinical audit of psychoanalytical psychotherapy for young people

A clinical audit of a community-based psychoanalytic psychotherapy service for young people between 12 and 25 was undertaken. Young people and a significant other, such as a parent or friend, were asked to fill in an assessment form at the start of treatment and as a follow up. This did not interfere with treatment

and, in fact, revealed useful information that did not emerge in sessions. The audit found young people showed improvement, in particular for young people who had social problems or were anxious and depressed. Young people who had problems with delinquent or aggressive behaviour showed less improvement.²⁵

about the profession

How child psychotherapy developed

Child psychotherapy developed from work with adults in psychoanalysis. Anna Freud, Melanie Klein and Donald Winnicott are the best known pioneers of psychoanalytic work with children. They observed how sensitive babies and children are to what goes on around them and developed ways of communicating with them through play.

The Association of Child Psychotherapists was established in 1949 bringing together professionals who worked in psychoanalysis and in child guidance. Many child guidance clinics were set up by education authorities following the Education Act 1944. The expansion of the child guidance movement was a practical response to distress in children after the second world war, as many children had emotional problems because of trauma, death of parents or as a result of being evacuated. However, as local authorities and education authorities have had pressure to cut costs, child guidance services have declined and many existing multi-disciplinary teams dispersed.

Training of child psychotherapists

Child psychotherapists come from many different backgrounds, but they will have an honours degree and professional experience in a relevant field such as education, social work, medicine or psychology.

Child psychotherapists receive intensive psychoanalytic training which is normally undertaken over four years full time or longer part time. Trainees undergo personal psychoanalysis to ensure that they develop sufficient maturity to cope with children's distress and ensure children's safety.

The training falls into two parts:

- During pre-clinical training, the trainee studies psychoanalytic theory and child development and undertakes detailed observation of infants, young children and their families.
- During clinical training, the trainee experiences a wide range of psychotherapeutic work with children. They also work intensively with three children of different ages and stages of development, under the weekly supervision of senior child psychotherapists.

Once training is completed, the trainee is eligible for membership of the Association of Child Psychotherapists. All trainees and trained psychotherapists must be registered with the Association of Child Psychotherapists in order to practise in the NHS.

Availability of child psychotherapists

Though there has been an increase since 1990, there are only 400 qualified child psychotherapists in the UK and some 100 in training. A survey in 1994 found that 44% of units providing community-based care for children and adolescents had some sessions provided by a child psychotherapist.²⁶ 75% of all child psychotherapists are employed in the Thames region. This is shown in Table 2.

Training places are in short supply. There are at present six schools providing child psychotherapy

TABLE 2 Child psychotherapists – where they work²⁷

Qualified child psychotherapists (WTE)	Total	%	Employed by			
			NHS	Local authority	Voluntary organisation	Private
North Thames	198	58	163	3	13	19
South Thames	57	17	49	1	1	6
South and West	36	11	32	1	0	3
West Midlands	14	4	12	0	0	2
Scotland	13	3.8	4	0	2	7
Anglia and Oxford	11	3.2	9	1	0	1
Trent	5	1.5	5	0	0	0
North West	4	1.2	4	0	0	0
Northern and Yorkshire	1	0.3	1	0	0	0
Wales	0	0	0	0	0	0

training; four in North London, one each in Edinburgh and Birmingham. Training schools within existing NHS clinical facilities are required in other regions. There are wide differences in the extent to which child psychotherapy training is funded by different health authorities across the regions.

NHS Executive Regional Offices have responsibility for co-ordinating the education and training of child psychotherapists along with other 'small staff groups'. In each region consortia of health authorities, GPs, local authorities and NHS trusts are responsible for commissioning professional education from local training bodies.¹⁶ North Thames Regional Office has developed a long term strategy to develop child psychotherapy services in all parts of the region. Advice on how to develop child psychotherapy services and include them in workforce planning is given in *Child Psychotherapy – Obtaining Funding and Developing Training in the NHS*, 1998.

7 conclusions

A framework for developing services for children and young people with mental health problems is needed that covers primary care, local services and specialised services.²⁸ Joint commissioning, where both health and local authorities plan and fund services, is essential to provide a co-ordinated service to children and their families.

Child psychotherapy services have an important contribution to make to child and adolescent mental health teams. However, there is a serious gap between the number of child psychotherapists required and those currently in practice. Therefore, building up child psychotherapy services for the future requires:

- Planning to ensure the most appropriate use of child psychotherapists as part of multi-disciplinary teams in children's service plans and health improvement plans
- An investment in the training of child psychotherapists and training schools to ensure that child psychotherapy services are available in all areas
- Research and audit on child mental health services and the place of child psychotherapy so that we know the most effective way of helping children, young people who have mental health problems and their families.

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