Psychotherapy Update

AUSTRALASIAN
PSYCHIATRY

Special population – child and adolescent psychotherapy

Australasian Psychiatry
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DOI: 10.1177/1039856216689622
journals.sagepub.com/home/apy

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Abstract

Objectives: First, to outline the paradigm change of the past 20 years that has transformed the theory and practice of child and adolescent psychodynamic psychotherapy; second, to update aspects of the current Practice Parameters for Psychodynamic Psychotherapy with Children to align with the paradigm change driven by the principles of regulation theory, relational trauma and repair, and the critical need for clinicians' self-care in trauma informed psychotherapy.

Conclusion: The emerging neuroscience-driven paradigm of psychotherapy poses challenges for the child and adolescent psychotherapist: to embrace the new conceptual reference points as organising principles leads to an urgent need to rethink traditional diagnostic formulations and time-honoured techniques for intervention. Our child patients and their families are entitled to benefit from the translation of the new research evidence from attachment regulation theory to clinical psychotherapy. Our clinical psychotherapy should sustain the 'best-interest-of-the-child' standards for well-being while also heeding Frances Tustin's warning for therapists to avoid the 'perpetuation of an error' by overlooking recent developments from allied fields in developmental psychology and the neurosciences.

Keywords: paradigm change, relational trauma and repair, child and adolescent psychotherapy

Child and adolescent psychotherapists today face the formidable challenge of embracing the paradigm change that has transformed the organising principles underpinning our profession.[1] While pregnancy, infancy and early childhood remain the constant in the human life-cycle, and the best-interest-of-the-child informs our ethical stance,[2,3] the major advances in neuroscience over the last 20 years have redrawn the boundaries of our understanding of the brain–mind interface and the doctrine of the unchanging brain, in essence leading to a new 'model of psychotherapy'.[4]

This paradigm change has special relevance to the theory and practice of psychoanalytically informed psychotherapy. Two decades ago the psychoanalytic model provided an in-depth 'psychology' centred on the unconscious wishes, feelings, desires, intentions and conflicts in childhood. Today, we privilege the implicit right brain networks to guide clinicians towards understanding the regulating mechanisms for emotions, sensations and vitality affects. It is a challenge to keep updating our thinking and practice in these times of rapid changes. In this paper I turn to a brief outline of some major trends that inform my current child psychotherapy practice.

The biggest challenge for me has been the need to reskill my clinical approach as I try to preserve both my traditional practice parameters[5] alongside the rapidly changing updates, to be outlined below after a brief historical review.

Background

Ritvo and Cohen[6] provide the valuable historical perspective from the American Academy of Child and Adolescent Psychiatry's 60-year history from the 1950s. They demarcate two major eras: first, 'the era of psychoanalytic hegemony' with both positive and negative outcomes, which ushered in the 'corporate hegemony', characterised by three major influences. First, the breakthrough in 'the use of medication in children began to accelerate'; second, the growing number of effective child psychotherapies, parenting interventions and evidence-based trauma focused therapies; finally and most significantly, the impact of managed care. The impact of managed care was important enough for them to conclude with the pointed observation that our current era,

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the 'second 30 years of AACAP's 60-year history can be though of as the era of as corporate hegemony.'

I found it disappointing that Ritvo and Cohen overlooked the significance of the 1990s as the 'decade of the brain', the provenance of our current paradigm change in child and adolescent dynamic psychotherapy detailed by Delgado et al.[4] They summarised the paradigm change as: first, the conceptual shift from the 'one- to two-person' model of psychotherapy; second, the fundamental bi-directional communication between therapists and patient; third, the central role of 'dissociation', in Schore's words as the 'bottom-line-defence', that is, a physiological process rather than a meta-psychological one. I add as fourth, the focus on the 'moments' of therapy change, following recent work on enactments and relational organisations.[7]

Over the last decade findings from neuroscience have clarified responses to critical questions posed by Schore:[8]

> 'What if the brain is evolving in an environment of not interpersonal security, but danger? Is this a context for the intergenerational transmission of psychopathology, and the origins of maladaptive infant health? Will early trauma have lasting consequences for future mental health, in that the trajectory of the developmental process will be altered?' (Schore,[8] p.207.)

Our understanding of the mechanisms underpinning aspects of developmental psychopathology, notably the diverse traumatic experiences and symptoms, necessarily extends the horizon of our traditional psychotherapy interventions – 'talk' and 'play' – to embrace sensory-motor psychotherapy[9] as the 'body keeps the score'.[10]

Expert clinicians and researchers are translating basic attachment and developmental neuroscience – attachment regulation,[1] mirror neurones,[11] the polyvagal theory[12] – to apply to moment-to-moment clinical oscillations in 'talk' and 'play' therapy.[13-16]

This evidence-based research has extended the traditional psychotherapy frame from the two-person dynamics of 'transference/counter-transference' to include the bi-directional communication of stresses, trauma and vicarious trauma, also inter-generationally and also to include cycles of abuse and neglect.[17-19] The bi-directional trauma communication has profound implications for our self-care as psychotherapists.

How should psychotherapists provide safety for patients and themselves?

The American Academy of Child and Adolescent Psychiatry (AACAP)'s[5] 12 recommendations for psychodynamic psychotherapy includes the basics such as knowing when to 'combine individual psychodynamic psychotherapy with other treatments such as group therapy, family therapy or psychopharmacology' and formulating a biopsychosocial treatment plan that emphasises '…the use of the spectrum of psychodynamic verbal interventions' (pp.547–552).

However, I have had to upgrade my clinical skills to include self-care during trauma informed therapy. For example, in patients with a trauma history, I now tend to listen more to the patient's, and my own, 'sensory-motor' and 'body' communications than the 'verbal' narrative. This needed profound changes to my previous psychotherapy technique, based on 'interpretations' and transference-counter-transference tracking.

In practice, I had to go beyond my earlier 'traditional' aims, which focused on uncovering the unconscious or 'psychic' origins for the child's behavioural, emotional or developmental symptoms. Instead, now I deal with the real 'relational trauma' being enacted between the patient and myself – especially mindful (since 9/11) of the accumulating 'data' on intergenerational trauma transfer.

My technique focuses on my sub-verbal relationship; I track my own self-(dys)regulated breathing, posture and prosody, to name just three channels of body-based communication, to provide reparative moments, as the counter to trauma's disrupted regulation.

Of course this approach opens up my vulnerability to vicarious trauma, a subject virtually absent in my old therapy training. Now, in contrast, Na'ama Yehuda[16] emphasised this point: 'Taking care of ourselves is important not only for us, but for our clients' (p. 224). We are trying to adopt this trend towards 'self-care' in our teaching and supervision.[17]

Thus, my current child psychotherapy formulations try to integrate the traditional diagnostic formulations with the neuroscience of trauma.[10,11,20,21] To do otherwise would run the serious risk of 'perpetuation of an error', Frances Tustin's[22] warning in her final self-reflective publication to future generations of psychotherapists to update our knowledge base to inform our clinical concepts and practice.

Outcomes

The rapid conceptual and research advances are transforming the psychotherapy landscape. The AACAP's recommendations, referenced above, published just one year before the *Diagnostic and statistical psychiatric manual of mental disorders*, 5th edition (DSM 5)[23] saw Cohen et al.,[13] in the year after, refine the Practice Parameters, emphasising trauma: '[I]t is incumbent on all mental health professionals to learn the new DSM-5 PTSD diagnostic criteria, including for young (<7-year old) children, and to gain the skills needed to sensitively and effectively elicit information about exposure to diverse types of traumatic experiences and traumatic symptoms from children across the developmental spectrum and from their parents or caregivers.' (p.10.)

Specifically Cohen et al.[13] warn: 'When children do not respond to a prescribed treatment, rather than removing

the original diagnosis and rethinking the underlying etiology, a common response is paradoxically to retain the original (incorrect) diagnosis and to add another inaccurate diagnosis. Often this problem is compounded by adding additional ineffective and inappropriate treatments, further obscuring the underlying *trauma etiology*.' (Italics added; p.10.)

Conclusion

An overview of the relevant literature clearly highlights how child psychotherapy has been transformed by principles from neuroscience-based evidence, as offered by 'regulation theory' and 'relational trauma and repair', compared with two decades ago. The challenge child psychotherapists face is how to update our clinical practice that at once sustains our traditional ethical standard – the best-interest-of-the-child – while simultaneously participating in the paradigm change. Child and adolescent psychotherapy, seen in this light, demands that we rethink and, where indicated, reformulate our clinical approaches to meet the emerging needs especially of those patients whose history involves previously unrecognised trauma.

Disclosure

The author reports no conflict of interest. The author alone is responsible for the content and writing of the paper.

Funding

The author received no financial support for the research, authorship, and/or publication of this article.

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