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Personal practice

Liaison psychotherapy in a hospital paediatric diabetic clinic

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SUMMARY A psychotherapist joined the medical team of the paediatric diabetic clinic three years ago. After some initial difficulties all agreed there had been appreciable benefits, not only to individual patients but also to the team in their handling of the psychological aspects of diabetes.

The relation between the psychological and physiological state of children with diabetes has been recognised for many years.[1–3] Various studies have investigated aspects of juvenile diabetes, nearly all using a linear hypothesis of cause and effect, such as the association observed between poor diabetic control and the emotional tone at home.[4] Development of the application of general systems theory emphasised the role of feedback mechanisms.[5] Minuchin proposed a tentative model to account for the structure and functioning of a family with a child with poorly controlled diabetes.[6–8] This holds that three factors in conjunction are necessary for the development of appreciable psychosomatic illness in children.

(1) The child is physiologically vulnerable, in this case, already has diabetes.

(2) The child's family has characteristics of overprotectiveness, rigidity, and lack of conflict resolution.

(3) The sick child plays an important role in the family pattern of conflict resolution; the symptoms in turn are reinforced by that role.

Despite widespread acceptance that family assessment and family treatment are helpful in the management of psychosomatic problems,[9] such skills are not currently part of most physicians' therapeutic repertoire.[10] Laron *et al* concluded that psychological stability is a basic factor in the control of juvenile diabetes and advocated a multidisciplinary approach to its treatment.[11] At the Israel Counselling Centre for Juvenile Diabetes, in addition to a medical review, counselling by either a psychologist or a social worker at each visit was shown over 10 years to have a beneficial effect on the child's diabetic control.

Setting up the liaison

Three years' experience of regular incorporation of psychotherapy skills within the paediatric diabetic clinic in Cambridge are described. The team consisted of one consultant, two part time paediatric senior registrars with a long term commitment to the clinic, and a paediatric registrar who joined the clinic for the two years of his appointment. There was a regular dietitian and a specialist nurse who worked solely with people with diabetes, both adults and children. A health service psychotherapist (JDJ) was approached by the specialist nurse to join the team. A meeting with all members of the team was then arranged and the psychotherapist joined the team at the weekly clinic in 1982.

In this area the child with diabetes was usually admitted to the paediatric ward for a few days at the time of diagnosis. The psychotherapist introduced herself as a member of the team. She only felt comfortable thus introducing herself once she was accepted as a member of the team. This required understanding the unstated rules by which the professional system functions; attempts to alter the structure and functioning of families are ineffective if the therapist has not properly joined the professional 'family'.

Liaison role

At each clinic the psychotherapist sat in with one of

the doctors or the nurse. Occasionally, a child, or more often his mother, asked to see the 'psychiatrist'. At the end of each clinic there was a team discussion about all the patients. Originally, patients were seen by the doctors in their order of arrival at the clinic. With a small number of attending doctors it was thought sensible for the child and his family to know all the members of the team. As a member of the professional 'family' the psychotherapist appreciated the physician's concerns but as a therapist she witnessed counterproductive confusion in the child and family exposed to different medical approaches. As a result, practice within the clinic was changed, ensuring increased continuity of medical care for the more psychologically vulnerable children. Dependence of children on an individual doctor was recognised and the beneficial aspects of such dependence better utilised.

Case report. An illustrative example is that of a 12 year old girl who had had diabetes for a year. She was a rebellious, surly child with erratic diabetic control. Since diagnosis she had had one admission to hospital in hypoglycaemic coma. She had one younger brother. Her father was on shift work. At the clinic her mother often looked worried and seemed unable to make clear to her daughter what she expected—for example, regular blood or urine tests, regular mealtimes, etc. After an early interview with the whole family, during which the psychotherapist tried (not very successfully) to enable the father to be more involved, her diabetic control improved a little. She saw a different paediatrician, a locum, in the summer preceding her move from junior school to a large comprehensive school. The change of doctor probably meant that an important life cycle event was missed. Neither the patient nor her mother was able to deal satisfactorily with the new school and the move coincided with another period of poor diabetic control. In retrospect, seeing the same paediatrician and being aware of life cycle changes would have been helpful to her.

Problems within the professional team

At times there are boundary and hierarchical difficulties within the professional system. In this clinic the constant professional was the diabetic nurse, who had considerable knowledge of the child's family and home life. Patients quickly worked out which problems to bring to the doctor and which to the nurse. Sometimes the offerings to each were very different; then confusion and occasionally disagreement arose between the doctors and the nurse. Sometimes outside agencies involved with the family became embroiled in dispute with a member of the clinic. The following case illustrates such a problem.

Case report. A 15 year old girl with diabetes lived at home with her mother, stepfather, and two siblings. She was seen towards the end of the clinic to avoid missing much school. The doctors in the clinic found her mother difficult and unwilling or unable to understand the principles of diabetic management. The patient's mother and stepfather had a poor relationship and quarrelled. The paediatrician concerned was surprised one afternoon to be handed a letter by the patient from her general practitioner in which he wondered why she had to come to the clinic so early and miss a whole afternoon's school. At a meeting between the clinic team and the general practitioner the psychotherapist pointed out the ways in which the professionals' disagreement seemed to mirror the disagreements of the family. The general practitioner and the paediatricians were enabled by their understanding to stop 'quarrelling'.[12]

Adolescents

Erratic diabetic control in adolescents is a well recognised problem.[13–15] Some families with adolescents who have such 'brittle' diabetes conform to the characteristics described by Minuchin, but some do not. At this stage in the life cycle greater independence is encouraged, separation from the family starts, and a degree of non-conformity is expected. It is at this point that diabetes seems to make unreasonable demands. It is necessary to consider both the internal world of the adolescent with diabetes (with the problem posed to self esteem, independence, sexuality, and the idea of being 'damaged') and the relational aspects of these problems within the family. Adolescents with difficult diabetes present a serious challenge to their paediatricians. Indeed, there are uncertainties at times about who is in control. There is a paradox in suggesting increased outpatient visits at the same time as encouraging independence in their diabetic care.

Case reports.

Case 1

The patient developed diabetes when she was 11 years old and her control was reasonably good for a year. The onset of puberty coincided with her older sister being sent away from home for flouting the family's code of acceptable sexual behaviour. No attempt was made within the family to resolve this

conflict. Her diabetic control deteriorated and she caused her family and the paediatrician anxiety and anger by omitting injections and diet breaking.

She was admitted at 14 years because of poor control. The paediatrician knew something of the patient's family, the main observation being that her mother was overinvolved and 'hysterical'. Little was known about the rest of the family except that her older sister was not living at home. There was a sense of crisis to which the psychotherapist responded by immediate intervention with the family while she was an inpatient. The paediatrician concerned was unable to be present at the initial interview. As a result, the purpose of the meeting was not clear to the family. Further discussions with the psychotherapist were resisted but restarted at the next crisis three months later.

In the course of intensive work with the patient, her parents, and sister the overinvolvement within this family was revealed by the father saying of the mother 'we are like one person sitting on two seats'. As a result of psychotherapeutic intervention the patient began to feel better and her weight increased from the 10th to the 75th centile in proportion to her height. The family did not feel comfortable changing so fast. They avoided further involvement by transferring themselves to another paediatric clinic.

Although a time of crisis can be a good point for a psychotherapist to intervene, it can be counterproductive to intervene too hastily. There is a fine line between using the crisis to enable change and mobilising family resistance by acting too quickly.

This case also illustrates the importance of discussion beforehand between the paediatrician and the psychotherapist.

Case 2

In spite of longstanding difficulties with diabetic control at transition points in the life cycle the psychotherapist may only become involved at adolescence.

An example of this is a 16 year old who had had diabetes since 5 years of age. When she was 8 years old her parents divorced and she and her younger sister lived with their father. Her diabetes was well controlled. Both girls then went to live with mother when the patient was 10. Her diabetes became unstable with rising glycosylated haemoglobin values and falling growth velocity. The paediatricians had always seen her as vulnerable to the stresses in her family, her poor growth, associated with unstable diabetes, being in part a reflection of those stresses. Despite having made that assessment, family meetings only occurred after an admission to hospital at the age of 16.

The paediatrician concerned set up a meeting in normal clinic time with the patient, her mother and sister, and the psychotherapist. Prepared by discussion about her poorly controlled diabetes and the role of the family dynamics, the psychotherapist was introduced in a way that enabled her to be effective. It seemed important that it was the paediatrician who had convened the meeting. During several further meetings with the family the psychotherapist and paediatrician enabled them to get on better together and improve their communication. It was then no longer necessary for the patient to use her unstable diabetes as a tool to control her family. Despite some minor setbacks, progress was maintained and on transfer to the adult clinic her height and weight had improved from the 10th to the 25th centile and she had a stable glycosylated haemoglobin concentration of 9·4%.

Case 3

Individual involvement with the psychotherapist in reference to a specific issue may be helpful.

A 13 year old boy had had diabetes for a year. His mother was anxious about his withdrawn manner and his preoccupation with death from diabetes. His glycaemic control was excellent and he seemed to have learnt the practicalities of diabetic management well. A meeting was arranged with the psychotherapist at which a family tree was drawn and the inter-relationships between family members clarified diagrammatically.

The patient seemed to be overprotected by his mother but unsupported by his father. Each worried about the other. After some discussion it was decided that he would be allowed to exert his own independence by organising his own snacks. In this small way he could begin his separation from his mother. A few weeks later this had been achieved. The boy was more talkative and less preoccupied with death, and the level of family anxiety was reduced. Focusing on the relational aspects of his problem allowed resolution of his internal worry.

The use of family trees

As in most clinics, the whole family is rarely seen except at times of crisis. Much family information is available but its therapeutic use is not always clear to the paediatric team. There is some reluctance in using family trees despite evidence of their usefulness. Liebermann suggested that this reluctance may arise from uncertainty in the handling of information presented by geneogram.[16] This usefulness is illustrated by the following cases.

Case reports.

Case 1

A newly diagnosed 8 year old girl was the oldest of three children. Her mother was sure that her daughter would die from diabetes like her own aunt. The mother's first cousin also died in a diabetic coma in his twenties, within the last few years. A knowledge of the family history made the mother's guilt and anxiety easier to understand and reduce. The question 'In what ways is your daughter different from your aunt and cousin?' turned out to be helpful. After a couple of outpatient visits the mother no longer mentioned the deaths in her family, but it can only add to the paediatrician's skills to be aware of this child's family history.

Case 2

A copy of the family tree (Figure) has now been put in front of the patient's case notes. The psychotherapist was asked by one of the paediatricians to see the boy, aged 9 years, who had been admitted in ketoacidotic coma. After a change in insulin regimen he was physically well but continually complained of feeling sick. The psychotherapist drew a family tree with him and his mother as a way of getting to know the family. As can be seen from the diagram, the family was complicated. The child's parents were divorced, he and his younger sister living with his mother and stepfather, plus two of the stepfather's sons, both of whom were a lot older than him. There were two sets of grandparents and one set of stepgrandparents. In talking about the family two important factors emerged—the child's rivalry for his mother's attention with his older stepbrothers and his anxiety about his stepfather's mother, who was ill in hospital. With the aid of the family tree his mother understood her son's problems and was able to reassure him more clearly. As a result of this short interview he was no longer sick and left hospital, and the beneficial changes have been maintained. The patient is now a lively 10 year old coping well with his diabetes within his family.

Discussion

A number of issues are raised by the inclusion of a psychotherapist within a paediatric team. The benefit to individual patients of such liaison is shown in the examples quoted. A more general effect was felt by the whole team in their handling of the psychological aspects of juvenile diabetes. Learning to place diabetes in the context of the family's life cycle allows a broader therapeutic approach, with attention to the whole family. Greater success is achieved, however, when there is paediatric concensus that family treatment may be helpful and when it is actively supported by the whole team.

Achieving professional collaboration is not always easy. There was initial apprehension on both sides. As in all mixed marriages it takes time and effort to make the marriage work! Collaboration can only work if there is a long term commitment on both sides. Change in any organisation is slow and to expect quick results inevitably leads to disappointment. The mutual frustration can then move to a symmetrical escalation with each partner, overtly and covertly, accusing the other of being unhelpful or slow to change. This type of escalation is more likely if the paediatrician and psychotherapist are competitive and not truly cooperative. Both partners must respect each other's therapeutic boundaries. A knowledge of the disease makes the psychotherapist more credible to both the paediatrician and the patient.

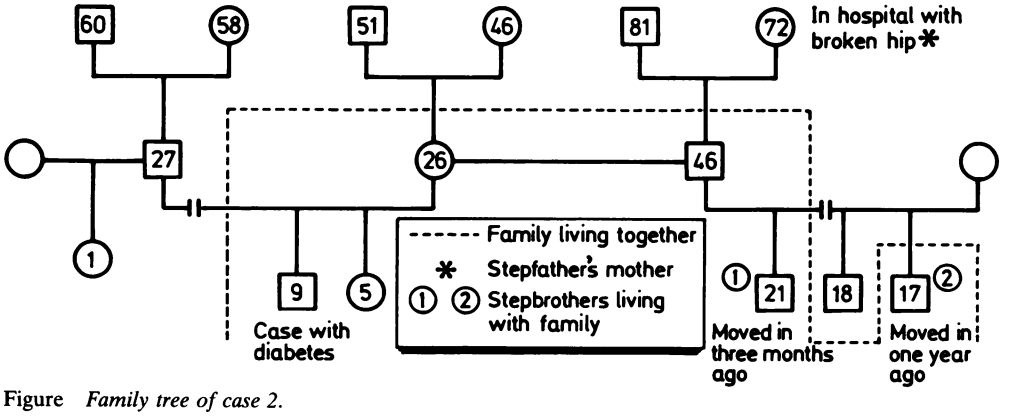

Figure *Family tree of case 2.*

The following questions have to be addressed at some level for the liaison to be successful. What are the agendas of the various professionals and what are their secret agendas? Does the psychotherapist want to teach the paediatricians about emotional development, family treatment, and psychiatric illness? Does the paediatrician wish to be relieved of difficult emotional problems by the psychotherapist? Paediatricians and psychotherapists tend to employ different conceptual frameworks, which can lead to mutual misunderstanding if not frank disagreement. Traditional medical training espouses a linear model of aetiology and appropriate treatment. A systems model, however, involves circular causal loops, such that a child's poor diabetic control, for example, affects and is affected by the family. Liaison can only be effective once the different approaches are understood.

The psychotherapist needs to be sensitive to the different abilities and wishes of the paediatricians and nurses in involving themselves in the emotional turmoils of their patients. The skill comes with learning when to press on and when to hold back. In our opinion it is the observation and comment on the therapeutic system from within that makes liaison effective. Such a system could probably be applied advantageously to the follow up of children with chronic diseases.

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