Case Studies in Child Psychiatry

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Learning from Our Patients

By

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Cambridge Scholars Publishing

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This book first published 2021

Cambridge Scholars Publishing

Lady Stephenson Library, Newcastle upon Tyne, NE6 2PA, UK

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

ISBN (10): 1-5275-7026-6
ISBN (13): 978-1-5275-7026-9

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PREFACE

I have wanted to write a book like this for many years.

The privilege of being able to listen to people trying to make sense of their lives, has been central to who I became as a professional. I have always wanted to show my respect for their stories of struggle and recovery. This small sample of key cases is my tribute to them and a way of showing my gratitude, even if the time is long past for thanks.

Of course, I have left the writing for many years, in part because of an absorbing, and busy, professional career, and a fulfilling and immensely satisfying family life. But also, I wanted to avoid the possibility of people and problems being recognised by those involved or by others. 'Primum non nocere' (first do no harm) has been a basic tenet of my professional life, and I would not want to remind people of painful times, even though the majority of these stories represent successful overcoming of life challenges. Neither would I want them to be subject to further enquiry by some overzealous journalist in these times of mass communication. I have changed names and some details to help disguise the stories, even if I have tried to be faithful to the circumstances and the process of therapy and recovery.

In choosing a title for the book, I do not mean to be disrespectful of the many teachers and supervisors who supported me throughout my lengthy training, as well as through personal difficulties, and my problems with the strictures of a formal examination process to gain necessary qualifications to practice. Of course, the process of supervision was crucial to my understanding of the cases, and I owe a considerable debt of gratitude to psychiatrists Ken Munro Fraser, H. Steven Greer, Jeffrey Gerard, Joe and Eddie Scanlon, Peter Eisen, Ross Kalucy and Rene Pols. In addition, there were other professionals like Kerry Callaghan, Michael White and, later, Steve de Shazer and Insoo Kim Berg who had a profound impact on my therapeutic endeavours.

In my professional life each case led to reflection on the people and their interaction with their families, their stories as they unfolded, and

my professional interaction with them as well as the interventions. I have added a reflection after each story to prompt further thinking in the reader. As will become clear, all the way through my life I have taken great joy in reading the available literature to expand my thinking and practical skills around my casework. I have added a list of relevant references to each case, but this is by no means exhaustive - just a starter for further study.

This is how it works. You have the privilege to listen to a story from a patient and perhaps family members. You explore relevant details and reflect on what they may mean, and how best to influence positive change and a return to healthy functioning. You may take relevant advice, in confidence from colleagues. You read the available literature related to a particular set of problems, as well as possible ways of intervening. And all of that helps personal development.

But it begins with people bringing their stories to you as someone who may be able to understand and assist them to work through and make necessary change.

These are the stories of young people and families who acted as catalysts to my own search for knowledge, experience and therapeutic skill as a child psychiatrist.

I have always been grateful.

Graham Martin
September 2020

INTRODUCTION

Beginnings

My first job after qualifying with my MBBS as a doctor began in April 1967, and was in the Accident and Emergency Department at King's College Hospital in Camberwell, South London. The roster for my six months varied from 68 hours per week to 96 hours when we covered nights, snatching fragmented sleep when the pressure of cases slowed in the small hours of the morning. Casework turned out to be 6 months of a rich, if steep, learning curve, varying wildly between the humdrum of coping with minor cuts, bruises and abscesses through primary assessment of cases of abuse and rape, to certification of death. While the registrar and consultant support were excellent, much of the practical wisdom came from nursing staff with years of dedicated experience.

At 9pm one night an unkempt man in his thirties casually walked up to reception and showed the nurse his arms. "I have been cutting myself." He was bleeding freely. A nurse and I were allocated to do the cleaning and suturing of a myriad of cuts on each arm, some shallow, some deeper. We were gowned and masked and finishing our set up when a registrar poked his head through the curtains:

"Sew him up without anaesthetic!" he said, and, disappeared.

I followed and challenged him: "I am sorry, but I am not sure I can do that."

"You will do what I tell you!" he retorted and began to march off.

"Seriously, that will cause unwarranted pain, and I could not do that to a patient."

"If you do not do what I tell you, I will report you for insubordination…"

"Seriously?"

"Seriously…" Then, as an afterthought: "Listen, this guy likes pain. He will probably enjoy the experience. In any case, you will cause an equal amount of pain sticking needles in to get anaesthetic to each of those cuts. Now get on with it."

I was unconvinced. When I got back into the cubicle I explained to the nurse, and she looked as troubled as I felt. But with reluctance we went ahead. We had both arms stuck out and tied down gently on rests; a cruciate position. Each of us cleaned the wounds on our respective sides, and then, cut by cut, we sewed.

With each suture inserted, our patient would say: "Oh, oh, do that again!" Or, "Do it again Doc, do it again!" And he did have a sort of smile on his face, even though from time to time it was contorted. The nurse and I looked at each other bemused and dismayed.

As we went on, we found out that our patient was from The Maudsley, a psychiatric hospital with a lengthy and illustrious history, which happened to be just across Denmark Hill. He did not appear psychotic to my untrained eye; just troubled by his life. He had attempted suicide several times. He reported that cutting himself controlled his feelings and stopped him from completing suicide. When we had completed all the sutures, we cleaned his arms and applied bandages. He signed himself out to return to his hospital ward across the road; "Thanks nursie, thanks doc, I will be fine."

Who at The Maudsley hospital had noticed his cutting behaviour? Why had a staff member at The Maudsley not managed his cuts? Why had he come across the road unaccompanied? Why did we not arrange for someone to go with him to ensure he got back to his ward? Why had the registrar reacted in such a strong way? Why did we concur, and cause further pain to a fellow human being? Who followed him up, and removed his sutures? Did they cause him further pain because his injuries were self-inflicted? Who followed his case from the psychiatric point of view?

This man had a profound impact on me, and I have never forgotten what I felt I had been forced to do. At that time, I did not have the knowledge or skill to try to understand how he had become ill. I could not make any sense of why he would want to hurt himself in this way. But I was intrigued.

Eighteen months later, as a senior house officer having attained the grand age of 24, I was based on the psychiatry ward at King's College Hospital, Camberwell, from October 1968 to September 1969. I gained part ownership of a small consulting room that had a collection of well-used textbooks and some newer paperbacks, a desk with two upright chairs, two comfortable chairs, and a couch! More importantly, and unlike the experiences of my previous eighteen months as a newly minted junior doctor, there were opportunities in the day to read bits of books and research articles. The job entailed 'clerking in' new patients, getting to know them, completing a physical examination, discussions with nursing staff, writing up the notes and making sure they had medications from before admission written up and prescribed.

Ward rounds were taken at a much slower pace than I had experienced before, with consultants and registrars trying to get a grip on the biological, psychological and family factors that might have contributed. The consultants seemed willing to hear out even the lowliest of nurses. Discussions around treatment were more coherent and even at times collegiate, which gave the ward a sense of being a team working together on the same problems, and in the same direction. I felt like I was home.

The casework was not easy. It was a Professorial Unit, but King's was also an acute general hospital serving the South London area, and was expected to share some of the load of psychiatric cases coming through Accident and Emergency. The Maudsley, of course, had a much larger capacity to take acutely ill patients in addition to those with severe or chronic illnesses. King's consultants also had the luxury of accepting cases from across London if they fitted specific professional interests. Even so, the inpatient unit was semi-acute and short term, the objectives being to sort out diagnostic issues and provide medications. There was time for some short-term psychotherapy, but it was recognised this was brief, targeted, and tailored to enable a local psychiatrist or psychotherapist elsewhere to subsequently take on the case.

The unit had a reputation for managing patients with Anorexia Nervosa, a main interest of Donald Liddell, the Professor, director and senior psychiatrist. But what that meant in practice was that we assessed and tried to manage people who had been to several prior

services and been unable to cope with the treatment offered or had rejected it. There is no clinical case harder than someone with Anorexia who has gained experience from previous admissions to hospital and honed a set of strategies with which to test clinical staff. And yet we had successes, and I put this down to the collaborative teamwork that included patients and their families.

Even without skills or training in therapy, I was encouraged to work with our families and try to understand the unresolved issues that might appear to be blocking progress. Even the re-feeding program was more collaborative than rigid and combative. Optimum weight targets were set but rarely gained.

Looking back, I can see that the underpinnings to therapies were more psychoanalytic, trying to match the internal working model of a patient's family life with the reality, or at least the reality we could discern on the ward. This may well have been influenced by Irving Kreeger, primarily a psychoanalyst, and with a part time teaching position at The Maudsley.

We had weekly small group, two-hour case-based seminars with Dr. Kreeger. He was a gentle thoughtful man who seemed to respect us as people, but always appeared slightly amused by us - as if he knew some secret (which he probably did). Irving was the first clinical teacher I had who shared his views about assessment of the suicidal patient, a special interest about which, in 1966, he had published a thoughtful and seminal clinical paper on the role of the psychiatrist. Considering how scary it can be as a junior doctor to have to assess a suicidal patient in Casualty, and make coherent and safe plans for follow-up, I guess Irving sowed a number of seeds for my future. Through that whole year, I never missed one of his seminars.

I probably would not have known this at the time, but there was also another piece of teaching about the role of the family that left its mark on me. There was considerable excitement about, and repeated reference to, the work of the Social Psychiatry Unit across the road at the Maudsley, focusing on people with schizophrenia and their social lives and recovery. In 1962 George Brown, a psychologist, and his colleagues (Elizabeth Monk, a research psychologist, George Carstairs and John Wing, both psychiatrists) had published a paper about the year following discharge for 128 men with schizophrenia. This was one of those pieces of research that would change and challenge

psychiatry for years to come. In simple terms it reported that if your family were controlling and hostile, and likely to express their emotion (now reduced to 'Expressed Emotion' or EE), then you were more likely to deteriorate and be re-admitted during the subsequent year. This essential message - that 'family dynamics are crucial to recovery' had filtered over Denmark Hill and been influential in our work with people with a whole range of diagnoses.

So, without much experience, and having minimal skill as yet, I often found myself sitting with a family exploring the way they understood the anorexia, the impact on their lives, and what they had found helpful or not. I did not have a plan, nor did I set out to intervene; rather I was just trying to understand. To be truthful, at that stage I did not even have a framework for therapeutic intervention.

A version of the session would find its way into the notes. Occasionally, bits would emerge during informal discussions with nursing staff, although more often than not I was just a sounding board for their thoughts (given they were often vastly more experienced than me). As with my prior 6 month experience in Casualty, I seemed to learn a lot about medicine and psychiatry from nursing staff. They had spent so many years in their role, had absorbed therapeutic skill, and were the backbone of the inpatient unit even if their work was not often openly acknowledged.

One of the other psychiatrists admitting patients to the ward, but with a markedly contrasting approach, was Dr. Anthony Hordern, who in 1965 had published a book on depression ('Depressive states: a pharmacotherapeutic study'). Dr. Hordern was a very different character to Donald Liddell or Irving Kreeger. He was precise, obsessive and had high expectations, and he did not want his patients to have psychotherapy from a junior doctor. Ward rounds began and finished on time, and Tony was focused on the symptomatic presentation and the clinical picture as presented by the patient. He appeared to have little interest in family dynamics and was quickly dismissive of 'speculative ramblings'. He was involved with Dr. Harvey Syme doing research into a new drug called clomipramine (Anafranil). As a result, any patients who were part of the study were expected to follow precise protocols. It was also expected that questionnaires like the Hamilton Depression Rating Scale had been completed and scored, prior to ward rounds. I can now understand this need for precision

having been involved in my own research over the last 30 years, but at the time it was all very irritating, and feedback was sparse.

Tony and Harvey were specifically involved in breaking new ground with Clomipramine, using it in intravenous infusion form. I was impressed by the discussions about its potential, listened avidly, and was sort of excited that research was being done on 'our' unit, even if I had had no training in or experience of intervention research. It was all a bit esoteric, and by the time anything was published, I was likely to have moved on.

Given the strict criteria for inclusion, most patients with depression were not involved in the clomipramine trial, but were treated in a more standard way, with older tricyclic medications in the form of tablets, or with electroconvulsive therapy (ECT). So, early on, I was trained in the application of ECT, mostly by watching the registrar who explained about the dose (the strength of input measured on a dial on the black box), but also the proposed number of sessions over time, the position of the electrodes on both temples, and a number of precautions that had to be in place before pressing the button. The length of ECT application was a little variable and depended on the ease of gaining a convulsion for our patient. At the time, the fact of a successful convulsion was said to be a critical feature, even if the only visible sign was a small movement of the big toe. The presence of an anaesthetist was critical. They gave the intravenous Thiopentone and muscle relaxant and monitored airways and recovery.

Although unilateral ECT was later to gain ground on the basis of fewer side effects – particularly reduction loss of memory – I do not remember us using it. The ECT was mainly given in an outpatient clinic, with up to 20 trolleys lined up, side by side. On occasion there would be someone from the inpatient ward beginning a course, but mostly they came in from the community for their treatment, resting afterward for a couple of hours to ensure recovery from both the treatment and the anaesthetic, then going home with a relative.

Over my year, I grew to loathe those mornings when I had to attend the ECT clinic. I knew very few of the patients, was unable to develop a relationship, hated the mechanistic and (what appeared to be) brutal process, and thought it inhumane lining people up in a row with limited privacy. From some of the stories, I began to hate the fact we might be damaging personal memories. The registrars just seemed to

accept the treatment prescribed by their consultants. So, who was I to know anything? I did what I was told, and had no-one with whom I could debrief or to whom I could grumble. But I have to say that in the few patients I got to know over time, there was a genuine lifting of mood and an acceptance that ECT had worked to get them back into life. I just wished I could have avoided being part of the process.

The Case that turned me away from Psychiatry

Betty was a faded looking elderly lady in her mid 60s. She was unable or refused to speak, sitting disconsolately in the upright chair across the desk from me. Getting a history was painfully slow with me asking questions and Betty writing her responses in an elegant copperplate on sheets of paper. She wasn't sure how her inability to talk came about but had woken one morning to find that she could not speak. She had had no sore throat, and there was no build-up to the problem; it was just there. She did try to mouth answers in a breathy and slightly gruff manner, but it seemed to make her angry with herself and the narrative would falter. Writing was quicker, albeit laboured.

Betty could think of no reason for her problem but thought she could have had a cold. Otherwise she was well, with no major illnesses, and had always considered herself to be a healthy person. Her husband had died some years prior, and she seemed to have managed her grief, and subsequently living alone, well. She had one daughter who lived in Bristol and had a busy work and family life. There was also a sister who lived across the other side of London, whom she had not seen for many years. They normally caught up with a phone call once a week, but this ritual had been curtailed by her problem. She had been examined by her local doctor and also by a doctor at the local hospital. No one could discover or suggest a physical cause. I repeated the systems examination concluding she was very fit for a woman in later life. A registrar from the Ear, Nose and Throat clinic came up to the ward and examined Betty but could find little amiss. At the ward round, all the staff confirmed the voice was severely limited and its quality had not changed since admission. One of the nurses had gently explored the relationship with the sister and discovered that over the years there had been discord, with a suggestion the younger sister may have taken over one of Betty's male friends in their courting days.

In my next session with Betty, I began gently to explore further her relationship with her sister. There were subtle changes in the way she sat, and she frowned rather a lot – at odds with her demeanour on the ward. She seemed quite uncomfortable.

I discussed this with the consultant, and he felt the most likely diagnosis to be 'Hysterical Aphonia'. He suggested I do some hypnosis to see whether we could find out more, to which my rather gauche response was: "How do I do that?"

"It's easy," he said "you just read a script in a quiet gentle manner, and when she is 'under' you suggest that when she wakes up her voice will have improved. I've got a book in my office that may help. Come downstairs with me and I will find it."

Bemused, I followed him and was handed a tatty paperback written by someone called F.L. Marcuse. The book 'Hypnosis: Fact and Fiction' had originally been written in 1959, and this copy had definitely been well used.

"So here we are, page 54. See here, you just follow this process and then slowly count down from ten to one. When you have finished, you slowly count back up from 1 to 10, and she will come around."

Back in the office, I thumbed through some of the background, and prepared some ideas for the next day, writing my own short 'script'. Betty was amenable to the hypnosis, and with the book on the desk open to page 54, I began. I could not believe the response as Betty's breathing slowed and her head drooped, sitting in the high-backed chair.

Taking it slowly, I lowered my voice to read out my short speech, suggesting some ideas about the origins of her loss of voice, and about her voice returning. I repeated the last phrase a couple of times, and then began the count. After some deep breaths, Betty looked up and smiled. She nodded when I asked if she felt OK, and we closed the session confirming the next day at 10am.

Betty was still smiling when we met up next day, and in the consulting room she began hesitantly in a slightly gruff voice to tell me all about her sister and how mean she had been over the years, and how awful it felt to be angry and disappointed with your own sister.

A couple of sessions later she told me how she had recounted some episode from her daily life during their last phone call, and the sister had laughed and abused her. Betty felt a surge of hatred and admitted she had momentarily wished her sister dead. And then she had hated herself. The next day her voice had disappeared.

Over the next week, we discussed some strategies about how to handle the next phone call. Apparently, being 'reunited', the two sisters cried through the whole call.

Amazing. My patient could patently see that I was reading from the book and my notes. How could reading a script have such a profound effect? And how did it give her the confidence in me to be able to talk about what had happened? Me, with my obvious youth and inexperience… Thank you Mr. Marcuse.

But four months down the track, I was to learn a harsh lesson that was to stay with me throughout my professional life. I can't remember how we got to discuss Betty, but I was told that she had been diagnosed with a laryngeal carcinoma, and the possibility of cure was somewhat remote.

How was this possible? How had we missed it? How had my consultant been so confident in his diagnosis of Hysterical Aphonia?

So, here is a truth. Hysterical presentations are common in younger people, and usually do not presage an organic illness. But in anyone older than 40, hysterical presentations almost always have an organic basis; you just have to find it. I think I, and a large number of patients over the years, owe a debt to Betty. I have never forgotten…

Despite that lesson, bit by bit I began to learn from my patients that anger, whatever its origins, can cause havoc with our internal world. Bottled up chronic anger eats into who you are and can destroy your life. Perhaps it is not so much the anger itself, but rather the conflict over how to deal with it. In part this depends on how we were brought up, how our parents managed tantrums when we were young children, and whether there were memorable sequelae from our being angry (for us as individuals, or for the person with whom we were angry). But there are also societal pressures against us being angry, and then acting on our destructive impulses.

So, I learned a powerful lesson about hidden physical illness causing psychological symptoms. I have never forgotten.

Despite the thrill of working with other patients in psychotherapy, by the end of my first year of training I found myself overwhelmed, and perhaps a bit cynical about psychiatry. It was to take me several years of working as a general practitioner to recover my enthusiasm for psychological interventions.

This book is, in part, the story of how I found my way back.

ONE

JO (15):
AN ATTEMPTED SUICIDE

Dr. Ken Munro Taylor was the area Child Psychiatrist for East Kent, which included Canterbury, Thanet and my General Practice area of Birchington on Sea, where I had worked for nearly two years. Ken placed an advertisement in the area newspapers seeking a GP assistant for a half-day session in the Child Guidance clinic in Canterbury. I was the only applicant, but I think Ken was pleased to have an applicant who had actually completed a full year in adult psychiatry. Enthusiastic in my new role, I enjoyed the casework assessments, the supervision, and the clinical discussions about new cases in team meetings.

Ken intimated at my interview there might be a possibility for a second session and, after 6 months of working with him, he offered me additional hours. While I had reservations about taking any more time from the practice or from my family life, I jumped at the opportunity.

The session was to be at Lanthorne House in Broadstairs, a late Victorian three storey building that housed severely intellectually disabled children on the first 2 floors, and children with predominantly psychiatric problems on the top floor.

Jo was admitted following a serious suicide attempt. She had packed up her belongings in a suitcase, intending to leave home permanently, but could think of no one she knew or trusted well enough to go to. She apparently sat on a cliff top close to home for some hours, and eventually decided that she had no option but to jump. She had thrown her case over the cliff - which act was noted by two passers-by who began talking with Jo. When she became more and more distressed, they were able to restrain her from jumping and called out for help. Jo was eventually bundled into an ambulance.

As much as staff could determine from the mother, Jo had been abused by her father over a lengthy period of time. The details of this were unclear. He had now left the marital home, but Jo was struggling with the impact of the abuse, and possibly the complex feelings about losing her father. She remained in her room at Lanthorne, with its barred window and a special nurse. At the weekly team meeting, there was little to discuss given she was almost totally mute, eating little, and looking for opportunities to escape. Ken suggested I might like to try some psychotherapy under his supervision, though members of the nursing staff were dubious she would begin to talk to a male, given her history.

I began that day, with the special nurse sitting just outside the door to the room. I introduced myself, told Jo what I had been told, acknowledged that she might be uncomfortable to talk with a male and then, over time, shared some superficial guesswork into the silence. Jo sat on the opposite side of the single bed facing away, very still, and with her hands in her lap and her head bowed. She gave away no other clues to how she might be feeling. I looked out the window at the treetop view for inspiration and found none. After about half an hour of painful silence, and with my amateur attempts to guess how she might be feeling, I called a halt to the session, apologised that I would not be able to return until the next week, and took my leave. I reported to the ward sister, wrote some notes, and went home.

The following week was not much better. Jo had rarely spoken to anyone during the week. She continued to be specialled, given we all imagined she remained highly suicidal. She had said very little to the special nurse. She had made an attempt to escape when she found a fire escape door had been left ajar, and had been chased and caught by nursing staff.

Eventually, filling the silence, I talked about what I understood to have happened, telling Jo about the concerns of the staff. I reflected they had all become attached to her and would be devastated if something happened to her. There was no visible response.

Through the prior week, I had given thought to how to break through the uncomfortable wall of hurt silence. I am not sure where the idea came from, but I had seen some doodling on a menu in her room, and small drawings in what appeared to be a diary (which had been closed

quickly when I was noticed to be paying it attention). I purchased a pad of art paper and some coloured art pencils. When I received the usual silent treatment ('my half an hour of being frozen out'), with no eye contact, none of my questions answered, none of my reflections or slight challenges responded to, I stood up, flung the art paper on the bed with the pencils and said: "OK, I get that you don't want to talk. I know that you are not talking to many of the staff or other patients. You must be bored out of your brain. So, I bought some paper and pencils, and thought you might like to draw."

There was a slight lift of the head with a flicker of eye contact. Then I walked out, as casually as I could, saying I would see her next week. I contained my feelings as best I could. How could you be angry with such a distressed young woman?

The following week, I was told Jo had been marginally more sociable, eating some meals in the dining room with other young people. She had also begun to respond to her special nurse. In her room, and seated in the armchair, I noted she had left her pad open on her bed. I asked if she would mind if I looked. It was passed across, without eye contact. The first page was filled up with a surprisingly well-drawn face, with small leather straps securing the top and bottom lips on each side with a buckle. Having worked a couple of weekends as a medical officer at the Lydden car and motorbike racetrack, my association to the straps was what you might see on the bonnet of a Mini to ensure it did not fly open during racing.

Hidden behind this drawing was a piece of thick card with a beautifully rendered black and white face etched into the card and surrounded by spider's web (see front cover of this book). A single tear was visible on the cheek. Her name was carved into the lower surround. The symbolism seemed immediately obvious, yet I took time to think through how to respond. Collecting my thoughts, I speculated the face on the card might well represent the pain that Jo was feeling. I let her know that I was impressed by the quality of her drawing; such artistic talent could really take her somewhere in her life.

I suggested the straps across the lips in the other drawing might well be there because she was frightened to talk about her experiences or believed she should not talk about some details of her life. I suggested

that she might fear getting someone into trouble if she were to tell her whole story.

Jo did not respond to these comments but seemed a little more relaxed than the previous week. I said I had been told Jo's mother had visited, and asked whether she had seen the artwork? This met with a shake of the head. I asked if Mum knew that Jo had artistic talent, and Jo began to tell me about some drawings she had done at school, one of which her mum had really liked. I asked whether she was missing school, and whether anyone had come to see her. She shook her head. After a pause I asked if she would be embarrassed if her school friends saw her in hospital? She nodded, but did not tell me any more. After a further pause, I asked about her little brother and how he was getting on at school? Initially she brightened and began to chat about him. But then tears began to fall, and I guessed she was missing him? She nodded.

The following week, the ward report suggested Jo was much improved. She had begun to talk to two other girls on the ward, and now had all her meals in the dining room. She had made a special relationship with one of the nurses, and also the art teacher - who seemed very keen to be involved.

When I was given permission to look at the week's artwork, there were two outstanding drawings. One was of a coffin, almost closed with the top slightly askew. It was ornately decorated. The second was of a young woman, elegantly dressed and standing by a round table which had an umbrella identified with the word 'Campari'. Perhaps the original had been in a magazine, but the copy was exquisite. Apart from some positive comments about the quality of the drawing, I mulled over what else to say. "It seems to me," I eventually suggested, "that we always have choices in life. If we go one way, we may be successful and have all our dreams fulfilled. If we go the other, then life may not be worth living." There were subtle movements of Jo's head, but otherwise she did not respond.

I suggested there might be other explanations. I had not been told exactly what her dad had done to her. In fact, all the staff had been respectful and avoided the topic. But if my imagination was correct, and I had been in her position, I might well have had thoughts of wanting to kill him and put him in a coffin. The head dropped lower, and tears began to fall.

She said quietly: “But I could not do that.”

“And it would not be right.” I added. In fact, if she did go ahead with something like that, it would totally ruin her life anyway – which was not the idea at all!

“But.” I added, “That should not stop you having normal human feelings against someone who did things that could have ruined your life.”

After a pause, I began a theme that we would return to many times over the next few weeks – that of “surviving and showing your father that you are stronger than he is.” In a quiet voice she said: “He is not my father.”

Day by day, Jo began to improve, pouring out artwork, having lengthy and constructive conversations with nursing staff and a social worker. She began to plan a return to school and home, and sessions were held with her and her mother to work through a plan for the future. The mother was adamant that she would have nothing further to do with the father. She would work to ensure that he would have nothing to do with ‘my daughter’. After just over 4 months, Jo returned to home and school, and continued to meet with the social worker from Lanthorne House.

A very peculiar thing happened about 7 or 8 months later. The IRA had been active in and around London with letter bombs going off on several occasions. The British public had been warned to be on alert. I had taken the train to Victoria Station in London to take some postgraduate exams. Nothing untoward happened as I walked back through the crowds to catch my train home. But on the News that night I heard that a letter bomb had exploded in a mailbox at the station. The story left me a bit shaky.

One afternoon, I retrieved a rather fat packet from our home post box. I could not discern the postmark. The writing vaguely reminded me of someone, but I could not be sure. Feeling the packet suggested it had a number of small objects in it, and something suggesting wires, but it was so carefully packed that it was difficult to tell. I was perplexed, perhaps overly anxious, with no reason to suspect someone might want to harm me.

Certain I was being a bit hysterical, I called the local police, who (despite my uncertainty over the phone) came immediately given I was their GP, and had done some local police surgeon work for them. One of them lifted the packet off the coalbunker, where I had left it. Gingerly feeling through the padded contents, he concluded it was unlikely to be dangerous. Holding it as far away from his face as he could (despite his comment), he very gingerly opened it with his penknife. The contents were bizarre – torn playing cards, a tiny noose made out of cotton, a serrated bottle cap, and scraps of paper with incomprehensible writing in the form of poetry. There were bits of wire, and an old sweet packet. We all three stood there and laughed, probably from relief. I am not sure it did my reputation in the district much good (or much harm), but I can guess that the story would have got around with considerable mirth.

Looking through the contents, I thought of Jo; it had some of her artistic quirkiness, and some of the script looked vaguely familiar. But I had no evidence to support my suspicions - and did not recontact. I did discuss it briefly with Ken Fraser (who also laughed at my discomfort), and he assured me Jo was doing well according to the reports from our social worker. She planned to get into nursing. Many years later I was to learn that she did become a nurse, and then completed her midwifery training.

Reflection

This was a case with powerful implications for my life. Despite the obvious clumsiness of some of the interpretations (and others not recorded here), this girl survived her decompensation as the result of her paternal sexual abuse. As far as we know she never became suicidal again and went on to complete a nursing and midwifery training.

When you are a small part of an inpatient team, there are many factors that may be more or less crucial to therapeutic change in the patients:

- being in a protective environment,
- being with other traumatised young people on their own journey to recovery,

- support and explanations from a range of professionals (the social worker, the art teacher, a special allocated nurse, other nurses, catering and cleaning staff),
- time to reflect as well as time to distance from the trauma,

In Jo's case, her contact with nurses may have been an especially important experience underpinning her later choice of career.

It is important to note that the use of medications in treating adolescents in 1972 was very limited, and Jo was not prescribed medication. In addition, family approaches were in their infancy, and probably limited to the giving of advice to parents (note: Salvador Minuchin's seminal 'Families and Family Therapy' was not published till 1974).

I would like to believe that the use of art in therapy broke the deadlock in the development of a therapeutic alliance. In addition, it was therapeutic in and of itself. However, at that time I had not read any works on art therapy. My experience was limited to having two parents who were both amateur artists, and some enthralling visits to galleries during my medical studies at London University. There had been some art used in therapy during my year of full-time psychiatry training at Kings College Hospital (1968-9), but I had had no formal training in how to use it in therapy and had been led to believe that art was largely recreational.

I had read widely in psychiatry. My first introduction to this was a paperback version of Freud's 'Psychopathology of Everyday Life' which I was lent (and read cover to cover) at the age of 16 following some intense discussions with an older school student who was himself to become a psychiatrist (Dr. Frederick Stamp, FRANZCP). This was followed by Adler's 'On Human Nature'. I was therefore very aware of the meaning of symbols and 'The Unconscious'. Despite only being one year, my training in psychiatry at King's College Hospital had expanded this knowledge under an eminent psychoanalyst, Dr. Irving Kreeger, and during registrar supervision. I had also had the clinical experience of supporting suicidal people at King's and exposure to and supervision from Dr. Stephen Greer. But I was still a novice.

My experience in child psychiatry at that time was limited to lectures, and two weeks at the Belgrave Hospital (part of the King's group) during which we observed play therapy, and group discussions, but had limited direct contact or responsibility.

My comments to Jo about her art were stilted, yet I believe they helped to forge the beginnings of a relationship. The black and white face in the spider web obviously represented sadness. It looked sad, the black and white made it bleak, and the tear was a giveaway. The web suggested being caught up in something you cannot control. The other painting of the face was a competent painting suggesting some talent and training. The two straps seemed to me to be an obvious symbol regarding not opening the mouth; that is not talking about your experience because it might lead to danger. I am sure others would have understood this from the painting. Later paintings also helped in opening up discussions about return to school and home, as well as an emerging future. If I had used question and answer as my approach to fact finding and relationship building, I believe the silences would have continued, the ice unbroken.

Obtaining the materials was 'on a whim'. Giving them to Jo had elements of a challenge. With another young person who had limited drawing skill, they might not have led to anything. These days I would suggest that I was attempting to shift Jo from her feeling state ('kinaesthetic') focus to a 'visual' focus (from a neurolinguistic programming (NLP) perspective), and we will come back to these ideas with other cases.

There are aspects of this case that need deeper exploration. There are many ways of approaching the therapy of this young woman, and when I reflect on what happened it was inept, with luck playing a large role. These days, possibilities of inpatient services capable of having a patient resident for this length of time are dwindling. I am sure that there are many ways in which Jo's problems could have been handled, and many ways in which things could have gone wrong. You may like to critique the case for yourself or discuss it with a colleague or a supervisor.

Jo's story and the process of therapy were influential in helpng me decide to seek further training in psychiatry. In particular I began to scour medical journal advertisements looking for Child and Adolescent training in Britain, and then further afield. I was so

intrigued by her and the many other young people I worked with at that time that I wanted to know more. I was unable to find a program in the UK that would accept me (and where the salary would support my growing family). Ultimately, I was to find a training program in South Australia, and leave General Practice in England, migrating with my wife and young family.

One last point is worth making. The story of Jo's attempted suicide and recovery stayed with me, adding to the experiences with suicidal people I had had at King's College Hospital. After many years of formal training in psychiatry, I became Director of a Child and Adolescent Mental Health Service in Adelaide in 1986, and as part of our research development and community commitment, I was to become deeply involved in community and national programs to prevent youth suicide. I guess early experiences are likely to have long term consequences. Thank you Jo.

TWO

STEPHEN (7): ON MANAGING ABUSE

This is a story from when I was a general practitioner in Birchington-on-Sea, a small seaside town on the North Kent coast in Thanet. While I had worked in the practice for nearly two years, I was very much the 'new boy', and there were still many patients on my Kent County Council GP list whom I had never seen.

One evening, a mother brought a rather 'small for age' 7-year old boy into the surgery. He had had a recurrent sore throat and seemed to have difficulty swallowing lumps of food. Mum had wondered whether he might have tonsillitis. I took the rest of a brief systems history, and then his temperature. He was a bit wary of me, but eventually I persuaded him to open his mouth wide enough for me to get a good view and he did indeed have lumpy reddened tonsils, very common in the age group (I was told later by one of my colleagues). He also had a bit of a cough so I asked him to lift his shirt up so I could listen to his chest.

He looked very uncomfortable, and the mother became very flustered. "Oh, that's not necessary. We don't want to take up any more of your time, doctor. Can we just have a prescription for his throat?" I insisted on the grounds it was important to ensure he did not also have bronchitis, and she looked as if she was going to argue. But then she gave in, and looked really deflated (and miserable, I later reflected). The boy himself was not too happy and tried to resist a bit, but I lifted his shirt at the front and pointed out where his heart was and had a listen. Then I turned him around to listen to his back. As I lifted his shirt he began to whimper and sniffle. And no wonder! Across his back were eighteen looped red marks (yes, I did count them!). At first sight these looked like the handle end of a dog's leash. This proved to be the case; our little bloke had suffered a right beating! With both mother and child in floods of tears, the story came out that the boy's father

had been really angry over some small defiance and had taken the dog's lead to his son 'to teach him a lesson'. "Please doctor, don't report him. I am sure we will all get over this." Gingerly I listened to the boy's chest, and then prescribed an antibiotic in liquid form. I was flummoxed; whatever should I do now? Nothing in my earlier psychiatric training had prepared me to manage this, my first experience of child abuse.

I discussed it with my senior partner John Hayden, and asked him what he would do?

"Do you want the truth?" he asked.

"Of course!" I replied.

"Well, I would go up to the house, and confront the bastard. I would threaten him that if he did not stop hitting his son, I would personally beat him up!"

"Oh."

"Well" he added, "you won't get the bastard to just pop down to the surgery for a nice little chat!"

I thought about that afterwards. John was about 5ft 6ins, and the idea of him confronting anyone was somewhat odd. Then I imagined myself banging on someone's door and grabbing them by the scruff of the neck, while I berated them. "Not likely", I decided. But I mulled the idea over and discussed it again with John next morning.

He reaffirmed his idea and suggested we could get the local police constable ('Noddy' to his friends) to back me up, if I thought I needed it. And so it unfolded.

At the appointed time that afternoon I drove to the estate, duly noting that all 6ft 4ins of Noddy was just down the road on his overly large bicycle. With my heart pounding I banged on the front door, preparing myself for a possible boxing match (me, with no skills at all!). A small meek man opened the door, looking slightly sheepish.

"Hello, doc, I rather thought it might be you. The wife said you might pop in some time. Would you like to come down to the kitchen for a cup of tea?"

I signalled the 'OK' to Noddy, and went inside, on alert but already somewhat relieved. We sat across the kitchen table, and he rehashed the story, saying how sorry he was that it had happened.

"I just lost my temper, and that was not really about Chris; it was something left over from work. It won't happen again…"

"Well" I said, "I am pleased it will not happen again. I discussed it with Dr. Hayden, and he said that if it did, then he and I would come down here and beat you up. So it might be best if we did not have to!"

He looked at me strangely for a long time, and I just looked back.

Eventually he nodded. "It won't happen again."

We parted friends, and from time to time he would come to the surgery for some small reason, and we would chat about his work or his family life. He kept his promise.

Reflection

I am not too sure what to make of this story, given my early registrar training was in trying to understand people and gently, respectfully, and collaboratively help them to sort out problems. Later I was to have formal training in seven or eight differing approaches to therapeutic intervention, none of which involved banging on the front door and threatening the patient or a member of their family with violence (I have grave doubts I could have managed that anyway). Yet it worked, in part perhaps because my patient's father was already feeling remorse.

I always wonder whether the story ever got out. Did he ever talk about these strange doctors while he was down at the pub with a couple of friends? I have no way of telling. I never had a third party quietly take me aside and suggest that it was not a good look for a doctor to have a reputation for threatening patients with violence. I do know that Noddy was to become an indispensible resource for me in the town. He would often drop by the surgery and leave a note about some patient in trouble, or would have a brief yarn with the district nurses, who would pass a message on. Definitely a member of 'the team'!