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Main Trends in Paediatric Psychosomatic Medicine*

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Abstract: The setting of a pediatric general department is described, which is not only identified by medical but also by psychotherapeutic, social and pedagogic needs of the patients and their families. This not only achieves shorter duration of particular disease but just as much a health improvement of the whole family using this comprehensive knowledge.

Zusammenfassung: *Hauptströmungen in der kinderärztlichen psychosomatischen Medizin.* Es wird das Setting einer allgemeinen kinderärztlichen Abteilung beschrieben, das nicht nur auf die medizinischen Belange abgestimmt ist, sondern ebenso auf die psychotherapeutischen, sozialen und pädagogischen Bedürfnisse der Patienten und ihrer Familien. Dadurch wird nicht nur eine kürzere Dauer der jeweiligen Erkrankung erreicht, sondern dieses ganzheitliche Vorgehen verbessert die Gesundheit der Familie insgesamt.

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Introduction

Clinical psychosomatic work, as diverse as it may appear nowadays, is basically rooted in two fields.

1. The understanding of a complex hierarchical system of psychoneuroimmunological processes from different subcortical centers to the peripheral receptors in various endorgans such as muscles, skin, peripheral endocrine glands and simular structures. Generations of scientists have made understood the complex feedback mechanisms between brain and periphery. One of them was Derek Gupta, who contributed to steroid, to pineal gland as well as to growth research. To have had the chance to work with him, to accompany him during parts of his scientific way as well as to remain one of his friends for more than

* Memorial lecture to Prof. Derek Gupta, who dedicated his life long work to the investigation of neuroendocrine mechanisms of men and particularly of children.

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30 years fulfills me with mixed feelings of grief and pride, that this outstanding man no longer is with us.

2. The second root of paediatric psychosomatic medicine is the clinical observation of patients, who suffer from many different symptoms and behaviour disturbances or a mixture of both, which cannot be explained by the pathophysiology of body systems alone. Here again the contribution of various people and streams in psychoanalytic and psychotherapeutic research has revealed many facts, that have not been explainable before. Being raised in both fields I was lucky to become aware, that daily suffering of children and their families could not be cured with drugs but that the repair of demaged bondings between children and their families was not less important than medical skill in the cure or the prevention of disease. Here again Derek Gupta with his deep humanistic and philosophical knowledge of oriental and western philosophy encouraged me, not to give up my opening of my medical viewpoints to the reluctance of many medical doctors to a broader scope of holistic medicine. So my paediatric clinical department has cristallised into four parts, all devided in in- and outpatient facilities in order to be able to accustom children and families before admission to our atmosphere as well as to support them over various times after discharge.

Setting

The department consists of four wards, which are situated in different small pavillions surrounded by playgrounds in a park like situation. To each ward belongs a psychotherapeutic, medical and nursing personel as well as teachers, social workers and persons like ergotherapists, physiotherapists and students doing different practical work.

1. The Baby Ward

where babies up to about a year are admitted with their mothers. The reasons for admission are physical illness or interaction problems. That means we have a dual function namely to treat sick babies and to give psychotherapy to young mothers, who are unsure, depressive or aggressive producing non organic feeding disorders, screaming babies or apneic attacks.

2. The Internal Ward

where children of all ages are admitted older than one year, coming from the general outpatient clinic with presenting physical symptoms of disease. Some of them are purely medical problems, some show psychosomatic or psychosocial problems in their background. They are filtered out for in- or outpatient child and family therapy. The distribution for these children is a very important and responsible activity specially in this ward, where we get completely unselected patients.

3. The Psychosomatic Children Ward

Here children are admitted from other doctors, schools, social workers via the psychosomatic outpatient clinic for specific problems of behaviour, eating distur-

bances, enuresis, encopresis with difficult family backgrounds. They usually pass a short diagnostic and a longer therapeutic admission.

4. The Ward for Juvenile Crises Intervention and Psychotherapy

The adolescents here come because of severe psychosomatic disease, after suicide attempts mostly from extremely difficult backgrounds. It is a highly selected population, for which there is great scarcity of treatment places. Among some drugs play a role, but we avoid these to admit. Therapy and family therapy during admission and after discharge is offered.

Results

ad 1. In the mother-baby situation we have a true prophylactic situation on the babies side but usually a heavily disturbed mother, who often needs in- or outpatient long term psychotherapy. We make the experience, that the pathologic interaction between mother and child needs proper diagnosis and treatment. Since the discovery of the significance of the interpersonal world of infant (Stern), it has become mandatory, to install these techniques also to the routine handling of pediatricians with babies and their mothers.

The most frequent symptoms are screaming, but feeding problems and colics of babies are also frequent presentations with depressive or hostile mothers.

The good results in this age group is based upon a great vital strength in babies to react upon slight positive change in the affection of mothers, who now believe in improvement and cure from the symptoms.

ad 2. Through the comprehensive care for children and their parents we register a remarkable improval of outcome of such families from the symptoms as well the negative fantasies, which go along them. The significance of symptoms gets less important in comparison to the voluntary coping in an active manner with the symptoms. Once the child has learned, there is a way out of his illness, of his depression and there are means to communicate with his family or peer group, hope arises and symptoms are getting less important. This is certainly a great help for the not yet fixed symptoms of younger children with wheezing, abdominal pain and bed wetting. The family system also changes from passive suffering and fear to hopeful active attitude and communication.

ad 3. The psychotherapeutic strategies including medical auxiliary treatment is offered to children on this ward. Specific group, individual and family therapy is the backbone of handling as well as motivation to school success, which is enhanced by specially trained teachers. The aim of therapy is more to the psychological integration less symptomoriented and to stimulate families to accept better behaviour and symptoms of their children.

ad 4. Adolescents up to 18 years are admitted here for crisis intervention, with severe eating or psychosomatic disorders or after suicide attempts. After a few days of medical and psychodiagnosis the decision is made, if we should keep the patient or transfer either to a closed institution (drug addiction), discharge for

outpatient psychotherapy or treat them as an inpatient for a longer period (as anorexia or broken home situation).

Each patient has an individual psychotherapy, somebody else takes ofer the family therapy and often we realise that a new start can take place between hostile and disappointed family members. In other families the adolescent takes a new start to work with our help. Many different ways are possible out of such crises with the help of our multiprofessional team. Patients can come back in need any time and they use this possibility. So far we have lost only two children among hundreds to suicide and no one to anorexia or bulimia. But these fights for these youngsters are tough and last long.

Conclusion

In all four parts of our department we have introduced adequate psychohygienic and psychotherapeutic measures to help families out of their one way destructive course. While in the babies we deal with healthy babies in need, we meet young mothers without social support. Up to now the interaction between mothers and children has not been focused in general pediatric work, which is so badly needed. The new baby research has shown us this therapeutic way, but up to now was restricted to child psychiatry rather than to clinical pediatrics. Our so called internal ward primarily was understood by ourselves as the “medical” ward but on a closer look, many subtle negative messages between parents and children counteract recovery in many “organic” desease patterns like asthma or even simple bacterial or viral infections.

We find it mandatory, to revise the general outlook on pediatrics.

Sick children never fall sick or become victims to accidents without a particular family and social atmosphere around them to injure their immune systems, their peripheral hormoneral equlibrims as well as their protective behaviour adequate to the particular Situation.

Even the beginning of neoplastic growth is discussed more and more in the light of such surrounding stress factors but up to now being multifactorial in is nature – we connot prove a particular factor as reason for a specific disease. This even in the light of modern psychoneuroimmunology still is the burden for psychosomatic medicine: that it can’t be proven by simple blood on simular tests for classification.

Therefore we better improve the actual lifestyle of such children, their surrounding atmosphere in a usually difficult society for them, in order to improve health and being, by using modern medicine, psycho- and family therapy as well as motivating them into a more optimistic and positive feeling and thinking.