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Case Study

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West Syndrome - The Mother and Child Relationship

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Abstract

This clinical case intends to demonstrate the psychotherapeutic intervention of a child neuropediatrically diagnosed with West Syndrome from 4 to 8 years. In addition to the neurological diagnosis, the boy in question presented a series of stereotypies and repetitive behaviors that pointed to autism spectrum dynamics. Being accompanied by a multidisciplinary team (neurodiatrician, speech therapist, physiotherapist and occupational therapist) in a children's clinic rehabilitation clinic, psychotherapy has become part of the treatment by the dynamics presented. Psychotherapy acted on the clinical condition mainly through play therapy and psychotherapeutic monitoring and family guidance from the maternal guardian. The relationship between mother and child was dependent and such dynamics were acting negatively on the child's development, accentuating the delay in neuropsychomotor development. Along with family guidance, the mother has become a key player in achieving improvements in the global behavioral framework. and independence from your child. From the psychoanalytical referential, the intervention will be reflected on the mother-child dynamics and the possibilities that this framework provides for child psychotherapy.

Keyword: West Syndrome; Mother and Child Relationship; Psychotherapeutic Interventions.

Introduction

Flip has a sweet smile on his face, he's smiling because it's something inherent to the field The fantasy is amusing him. Externally reacts somewhat automatically to the going and it comes from the people around you. Make eye contact, fleeting, but do it. It's not about making many friends, likes staying in your corner, taking care of whatever falls into your hand, preferably if it is circular or if it makes any sound.

It's not much prose either - his speech is rare, and when it occurs, it's to repeat something that has just been spoken to you, as an echo, or to transmit, in an inverted form, your desire or desire: "Want to pee...Want the ball...Want to eat a cookie". hasn't been heard the self-designation "I" be expressed by him. As he plays, he makes faces, they repeat as the same Just kidding. Allows another to join in the game, but evadingly ends up "eliminating" the presence of this other by giving him his indifference.

When evaluating him for the first time, he cried and cried a lot. The mother was asked to leave him on the floor, a factor that left him very frustrated and dissatisfied. I didn't want to leave the body maternal. Her screams and cries of despair sounded like a person being cut into its flesh. He didn't show any self- or heteroaggressiveness, filled the room with its sharp timbre, indicative of its suffering. THE mother also could not bear to keep him away for too long - the suffering of both was involved in bodily separation. As soon as the mother returns him in her lap, the crying stops as if there had never been a reason for it. The mother says that he is afraid of everything. It gets scared very easily and always seeks maternal protection. Your scream and cry also appear when you feel like it or desires denied, regardless of whether the reason for the denial is clear or necessary, the presence of this, makes him suffer. She has great difficulty eating, so much so that her weight is lower expected and her appearance is very fragile.

His attention is distracted and his mood is unstable. The need for psychotropic drug intervention and the need for an analytical intervention about mother-child symbiosis. clinical history Flip was evaluated by the multidisciplinary team of the Instituto Recanto Nossa Senhora de Lourdes in mid-2005. After evaluation, he started treatment in a regimen outpatient clinic with Speech Therapist, Occupational Therapist and Physiotherapist when he was one year and ten months old. He had been referred from another hospital institution that, through neurological examinations and consultations, he diagnosed the case as a syndrome of West. The child had "normal" development until 3 months of age when they started the spasms that got worse in frequency and intensity over time.5

At 6 months, the diagnosis of West Syndrome was closed - he got control of the spastic seizures at 8 months of age. The outpatient Neuropediatrician evaluated the case and raised the diagnostic hypothesis of a West Cryptogenetic Syndrome with severe behavioral and cognitive sequelae. Although the same continued to be seen by a neurologist in another sector, which would prevent any change in the medication administered. Contact was made with this doctor and he said he would follow up the case. At the clinic, Flip participated in physical therapy exercises and Occupational Therapy quite

independently on a first superficial observation - in fact, I just repeated the exercises automatically and when I finished leave the room and climb the mother's body. He was getting results from the stimulation of these exercises, so much so that he obtained improvements in his gait and the execution of many of the ADL activities (Activities of Practical Life), but it was over time that the speech therapist began to notice a repetitive, isolated and affective behavior blunted in the patient. This made his work difficult, as he needed attention, will, cognition and mainly talked about his patient. When Flip entered the institution, he was one year and 10 months old, and despite the visible neuropsychomotor delay, the most needed therapy at that time was stimulation in the areas of Physiotherapy, Speech Therapy and Occupational Therapy - but now, from the observations made by the team that served him, of aggravation in the trend isolation, speech denial or echolalic speech, gestural stereotypies and behavior, that a new assessment and possible psychological intervention was required. Flip was 3 years and 8 months old when he started the follow-up brief psychotherapeutic.

About West Syndrome

It is "a peculiar form of infantile convulsion" which is the flexion spasm. associated with recurrent mental retardation, according to LEFÈVRE (1990). this affection appears in infants (between 1 and 12 months) and may be the first manifestation of anterior, post, or neonatal encephalopathy (AJURIAGUERRA, 1992). MANREZA & Collaborators (2003) define West syndrome as a severe encephalopathy. that affects infants and seems to represent nonspecific brain response to insults. to the Central Nervous System at this age - this is characterized by spasms, which usually occur in clusters, EEG (Electroencephalogram) showing pattern hypsarrhythmic and neuropsychomotor development involution (DNPM).

The etiology is classified as symptomatic, cryptogenic and possibly symptomatic. In the symptomatic forms, the most common etiology is of prenatal origin such as malformations, neuronal migration disorders, infectious processes, and more rarely of postnatal origin manifested in the first months of life as hypoxic-ischemic encephalopathy, severe hypoglycemia, cardiorespiratory arrest, etc. The idiopathic form is an accepted penalty for some authors. A family history of epilepsy and febrile seizures is present in 7 to 17% of children with the present syndrome. The idiopathic form is characterized by the absence of significant psychic involution with the maintenance of visual ability, absence of brain lesions and favorable evolution (MANREZA & Collaborators, 2003) Still following MANREZA & Collaborators (2003), by whose authors there is an account of more accurate and research in several specialized sources, the prognosis of epilepsies that progress with spasms is not good, because although the crises remit in about 30% of patients in the first year and 50% in the second, in 50 to 70% other types of seizures, as well as other severe childhood epileptic syndromes such as Lennox- Gestaut, in 20 to 50% of cases. Another aspect is the encephalopathic process that determines DNPM delay, being rare children who only evolve with small equelae, such as delayed language acquisition or schooling disorder.

Thus, we have a hazy prognosis, most children affected, even obtaining control of spastic crises, would be bearers of neurological sequelae and later mental disorders. COHEN & TAFT (1971) were the first researchers to raise several hypotheses regarding the relationship of West Syndrome with behavior autistic. Many researchers, including ORRÚ (2002), ROZFONYI-ROESSLER (2002), RABAY & Col.(1996), SCHWARZMAN & ASSUMPÇÃO (1995), has pointed out the development of comorbidities such as childhood psychosis and autism from cases in which there was a previous diagnosis of West Syndrome.

Psychotherapeutic development: application of brief therapeutic intervention When Flip was evaluated, the previous development of its history was unknown. clinic, as the psychotherapist did not participate at the time of assessment and admission to the outpatient clinic. After evaluating the boy and interviewing the mother, a hypothesis was raised. diagnosis and organic psychosis, as there is a previous syndromic history. THE behavioral dynamics, stereotypies, the use he made of language, matched a lot with autism - but the symbiosis with the mother figure and the presence of other factors such as the presence of eye contact, affective bonding differentiated with different people, made the diagnostic hypothesis to establish ground about the organic psychosis than autism. Psychiatrically, the boy would probably be diagnosed as having a Pervasive Developmental Disorder organic etiology.

The association of autistic and psychotic conditions in the clinical evolution of West Syndrome is described by several researchers - recently MUÑOZ, MONTSERRAT, SALVADÓ & SANTASUSANA (2006) pointed to recurrent studies that have verified the development of the autistic spectrum resulting from epileptic conditions: "association between epilepsy and autism can be estimated between 7-42 percent." Taking based on this point, it is considered necessary to pay attention to another fundamental importance, few works are discussing clinical therapy with the child and family, other than drug treatment that focused mainly on controlling the convulsions.

Given the behavioral characteristics developed by the child, the present outpatient clinic could not continue the consultations as the public served was restricts children with intellectual disabilities and the team was not specialized to act with psychosis and/or childhood autism. The case would have a better prognosis if attended to by a team that best understands your needs.7

In a meeting, the referrals to be carried out were decided, however, knowing due to the slowness of the public health system, the present clinical team did not want to leave the case discovered and it was established that the psychologist and the neuro pediatrician would monitor the case until the referrals were carried out. Authorized by the neurologist at the other institution, the neuro pediatrician added a neuroleptic to alleviate psychomotor agitation and anxiety.

The mother was informed that the psychotherapist would follow up the case until the referrals were made and she understood that the clinical work in question would have a brief character. It focused on the look and psychotherapeutic interventions from the mother-child symbiosis.

It was noticed how much the insecurity and intolerance of contact with the external environment were linked to maternal protection and dependence. In this way, preference was given to individual appointments with Flip, but the mother was constantly guided and called to reinforce strategies and guidelines.

Flip entered the room, picked up the piano and always played the same key, which reproduced the sound of some animals. This repetition gave him a lot of pleasure, visible in front of his agitation. motor and laughter.

The piano was placed in front of the mirror, which made him continue to play the same key, but now he was watching himself in the mirror and sometimes stopping to face himself.

The mother complained that she couldn't make him walk, as he only accepted to go on her lap, otherwise cry. The mother was instructed to always put him on the floor and support his crying and crises, talking to him about the importance of him walking with his own feet. It was also asked that he be placed in his bed and that he not sleep more in the company of father and mother. For two sessions it was necessary to reinforce this with the mother accompanying her out of the clinic so that Flip does not "scale up".

In the third session, Flip came walking, and the mother told him very happy that he was now walking alone and he was even running "runs" (sic). also, "it seems to be less afraid" (sic). As for food, the mother reported that it was very difficult for Flip to eat food, she loved snack food and took his bottle twice a day. He refused to take any other liquid or use the cup. It was pointed out to the mother that the bottle element acted, as did the carrying on the lap, for the repetition of a reluctant pattern and infantilized in Flip. It was advised to simply suspend the bottle and if it asks for something to drink that comes in small cups. The mother asked if she should be "doing this at once" (sic) and this was suggested as a strategy at this time.

After a session, the mother says that now he was eating food, "until he's been eating carrots, imagine, he's never eaten vegetables before" (sic). He cried with the removed from the bottle, but now accepted to drink other liquids and in the cup.

In the session, it was perceived that, despite continuing to look for the piano and having repetitive behaviors, Flip varied the games more, using more speech during playing - it was an echolalic speech, repeating jingles or words that the psychotherapist had told him, but there was a greater interaction taking place on the part his.

It was possible to work for two months with Flip, in a session of half an hour a week. There were thus a total of 7 sessions carried out. It is validated that there was therapeutic efficacy from repetitive patterns of mother-child symbiosis that have been reduced to the point of stop and with that act on limiting beliefs.

This would not be possible if a therapeutic partnership had not occurred, in this case between the psychotherapist and the mother. It is reflected that the temporal limitation greatly accelerated the results obtained - such limitation made the mother try harder to obtain higher and effective results.

Focusing on the mother-child dynamic, it opened up a range of possibilities glimpsed in the sense of the potential for change inherent to Flip and the need for work the family context to offer the place to be subjective to Flip, giving it autonomy and independence to name oneself "I".

LACAN (2003) points to the symptom occurring, in the infant being, in the "sticking" of the relationship mother-child or else of the child represent, through the symptom, the truth of the couple. In a specific case, the existence of the first case is noticed, of the child being alienated from his desire in front of the maternal will, thus carrying the maternal phantom. Faced with the case as it was exposed, these were just some of the clinical evidence that could be described, researched and, from now on, problematized.

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