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“The menace of psychiatry”: does it still ring a bell?

Sebastian Kraemer

In 1931 a Chicago paediatrician Joseph Brenneman wrote “there is a menace in psychologizing the school child, psychiatrizing his behavior and overorganizing his habits and his play”.1 He attacked the psychologists of the day for interfering with the innocence of childhood. “What do I object to … is the unwarranted psychiatric injection of sex into child life”.2 Paediatricians could manage the problems of childhood without this kind of nonsense. A decade later the child psychiatrist Leo Kanner, who had already pioneered a joint clinic with a paediatrician at Johns Hopkins Hospital, noted that there was “a tendency to ridicule and resent any psychiatric offerings”.3 Citing Brenneman, later American psychiatrist at Johns Hopkins Hospital, noted that there was “a bind. Unless they have worked with responsive and effective liaison colleagues, paediatricians are in no position to spell out to managers and commissioners precisely what it is that they require. The result is a collective neglect of liaison. Promising national guidelines are not implemented. The cultural gap between mental and physical disorders is sustained both by lack of understanding and by limited services.

While paediatrics has become more aware of psychosocial aspects of child health its core task remains, as it should, the diagnosis and treatment of physical illness. We now know that paediatric patients exhibit high rates of psychopathology yet most of those affected are not referred for mental health assessment.4 A significant minority also generate child protection concerns. Troubled children can sound and look normal, which only adds to the clinical impression that all they need is firm advice or encouragement. If this fails then a referral may be required, which can create a problem of its own.5 “Could you please see this young person whose diabetes is out of control?” “Well, I could, but what is the problem, precisely? Does the patient want to see me, or a psychologist? What do the parents say about a referral to mental health?” “Would you like to see the patient and his family with me?” The paediatrician wonders “why do they make everything so complicated? Why are there different specialists in mental health (and why do they seem to disagree amongst themselves)?”. Patients and their parents may not like it either. “He’s not mad” says the mother, while the child silently agrees, hoping no one is going to embarrass him with questions about his private feelings. Parents are not keen to discuss their children’s emotional problems with paediatricians but — like most people — are also anxious about mental health consultations, in case something painful should emerge. This process is quite unlike getting an opinion from surgical or other specialist colleagues, who, accustomed to the often transient or treatable nature of childhood emotional problems, tend to forget the links with adult mental ill health”.6 However we try to narrow the gap, there is an enduring and necessary tension between us. Like a parental couple our alternative perspectives together create a fuller picture than either could alone. Speaking in the 1960s of the relationship between paediatricians and child psychiatrists, the British paediatrician John Apley said “There has been a long and desultory fluctuation between them but it is high time they were married — if only for the sake of the children” (cited by Hersov).7

WHAT IS LIAISON, ANYWAY?

Because relatively few have seen what good liaison services can do, demand is not well articulated. “Is it just for psychosomatic patients?” It is not. Consider the following examples. Teenagers who have acute psychotic episodes or have harmed themselves deliberately are increasingly frequently admitted to children’s wards. All need physical and mental health attention in the hospital. Many are at social risk. Metabolic, immunological, infectious and brain disorders can present with behavioural symptoms. Then there are the often unrecognised mental disorders in children with life-limiting or chronic diseases,8 the management of which can be helped by psychological intervention.9 As well as being frightening for parents,10 caring for very sick or dying children is stressful for staff, especially in intensive care.11 Premature birth is usually a family crisis12 and more likely to occur where there is social disadvantage.13 Integrated mental health in the perinatal period is still in its infancy14 but is potentially the best opportunity for preventive intervention,15 including child and family liaison and social work. Attachment and developmental disorders are common in paediatric practice. Children who have been badly injured or burned, or whose parents are seriously ill (or have died)16 in adult wards of the hospital often have mental health needs, usually neglected. Patients with disabling symptoms not fully explained by organic pathology — somatisation and
conversion disorders,23 confusion states, habit disorders, unusual seizures or pains, fatigue and refusal syndromes, eating and elimination disorders — provoke familiar splits between colleagues.24 Careful joint work is required. Anxieties about a parent’s mental state or capacity to care for her or his children are common.

By no means all of these problems need referral to mental health, but clinic and ward staff must have protected time and space to meet together and discuss them with colleagues they know well. These are not conversations that can be had over coffee, nor with an unfamiliar specialist from another place.

**A NATIONAL BLIND SPOT**

While many individual paediatricians and nurses have created successful liaison partnerships with psychologists, psychiatrists, child psychotherapists, family therapists and mental health nurses, our commissioners and national institutions easily forget. The two NHS National Service Frameworks (NSFs) that included paediatric liaison25–26 are regularly ignored. England’s Healthcare Commission report on services for children in hospitals27 does not mention their psychological or emotional needs. A Department of Health review of the implementation of children’s NSFs28 refers only in passing to paediatric liaison, and makes no reference to mental health in the section on children in hospital. The Royal College of Paediatrics and Child Health’s (RCPCH’s) Services for Children in Emergency Departments29 was produced by eight professional associations or colleges, none of them mental health, and barely acknowledged psychological or emotional issues. A BMJ editorial on child health in England by a former President of RCPCH omits hospital mental health.30 A comprehensive consultation paper from RCPCH on the future of child health services31 contains a section on behavioural disorders, but does not describe hospital liaison nor any of the other functions it can perform. All these were published in 2007.

There are signs of change, partly driven by crises in child protection. In 2008 another former President of RCPCH and a child psychiatrist jointly called for an integration of the psychosocial into medical practice: “safeguarding, child protection and the mental health of children and parents are inextricably intertwined and are as much the stuff of modern paediatrics as biochemistry, genetics or therapeutics”.32 Will such voices be heard? Repeated exhortations for cross-agency collaboration are faithfully incorporated into national guidance and protocols but have not had much impact on commissioning. Institutional resistance does not disappear because documents say it should. The RCPCH “Child in Mind”33 initiative to enhance mental health approaches for paediatricians is welcome, but its further development has tantalisingly stalled. The more familiar paediatricians become with psychosocial thinking the better they will work with mental health and social work colleagues, and the greater authority they will exercise in pressuring managers and commissioners for better services. The latest review of child and adolescent mental health services in England says that “urgent attention is required” to implement existing policy in paediatric liaison.34

**NARROWING THE GAP**

Besides treatment the object of mental health liaison is to improve the resilience of child patients, to ensure they do not spend unnecessary time in hospitals35 and to support the professional development of those caring for them.36 Mental health and paediatric staff learn from one another, especially when they work in the same building and meet regularly.37 This can never be a totally harmonious partnership. Like any marriage it has to tolerate differences in perspective that are essential to its functioning. The challenge for hospital paediatricians is how to become active advocates for a service that brings real benefits to their patients and staff, but which at the same time makes their work more complicated. On our own, mental health professionals carry little weight in the acute sector, especially while it is being drained of resources by government policies aiming to provide more services in the community. There is no detailed advice for commissioning new liaison teams.38

Mental health staff working in hospital child health must expect a certain level of misunderstanding and even resentment. We can narrow the cultural gap by becoming part of paediatrics, meeting in corridors and canteens as well as wards and clinics. Yet even on the occasions when we can do little to improve the condition of a patient, our very presence highlights the limits of medical and nursing competence. The message we bring is that doctors, nurses and allied professionals will not always be able to manage alone. It is as if child mental health practice had opened a previously unknown room in the paediatric house to reveal quite new kinds of anxiety and sorrow in the complex lives of children.

We are not a menace, but do disturb the centre of gravity of paediatrics. A successful partnership between us enriches the care of children and families.

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