

Who needs child and adolescent psychiatrists?¹

Sebastian Kraemer, Tavistock Clinic and Whittington Hospital, London UK
kraemer@doctors.org.uk

Child psychiatry is a relatively new specialty. It is inevitably a hybrid, containing elements of its ancestors (and cousins) - paediatrics, psychiatry in asylums, care of the mentally retarded, psychoanalysis, psychology, psychiatric social work, remedial education and criminology (Parry-Jones, 1994, pp. 794-812). One of the privileges of our profession is that it is a 'broad church', reflecting the fact that, in spite of the immense scientific advances of recent decades, there is in most cases no 'right' way to work. This is a precious freedom but it is also a problem. There is no other medical specialty that contains such a range of views about the nature of our task, and how it is to be carried out. (Perhaps obstetricians come closest, in that they do argue quite fiercely about methods of delivery, but not so much about their primary task).

Members of the public, including parents of prospective patients, the children themselves, journalists, politicians, our friends and relatives also have a legitimate interest in defining our profession. So, of course, do other doctors and public service professionals in education, social work, primary care, police, probation, the law and voluntary agencies. Although it may not seem so to others, child and adolescent psychiatry often comes 'at the end of the line' when all previous efforts to help a child have been exhausted. Yet even our own employers and commissioners may have only the vaguest ideas of what we are about.

One answer to the title question is that people need us: "*when a detailed and broad ranging assessment of a case is required, as when the presentation of a problem is complex or unusual, or when a wide range of aetiological factors are present, physical, emotional and social, or where there is doubt about the diagnosis*" (Royal College of Psychiatrists, 1990²). It is reasonable to expect medically trained staff to know about physical illnesses and treatments, but it is hard in official documents to address more openly one of the core function of psychiatrists, which is the *management of anxiety*. Even quite inexperienced trainees find that in cases where there is concern about madness or dangerousness in a child or young person their colleagues (including other doctors, such as GPs, paediatricians, and adult psychiatrists) will look to them for advice, and action.

¹ Edited extracts from Kraemer, S (1999) 'Who needs child and adolescent psychiatrists?' *Clinical Child Psychology and Psychiatry* 4: 121 - 127.

² There is no more recent statement of this kind from RCPsych (note: March 2012)

Adolescents who are acutely disturbed always need to be seen by a child psychiatrist. Adult psychiatrists do not like dealing with this age group, even though the clinical presentation of severe mental illness is unlikely to be greatly different from what they are used to in young adults. Such patients may require admission, and part of the general psychiatrist's resistance to taking on younger patients is due to the widely shared conviction that an adult ward is no place for adolescents. Is this because such places are not perceived as therapeutic, even for adults? Another reason may be that a young person's madness is so much harder to see in phenomenological terms alone. The assessment of the mental state is overwhelmed by the thought that this could be one's own child, or perhaps oneself not so long ago. Training in general psychiatry does little to prepare a psychiatrist to take a developmental view of clinical problems. One can still read case histories of adult patients with serious mental illness in which the early history is reported as "normal childhood". The context of mental pain and suffering always includes past and present relationships. This is as true for adults as it is for children (Read & Bentall, 2012).

Training and scholarship

Child and adolescent psychiatrists have almost always had longer training than any of the other professionals in the CAMHS team, much of it as doctors in hospitals. Here they will have been exposed to intense and intimate experiences, such as childbirth, a miraculous and brutal event for which few are prepared. They become familiar with situations in which people are suddenly ill or injured, or just dead, with bereaved relatives standing by. Later, as trainee psychiatrists, similar crises occur in the face of mad and dangerous patients. Whether or not young doctors are equipped to deal with all this, they have to. Part of the job is accepting the expectation - one can properly call it a projection - that doctors are there to help in an emergency. ("Is there a doctor in the house?") It is surviving this kind of initiation, quite separate from what we have learned in tutorials, that gives us a certain authority. People have the same kinds of thoughts about police officers, which also come from universal childhood experiences.

Of course a doctor is also meant to be a learned person, and research and scholarship are continuing obligations for all of us. But it is significant that the learning, even before we make contact with patients, has an experiential element. While trainee lawyers spend hours memorising statutes, medical students have to work in small groups to dissect a dead body. I did not have any kind of tuition that addressed the emotional impact of this, dissipated mainly by dreadful jokes and fooling around when the instructors were not looking. During clinical training the impact of living people on doctors is just as powerful, if not more so. Patients expect us to help, and every doctor knows how terrible it is when we fear that we are unable to do so, for example when someone has died, or is

likely to. In any case, our knowledge is never enough. However much we know, it cannot answer conclusively the question "What am I to do now?" For child and adolescent psychiatrists this is a particularly obvious predicament, given the complexity and uniqueness of almost every case. In order to manage the anxiety of others we need to be able to manage our own.

Diagnosis and intervention

It is clear that we want to establish a database of treatments based on diagnosable conditions, a wholly laudable goal. The trouble is that the goal is nowhere near being reached. The majority of the problems confronting us in the field stubbornly refuse to fit into this Procrustean bed. We have yet to develop methods of study that actually give us answers to the majority of problems we face in the clinic. Child mental health problems do not present themselves in tidy packages (Rutter, 2011). At the point of referral and first clinical exploration there is always a clamour of voices from parents (often separated), teachers, and other professionals, which makes the initial assessment an exercise in calming things down, to get the bigger picture. All of our child and adolescent mental health professionals can do this, but there is a tendency for the most awkward and unpleasant cases to finish up in the lap of a psychiatrist, and that is as it should be.

The traditional medical privilege is a prescription, and the use of drugs has greatly increased in child and adolescent psychiatry. Many are powerfully effective, yet rarely so on their own, without other interventions and care. As Overmeyer et al (1999) point out, when you know you have a sharp tool available the rest of the task seems rather dull. More patients means less time. "It is concerning that the increased use of medication may be a reflection of pressure on services" (Doerry 2003). There is a risk that commissioners and managers will try to restrict us to a narrow definition of medical competence where diagnosing and prescribing are both necessary and sufficient core tasks for child and adolescent psychiatrists.

Along with prescription, making a diagnosis is traditionally regarded as an exclusive prerogative of the doctor. This, too, poses greater problems for child and adolescent psychiatrists because, as Goodman and Scott acknowledge: "our current ideas are like early maps of largely unexplored territory – better than nothing provided you do not take the details too seriously" (2005). Further, in the majority of cases the diagnostic category on its own (e.g. conduct disorder) tells us very little and is no mystery at all. But, as in all branches of medicine, good communication between colleagues - and the development of our specialty - depend on common terminology. The recognition of a specific condition, whether treatable or not, can make a difference to one person's life. In work with paediatricians it is particularly rewarding to be able to tease out the

relative contributions of mental and physical disorders to puzzling symptoms (Kraemer 2010).

Yet beyond diagnosis there is the important task of assessment, which puts the problem in its context. This is a process of exploratory consultation, sometimes simply to a child and a family, but more often to a network of colleagues in the community as well, in which the making of a diagnosis plays only a part. Several meetings, in different places and with different people, may be necessary. The desired outcome is that the problem makes more sense than it did at the point of referral, which leads to more appropriate and efficient interventions.

Drawing a line

In a significant minority of cases the psychiatrist is the one who has to say that there is no place at this moment for formal mental health treatment. This is most likely in social service cases where the hope is that treatment for a child, or for the whole family, may reduce their pain and distress. We have referrals of children who have been emotionally or sexually abused, as if therapy would undo the abuse itself. Of course we can be helpful in such cases, but part of that help may be to say, for example, that the child or children should not remain in their parents' home, and that treatment should only be offered after social service and legal action has been taken. This sort of opinion is quite different from one which says "there is nothing we can do". It is, on the contrary, an intervention in itself even though it may turn out to be the only contribution from the child and adolescent mental health services. At best these explorations can restrain fruitless initiatives and help to focus resources where they are most useful.

Child abuse can cause enormous anxiety, perhaps greatest when it is sexual. Psychiatrists are not necessarily more expert in such matters, but are still expected to give opinions about the management of the case, and the clinical and emotional needs of the victims. The degree of disturbance in the perpetrators of child abuse and neglect may require a psychiatric view, too. While adult psychiatrists may be invited to comment on that, they have little to say about its effects on the child.

The delicate processes of liaison and consultation, essential in all child mental health professions (Kraemer, 2010), are intrinsic to assessment, and are perhaps the most frequently required of all the skills of a child and adolescent psychiatrist. Courts, in particular, are very keen to have psychiatric assessments in complex cases involving abuse or family conflict, or both. A considered expert statement to the court about the needs of a child is a necessary part of the child psychiatrist's duties.

The unavoidable social context

Alongside wide clinical and scientific knowledge, child and adolescent psychiatrists must also be able to work at different levels of organization, from the molecular to the political, sometimes simultaneously (McFadyen & Roberts, 1997). This is not a simple matter, because it means accepting several different kinds of theory about the origins of child mental disorders. In effect we have to speak a number of languages, at least one of them fluently. Because it has such a broad range, it is never possible to be equally competent in every area of child and adolescent psychiatry. All of us will have at times the uneasy feeling that there are aspects of the job at which other child psychiatric colleagues are evidently more knowledgeable than oneself. Consultations *within* the profession are therefore necessary, since no one can know it all. Given the wide angle of child and adolescent psychiatry this is inevitable, while frequent attempts to narrow the field may be to reduce this particular anxiety. The truth is that even our best knowledge does not always enable us to facilitate change in the face of the intractable and long-standing problems we are asked to solve.

Regardless of any particular special interest we may have, if we are curious about the nature of mental disorder then we are bound to see the extent to which it is dependent on relationships, especially between children and parents, or other caregivers. And whatever causes a child's illness, it always has effects in his or her family. In their day to day work with patients all doctors have to deal with other people as well, but their training does not usually reflect that, being focused almost exclusively on the disease in the patient, which occupies only a small part of the whole spectrum of postgraduate medical practice³. There are few signs that this is changing, but at least learning about social and psychological aspects of health and training in interviewing patients are now part of the medical school curriculum. I and my contemporaries in the 1960s were just expected to get on with it, perhaps by identification with our teachers, some of whom were appallingly insensitive. Child and Adolescent Psychiatry is one of the most specialised branches of medicine but it is also a model for a truly comprehensive approach (which has something in common with general practice) that should be followed by others.

³ The former Leeds University professor of paediatrics Robert Smithells writes about his professional development. He describes "the second decade – the decade of diagnostic disillusion – [that] was dominated not by diseases but by children. On the one hand, the vital influences of home and school (but especially home) illuminate almost every health problem in childhood. On the other, so many 'diagnoses' prove to be but labels, flags of convenience which make the doctor feel he has conquered a problem. Thus asthma and migraine prove to be symptoms, not diseases; translations of the clinical history into medical shorthand. We are left to find out why this child experiences recurrent attacks of wheezing and that one recurrent headaches" (1982, p135)

Finally, the social context. The outcome of good practice in child mental health is not simply a private matter. It is also a social one. Undeniably some later problems, social, medical or psychiatric, are averted by successful interventions, even if we do not know how many (Read & Bentall, 2012, Murray et al, 2011). But given the small number of cases we can treat compared to the enormous prevalence of suffering, there is no escaping a preventive and political dimension in our work for children that goes beyond the clinical. We not only observe their emotional lives, we have to fight for their proper care and attention. There are few other professions that can carry such authority as witness to the real experiences of children and families. Widespread ignorance of the nature of child psychiatry is not simply due to lack of information. It is evidence also of a wish to make invisible the mental pain of young people and their parents. Some psychiatrists prefer to leave this aspect of the job to others, but this is in my view both unscientific, and an abdication of duty. We have an obligation to respect not only the biological but also the psychological forces in a child's development, and to see both as embedded in society (Kraemer, 2011). There is no other branch of medicine that is more powerfully confronted with the context of its patients' lives than ours.

References

Doerry, U & Kent, L. (2003). Prescribing practices of community child and adolescent psychiatrists. *Psychiatric Bulletin* 27: 407-410

Goodman, R. & Scott, S. (2005). *Child Psychiatry* (2nd edition), Oxford: Blackwell, p26.

Kraemer, S. (2010) Liaison and co-operation between paediatrics and mental health *Paediatrics and Child Health* 20: 382-387
10.1016/j.paed.2010.02.012

Kraemer, S. (2011) *Survival or development? The infant policymaker*. Family and Parenting Institute
www.familyandparenting.org/our_work/Parenting/Tavistock+Clinic

McFadyen, A. & Roberts, J. (1997). Professionals must offer a multifaceted approach (letter). *British Medical Journal* 315, 312.

Murray, L, Arteche, A, Fearon, P, Halligan, S, Goodyer, I, Cooper, P. (2011) Maternal Postnatal Depression and the Development of Depression in Offspring Up to 16 Years of Age. *Journal of the American Academy of Child & Adolescent Psychiatry* 50: 460-470
doi: [10.1016/j.jaac.2011.02.001](https://doi.org/10.1016/j.jaac.2011.02.001)

Overmeyer, S., Taylor, E., Blanz, B., Schmidt, M.H. (1999). Psychosocial adversities underestimated in hyperkinetic children. *Journal of Child Psychology and Psychiatry* 40: 259-263

Parry-Jones, W. (1994). History of Child and Adolescent Psychiatry. In M. Rutter, E. Taylor & L. Hersov (Eds.), *Child and Adolescent Psychiatry: Modern Approaches*. Oxford: Blackwell.

Read, J., Bentall, R. (2012) Negative childhood experiences and mental health: theoretical, clinical and primary prevention implications. *British Journal of Psychiatry* 200: 89–91. doi: 10.1192/bjp.bp.111.096727

Royal College of Psychiatrists (1990). Role of the Child and Adolescent Psychiatrist. *Psychiatric Bulletin*, 14: 119-120.

Rutter, M. (2011), Research Review: Child psychiatric diagnosis and classification: concepts, findings, challenges and potential. *Journal of Child Psychology and Psychiatry* 52: 647–660. doi: 10.1111/j.1469-7610.2011.02367.x

Smithells, R.W. (1982) In praise of outpatients: partnerships in paediatrics. In (eds.) J. Apley & C. Ounsted, *One Child*, Clinics in Developmental Medicine no. 80, London: SIMP, 135-146.