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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 I do 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 psychiatrists[4 5] have written about their relationship to paediatrics. The theme is familiar: paediatricians are frustrated — even irritated — by child psychiatrists, who seem to live in a world of their own, on a different timescale, speaking a mystifying language.

THE CULTURAL GAP

Much has been learned since those days, on both sides of the Atlantic. The pioneering work of many paediatricians, psychiatrists, psychologists, psychotherapists, nurses and social workers has changed the landscape, yet the geology beneath still bears separate strata for medicine and mental health. Although ambivalence is now more muted, the marginalisation of mental health in hospital paediatrics continues into the present century. This is partly due to the fact that mental health provision for some paediatric departments remains uncoordinated, confusing or inaccessible. Even in London, where some richness of resources might be expected, only a minority of departments has a dedicated liaison service.[6] Despite a strong desire from the vast majority of paediatricians for more, most of them have not had a satisfactory experience of it. This is 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[7] 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[8] yet most of those affected are not referred for mental health assessment.[9] 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.[10] "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[11] 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 are part of the same culture and usually do what they are asked.

In a systematic comparison of specialists' attitudes, Enzer *et al*[12] contrast the optimistic view of paediatricians about childhood with that of psychiatrists, who see it as a time of powerlessness and conflict. The same patient presents different prospects to the two kinds of specialist. Mental health problems in young people can "… presage long-term chronic problems that last throughout adulthood … a timely reminder for paediatricians who, accustomed to the often transient or treatable nature of childhood emotional problems, tend to forget the links with adult mental ill health".[13] 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 flirtation between them but it is high time they were married – if only for the sake of the children" (cited by Hersov[14]).

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.[15] As well as being frightening for parents,[16] caring for very sick or dying children is stressful for staff, especially in intensive care.[17] Premature birth is usually a family crisis[18] and more likely to occur where there is social disadvantage.[19] Integrated mental health in the perinatal period is still in its infancy[20] but is potentially the best opportunity for preventive intervention,[21] 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[22]) 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

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conversion disorders,[23] confusional 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 liaison[25 26] are regularly ignored. England's Healthcare Commission report on services for children in hospitals[27] does not mention their psychological or emotional needs. A Department of Health review of the implementation of children's NSFs[28] 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 Departments*[29] 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 services[31] 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 pressing 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 hospitals[35] 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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REFERENCES

1. **Brenneman J.** The menace of psychiatry. *Am J Diseases of Children* 1931;**42**:376–402, 391.
2. **Brenneman J.** The menace of psychiatry. *Am J Diseases of Children* 1931;**42**:376–402, 396.
3. **Kanner L.** The origins and growth of child psychiatry. *Am J Psychiatry* 1944;**100**:139–143, 141.
4. **Work HH.** The "menace of psychiatry" revisited: the evolving relationship between pediatrics and child psychiatry. *Psychosomatics* 1989;**30**:86–93.
5. **Fritz GK.** Consultation-liaison in child psychiatry and the evolution of pediatric psychiatry. *Psychosomatics* 1990;**31**:85–90.
6. **Woodgate M,** Garralda M. Paediatric liaison work by child and adolescent mental health services. *Child and Adolescent Mental Health* 2006;**11**:19–24.
7. **American Academy of Pediatrics Committee on Psychosocial Aspects of Child and Family Health**. The new morbidity revisited: a renewed commitment to the psychosocial aspects of paediatric care. *Pediatrics* 2001;**108**:1227–30.
8. **Hysing M,** Elgen I, Gillberg G, *et al*. Chronic physical illness and mental health in children. Results from a large-scale population study. *J Child Psychol Psychiatry* 2007;**48**:785–792.
9. **Glazebrook C,** Hollis C, Heussler H, *et al*. Detecting emotional and behavioural problems in paediatric clinics. *Child: Care Health Dev* 2003;**29**:141–9.
10. **Abrams A,** Rauch P. Pediatric consultation. In: Rutter M, Bishop D, Pine D, Scott S, Stevenson J, Taylor E, Thapar A, eds. *Rutter's child and adolescent psychiatry*. 5th edn. Oxford: Blackwell, 2008:1143–55.
11. **Briggs-Gowan MJ,** Horwitz SM, Schwab-Stone ME, *et al*. Mental health in pediatric settings: distribution of disorders and factors related to service use. *J Am Acad Child Adolesc Psychiatry* 2000;**39**:841–9.
12. **Enzer NB,** Singleton DS, Snellman LA, *et al*. Interferences in collaboration between child psychiatrists and pediatricians: a fundamental difference in attitude toward childhood. *J Dev Behav Pediatr* 1986;**7**:186–93.
13. **Reading R.** Current literature [Mental health of young people: a global public-health challenge. Patel V, Flisher AJ, Hetrick S, McGorry P. *Lancet* 2007; 369: 1302–13]. *Child: Care, Health Dev* 2007;**33**:647–8, 648.
14. **Hersov L.** Child psychiatry in Britain – the last 30 years. *J Child Psychol Psychiatry* 1986;**27**:781–801, 788.
15. **Winkley W,** Landau S, Eisler I, *et al*. Psychological interventions to improve glycaemic control in patients with type 1 diabetes: systematic review and meta-analysis of randomised controlled trials. *Br Med J* 2006;**333**:65–8.
16. **Sloper P.** Predictors of distress in parents of children with cancer: a prospective study. *J Pediatr Psychol* 2000;**25**:79–91.
17. **Fischer JE,** Calame A, Dettling AC, *et al*. Experience and endocrine stress responses in neonatal and pediatric critical care nurses and physicians. *Crit Care Med* 2000;**28**:3281–8.
18. **Jotzo M,** Poets CF. Helping parents cope with the trauma of premature birth: an evaluation of a trauma-preventive psychological intervention. *Pediatrics* 2005;**115**:915–19.

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19. **Smith LK,** Draper ES, Manktelow BN, *et al*. Socioeconomic inequalities in very preterm birth rates. *Arch Dis Child – Fetal and Neonatal Edition* 2007;**92**:F11–14.
20. **Currid T.** Improving perinatal mental health care. *Nursing Standard* 2004;**19**:40–3.
21. **Swanson JD,** Wadhwa PM. Developmental origins of child mental health disorders. *J Child Psychol Psychiatry* 2008;**49**:1009–19.
22. **Dowdney L,** Wilson R, Maughan B, *et al*. Psychological disturbance and service provision in parentally bereaved children: prospective case-control study. *Br Med J* 1999;**319**:354–7.
23. **Garralda E.** Functional somatic symptoms and somatoform disorders in children. In: Gillberg C, Harrington R, Steinhausen H-C, eds. *A clinician's handbook of child and adolescent psychiatry*. Cambridge: Cambridge University Press, 2006:246–71.
24. **Dunger D,** Pritchard J, Hensman S, *et al*. The investigation of atypical psychosomatic illness: a team approach to diagnosis. *Clin Pediatr* 1986;**25**:341–4.
25. **Department of Health**. *Getting the right start: National Service Framework for Children. Standard for hospital services*. London: DH, 2003:4.24–4.27.
26. **Department of Health**. Promoting the mental health and psychological well-being of children and young people: Report on the Implementation of Standard 9 of the National Service Framework for Children, Young People and Maternity Services, DES/DH, 2006.
27. **Healthcare Commission**. *Improving services for children in hospital*. London: HC, 2007.
28. **Shribman S.** *Children's health, our future: a review of progress against the National Service Framework for Children, Young People and Maternity Services 2004*. London: Department of Health, 2007.
29. **Services for Children in Emergency Departments**. *Report of the Intercollegiate Committee for Services for Children in Emergency Departments*. London: RCPCH, 2007.
30. **Craft A.** Are health services in England failing our children? *Br Med J* 2007;**335**:268–9.
31. **Royal College of Paediatrics and Child Health**. *Modelling the future: A consultation paper on the future of children's health services*. London: RCPCH, 2007.
32. **Hall D,** Williams J. Safeguarding, child protection and mental health. *Arch Dis Child* 2008;**93**:11–13, 11.
33. **Royal College of Paediatrics and Child Health**. http://www.rcpch.ac.uk/Education/Education-Courses-and-Programmes/Child-In-Mind (accessed 28 Apr 2009).
34. **DCSF**. Children and young people in mind: the final report of the National CAMHS Review, London, 2008: 7.59.
35. **Houts CB,** Turbett JA, Arnold LE, *et al*. Cost of medical/surgical pediatric hospital days preventable by psychiatric treatment. *J Am Acad Child Adolesc Psychiatry* 1985;**24**:227–30.
36. **Drake R,** Davidson S. Development of qualified nurses' psychological skills: an evaluation. *Paediatr Nurs* 2006;**18**:32–6.
37. **Wright B,** Kraemer S, Wurr K. Paediatric liaison. In: Richardson G, ed. *Child and adolescent mental health services: an operational handbook*. 2nd edn. London: Gaskell, 2009:ch. 16.
38. **Kraemer S.** *Notes on paediatric liaison: CAMHS-PL*, 2009. http://sebkraemer.googlepages.com/CAMHS-PL.doc (accessed 28 Apr 2009).

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