

From industrialised to mindful medicine: including the politics of need and trust in child psychiatry

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ARTICLE

SUMMARY

Diagnostic systems are not conducive to compassionate health-bringing psychiatric treatment. The systems were built around the fallacy that the politics of biomedicine could be reliably applied to the emergent properties of human psychological suffering and enable diagnosis-specific treatment packages. The resulting industrialised medicine, which reified people, failed to facilitate the compassion needed for healing. This article outlines an approach to psychiatric practice that involves understanding children's suffering and vulnerabilities in terms of their attachment strategies and adaptation to their context and takes a mindful approach to developing compassionate collaborative treatment goals (intelligent kindness). A shift towards mindful psychiatric medicine would encourage politicians to serve the people by addressing the contexts associated with human suffering and what makes people vulnerable, especially social inequalities. Healthy societies in which the psychiatric dis-ease of the population is adequately addressed will not be built with limited biomedical understanding of dis-ease.

LEARNING OBJECTIVES

After reading this article you will be able to:

- describe the function of mindfulness in collaborative treatment planning
- distinguish industrialised medicine from mindful medicine
- create an outline of the moments to include in creating a mindful formulation for a treatment plan.

KEYWORDS

Attachment; public health; mindful medicine; diagnoses; clinical formulations.

clinicians, patients and their carers. The dynamics cross the generations, often including at least three generations. Initially, only parents are mindful, but infants have powerful signals for eliciting responses from parents. Vehement cries become more or less successful in releasing a caring and timely response from the adults. Through the interactive dance around meeting the needs of the infant, trust can be built that the adult has the child's needs in mind or, conversely, distrust that the adults will be helpful and timely. This depends on infants being able to rely on being protected and comforted when distressed – or at least know what they need to do to ensure that the responsible adults (be they mothers, fathers, grandparents or others, whom I will refer to as their very important people or VIPs) provide as much relief as possible, as soon as possible. 'Goal-directed' caring (the adult knows best that food is required for the infant, for example) transitions gradually to 'goal-corrected' caring, when the young children's growing communicative skills inform VIP practice concerning meeting their needs in a partnership – a reflection of what comes to identify the productive treatment alliance. Both parent and child learn to have the other person's perspective in mind, and fit their responses to each other to maximise their sense of being on top of their difficulties through mutual social responsiveness. They become mindful of each other. This reciprocal mindfulness is also needed in current medical practice between doctor and patient – and the young patient's parents. Yet this is threatened by the emphases of industrialised medicine (Montori 2022), with a fast efficient production line philosophy where the health professionals determine the treatment plan within strict parameters determined politically. It is also missing if a health service demands that patients decide on treatment priorities to counteract the belief that 'paternalistic' doctors determine treatment single-handedly. Yet being mindfully involved is the element that is most desired by every ailing patient, whatever their diagnosis. It cannot surprise us that nurses, followed by doctors, are the most trusted professions in the UK (Ipsos MORI 2021).

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'... of necessity all living organisms endeavor to preserve themselves without conscious knowledge of the undertaking and without having decided, as individual selves, to undertake anything.'

(The conatus statement: Spinoza, 1632–1677, cited in Damasio (2003: p. 79))

Mindfulness of others' needs arises on the basis of developmental processes in families, the families of

BOX 1 Terminology

VIP	'Very important person' who meets the child's need when in distress.
RDoC	Research Domain Criteria – the RDoC project is looking for pathognomonic equivalents for mental disorders independently of current diagnoses.
HiTOP	Hierarchical taxonomy of psychopathology, a scientific attempt to develop a dimensional system for classifying mental health problems.
World 1 and World 2	In Popper's conception of reality, World 1 is the physical chemical world preeminent in the biomedical model, whereas World 2 concerns mental states and processes.
PPCT	Bronfenbrenner's process–person–context–time model conceptualises the ecology of human development with more complexity than in his original ecological model (see Fig. 1).
Semiotic niche	Semiotics is the study of sign processes and making meaning. With a semiotic niche we need to think of a limited milieu which shares a common understanding of the signs and the meaning conveyed.
Complex system	In a complex system no elements are independent of the other elements in the system.
Emergent properties	In a complex system properties arise that are not present in the constituent elements of the system, but arise from the interactions between the parts.
Code duality	A recursive and unending exchange of messages between analogue and digital coding across all levels, from microcellular structures to communication between people. For example, behaviour is necessarily analogue, yet the memory giving rise to the action pattern is believed to be digital – either/or.

Our survival and comfort under duress rely on such trust.

Diagnoses in child psychiatry

Child psychiatric diagnoses have been developed within the reductionist biomedical paradigm, the dominant politics of medicine. But they do not fit, even though various exercises are still looking for biomedical equivalents, such as the Research Domain Criteria (RDoC) project (Cuthbert 2013, 2014), or for an alternative dimensional diagnostic

system, such as the hierarchical taxonomy of psychopathology (HiTOP) (Kotov 2017) (Box 1).

Zeanah and colleagues (2011) put it that there was a need to shift the clinical frame from an individual child to a child developing in the context of caregiving relationships. To put child psychiatric practice on a sounder footing psychiatrists need to conceptualise both the developmental processes that put the child's health and illness careers onto differing developmental pathways and the factors that maintain them there. Only then will clarity in what treatment has to address lead to developments in therapy

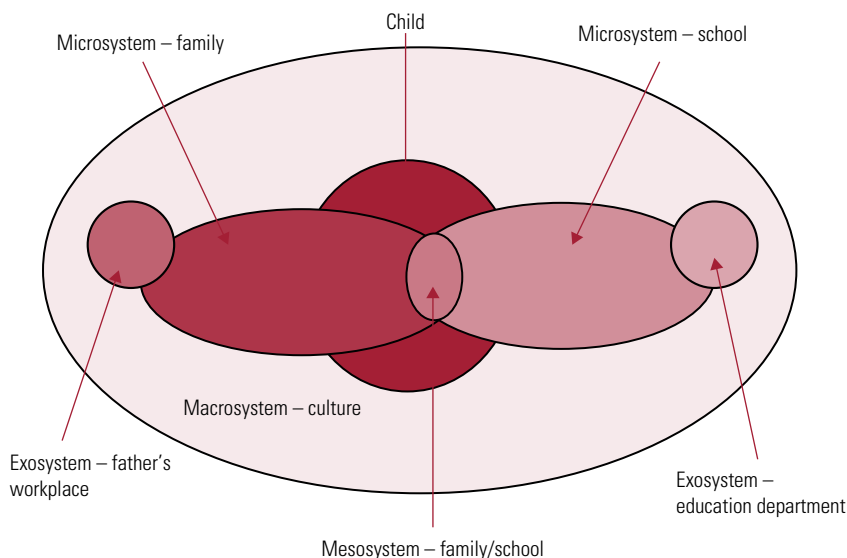


FIG 1 Modelled on Bronfenbrenner's 'ecology of human development' (Bronfenbrenner 1979), illustrating examples of systems that influence child development.

and advances in politics addressing environmental factors relevant for achieving greater health, and overcome the various limitations to treatments with currently approved approaches.

Interpretation of the child's state

First we need to wed the various concepts used to describe poorly children to the developmental processes substantiating their developmental pathways. Let us identify first with the parents who are keen to assess their child's state of distress accurately and decide how poorly the child is. They have skills in minding their child, knowing the child's usual ways of responding in their shared semiotic niche (Hoffmeyer 2008), their shared language (in its widest sense) for coping and complaining (Wilkinson 2003). What do their quirks mean? Initially they only have the infant's change in current level of functioning to go by, combined with the history of how their child's functioning has changed over time, in which circumstances and with which associated physical signs. Is the child behaving as usual? A hand on the forehead – flushed face? The sign in the child becomes a signal for the VIPs, based on their interpretation of what is making a difference to the child's state. The VIPs respond in the light of their interpretation and provide the child with an experience that a collection of signs functions as a symptom of a state that requires intervention (Wilkinson 1988). This process leads to error if the natural noise in the child's behaviour and complaining is given significance due to the interpretative biases and sensitivities of the caregiver – and what are culturally acceptable interpretations. These might be linked to the VIPs' own experiences of illness or trauma – for example, somatoform disorders are associated with greater bodily preoccupations in children whose parents have similar health beliefs (Marshall 2007) – part of their shared semiotic niche. In the language of the disco, it can produce the screech of feedback, as when the microphone and the loudspeaker are too close and the amplifier is turned up high. Clinical practice needs to know what turns up the VIPs' sensitivities about the need for action and how the family regulates interpersonal intimacy – being mindful of their needs. The VIP response can also give illness-type symptoms leverage outside the dis-ease paradigm within which they were initially interpreted.

Symbols and signs: coding duality

Symbols, as in culturally accepted symptom aggregations and diagnoses, and signs, as in the bodily expression of state, are of different logical types (Bateson 1979: pp. 127–143; Harré 1991). To

borrow from the language of biosemiotics, it is as if the analogue information of the continually varying state of the child (consistent with a dimensional approach to diagnosis) gets transformed into a digital code – and this two-sided quality, as in code duality (Hoffmeyer 2008: pp. 71–109), is repeated in the observations of clinicians to determine the diagnosis (the child has a diagnosis or does not). The critical challenge in child psychiatry concerns this code duality and how the analogue and digital information transformations affect how parents and clinicians respond to graded subjective states of discomfort and talk about them as things with identity. This is dramatically revealed in the code duality of sex and gender. Nevertheless, subjective states of discomfort can suddenly reach a crisis point, as in 'feedback' (for other rapid shifts in behaviour and affect, these can best be modelled mathematically using catastrophe theory (Woodcock 1978)). Mindful medicine includes and addresses the constantly evolving subjective states of the VIPs and child and the way they interact, whereas industrialised medicine is more closely aligned with having a diagnosis or not, the digital approach, rather than the dimensions of subjective distress, the analogue experience.

The utility of diagnoses

The utility of diagnoses is in their implication of guiding towards a helpful response, within the overarching paradigm of ensuring survival and minimising discomfort. But there is another paradigm of secondary importance that helps ensure survival: if the stress level is kept within bounds, an allostatic process, there is optimal integration of information from all memory systems, the implicit and explicit systems with their own underlying subsystems, to inform action. If not, then implicit learning will force through impulsive responses without reflection on the potential consequences (Wilkinson 2022). The goal for the RDoC (Cuthbert 2014) is to increase the utility of diagnoses; searching for validity is no longer the issue for the National Institute of Mental Health in the USA. Such utility, which is person centred rather than diagnosis dependent, is the lodestone of precision medicine. Mindful medicine has the same potential.

Developmental psychopathology and child psychiatry

Sroufe & Rutter (1984) described how they saw the difference between developmental psychopathology and child psychiatry. The former was seen as focusing on the origin and course of divergent adaptation, whereas the latter began with diagnoses and then looked for prognoses and relevant treatment of the

a. It is of interest that Melanie Klein's approach to treating disturbed children was to insist on seeing them alone and effectively adopting the same premises as the biomedical model: the child was being sent for repair.

b. For the first time DSM-5 has created a diagnostic category emphasising family context (Bernet 2016).

c. Currently in Norway the Health Directorate has decided to exclude all except the axis I ICD-11 diagnostic category in future documentation of clinical practice, thus cementing the industrial model and enabling political neglect of relevant contextual factors.

diagnoses. From the start of the discipline outside psychoanalytic circles^a the psychiatric gaze had built its treatment edifice on diagnoses as given entities, which needed understanding and responding to, on the same model as infectious diseases in somatic medicine. If diagnoses have no validity, in spite of repeated efforts at refinement over decades, then this project has failed.

An example: ADHD and complex systems

The diagnosis of attention-deficit hyperactivity disorder (ADHD) is currently seen as a category of neurodevelopmental disorder, analogous to a biomedical condition. The dimensional range of ADHD symptoms has been packaged to fit the prevailing diagnostic systems, albeit with modifications to diagnostic criteria over the years along the journey from hyperkinesis to ADHD. But ADHD should definitively not be regarded as a category (Coghill 2012). The symptoms do not constitute something a person has or does not have, but reflect dimensions of function in specific contexts. The world at large has yet to drop this misunderstanding. There are many vested interests in encouraging us to think about ADHD as a condition that primarily requires working with an individual patient and where medication is usually required – and that absolves everyone of personal responsibilities for enabling these young people to work towards more balanced ways of living with their predispositions. Not least schools are absolved from considering why it is often the youngest boys in the class who display most symptoms. Why does the prescription of medication for ADHD differ by a factor of 20 between the Nordic countries? There is no question that genetic and neurological factors can play a role, as well as the form of early care and, as with school expectations and structure, other environmental factors. The issue becomes how the child has adapted to the demands of his developmental niche given his initial resources, with a more or less mindful approach from those supporting the child.

The challenge is related to the way people develop, how nature, nurture and environment interact. People are complex systems of nested complex systems, living in complex social networks influencing the biology of the interacting and recursive complex bodily systems – and just as confusing! Just saying one uses a biopsychosocial model, and so implying these complex system effects, is not enough alone to advance clinical practice. In Popper's terminology, the World 1 elements are in a complex relationship to World 2 elements (Popper 1977: p. 36) (Box 1). Yet diagnoses are built on a biomedical premise founded in World 1 understanding. Complex systems, as entertained in

the biopsychosocial model, give rise to non-linear results with emergent properties, such as psychological suffering. To give an example from another field, predicting the results of climate change from all the complex recursively interacting systems that from moment to moment give us our weather depends on understanding the non-linear results of complex system interactions. Using diagnoses is like using the weather forecast, whereas treatment entails addressing the interacting systems giving rise to the storm of ADHD, and the precipitating and maintaining factors leaving the patient in a state of dis-ease.^b

Towards an ecobiopsychosocial model

Ecological processes have to be included in conceptualising what is going on with subjective dis-ease, currently packaged into diagnostic categories. Symptoms overlap between different diagnoses, blurring the boundaries between categories (Kendell 2003). Bronfenbrenner (1979) made an excellent start in providing us with a conceptualisation of the ecology of human development (Fig. 1). But we need to acknowledge that this is a gross simplification, something he tried to address subsequently with his 'PPCT' modification, i.e. including process–person–context–time (Bronfenbrenner 1995), which importantly includes the developmental processes over time. I suggest that the way forward is to convert child psychiatry to the tenets of developmental psychopathology, and place adaptation and the understanding of complex systems at the core of its practice. The biomedical model appears to be maintained because child psychiatry has built its clinical 'house' on the sands of this model. It has invited industry to make use of these unreliable categories, as if they were individual personal failings, rather than the subjective dis-ease of patients who have adapted to their context given their resources, some of which will be associated with predisposing biomedical diagnoses and the processes moulding their behaviour in their developmental niche. What started as a useful adaptation can prove singularly unhelpful in new contexts. This brings us back to including attachment strategies as adaptation to context (Crittenden 2021) in clinical formulations and the importance of retaining a multiaxial classification system with the transition to ICD-11, as recommended by Rutter (2011), so that context and the patient's differential susceptibility to that context receive the attention they deserve.^c We need to move to an ecologically informed biopsychosocial model (Bolton 2019).

Attachment strategies and developmental psychopathology

Attachment theory has spawned various schools of thought, changing over time, while continuing to

build on Bowlby's insights (Duschinsky 2020). For my purposes here we need to use the developments that have most closely addressed the adaptations for handling close relationships, developed to cope with the more extreme processes affecting the needs of vulnerable young people (Crittenden 2021).

One of Bowlby's lesser known insights was to suggest avoiding descriptive labelling. Instead he suggested the different groups should rather be known as the types A, B and C attachment behaviours and, in older children, their attachment strategies, until we knew more about what characterised these groups. This appears to have been sound advice, as generally the subsequent label of 'secure' for type B, for example, has led to a moralising about what has been seen as a desirable strategy, rather than all strategies being the result of optimal adaptation to the contingencies within which the infant is developing. The patterns in these contingencies reflect the politics of need and trust, the defining of another person's needs by someone in power, with the consequences for trust between the involved parties depending on the accuracy of the identification of need and respect for their individuality. This is central to why the clinical process needs to be guided by goal-corrected partnerships, rather than goals of treatment being determined by either the patient or clinician alone. The power politics within families, and institutions such as nurseries and childcare services, are only more or less in tune with the needs of those in their care.

Note the transition from referring to attachment behaviour in infants to attachment strategies, where the behaviour has become strategic in light of the infant's developing theory of mind. Infants' initial VIP contact is through what we term primary intersubjectivity, the mutual gaze. A 1-year-old shares gaze and brings shared objects into focus with their VIP – secondary intersubjectivity; and, at least by 2 years old, they have developed a tertiary intersubjectivity, an emergent phenomenon, in which mind-reading skills play a role in how they adapt their responsiveness to VIP initiatives (Box 2). Their behaviour has become strategic, taking into account the other person's anticipated intentions, through reading the state of the other person and adapting accordingly. Mindful medicine needs the same sense of taking into account the patient's mind in producing goal-corrected partnerships. In such partnerships all the infant's initial predispositions are playing maintaining roles, which have become more or less modified through early development.

When attachment strategies fail to adapt

Each attachment strategy has its advantages and disadvantages depending on context. Type B

BOX 2 Intersubjectivity

Primary intersubjectivity: Shared facial contact in which two people become in tune with each other. Classically used to describe the shared gaze between a mother and her newborn.

Secondary intersubjectivity: When mother and infant gaze at an object that holds their shared attention.

Tertiary intersubjectivity: When an infant has refined his or her mind-reading skills and can implicitly deduce the needs and intentions of the other person so that they are mutually mindful of their subjective worlds.

results in the ideal victim for a psychopath, and is not necessarily 'secure', as in one label given to type B; type A can be the ideal self-sufficient survival strategy in a civil war; type C can be ideal for different circumstances, such as forcing yourself to the front of the queue in a stretched health service or, for a manipulative politician, avoiding taking personal blame (Box 3). But in new contexts, a strategy that was advantageous to maximise available care and survival at home can prove to be a liability or, if lucky, an opportunity for further development – changing school, moving house, long-term relationships, a pregnancy, among others. However, if the opportunity is missed, then behaviour that ensured the available care at home can either escalate, according to the practice of 'maybe more of the same will force a response', or enable a more extreme form of self-sufficiency. This can bring the child to the attention of others as 'disordered'. Symptoms have communicative force and are not equivalent to signs of disease. Their origins have to be understood in terms of their history of interpersonal effectiveness.

Sameroff's (2009) transactional psychology has provided us with an approach that links attachment theory and adaptation. Through acknowledging the importance of the transacting genetic, constitutional, neurobiological, biochemical, psychological

BOX 3 Attachment strategies and mindfulness

Type A: The individual finds it more natural to be more mindful and responsive to the needs of others, to the relative neglect of their own, especially when under stress.

Type B: The individual manages to keep their mindfulness of others without losing attention to their own needs.

Type C: The individual has a relative neglect of the needs of others, being especially minded of their own needs when under stress.

and sociological factors in the determination of behaviour, he has assisted with building a bridge to an alternative to diagnoses to inform the treatment formulation. Remembering the way complex systems function, he has pointed out that each of these factors changes the others through their dynamic transactions. Gene expression is changed in different environments; the care of the infant shapes brain development, etc. And potentially states get transformed into traits.

How do we get from diagnoses to mindful medicine?

‘When a trusted health professional explores a patient’s need, a relationship is formed. This relationship is key to agreement and to shared actions that might follow.’

(Batalden 2018)

The quote above could just as well describe the parent of an infant trying to establish the nature of their child’s discomfort. When need is greatest, such as when an infant’s discomfort is greatest, then clinician or VIP will hopefully rely on an openness to all possibilities and not jump to premature conclusions. And yet there is little help to be gained from the newborn, signalling with all her might through her primitive cry. The power balance is skewed. In this predicament, which all parents have been through, we throw in our prescient intuitions, which become further shaped by how successful they become in achieving calm – for both VIP and infant. But we must not exclude the way in which these intuitions arose. We are already on a pathway of attachment adaptation, formed through how our own brains have been attuned to the signals of others’ caregiving. Strathearn et al (2009) have shown the varying activation patterns in reward areas of the brain when caring for one’s own infant, and their associations with different attachment strategies of the mother.

Varieties of ‘dis-ease’ and the goal-corrected partnership

One of the key ideas from attachment theory was to frame treatment in terms of developing goal-corrected partnerships, rather than a goal-directed partnership determined by one or other party to the treatment relationship. This originated from observations of the way in which cooperation between infant and parent developed (Marvin 1999). To advance cooperation in addressing ‘dis-ease’ we need to differentiate between the concepts of (a) illness, for our subjective discomfort, (b) disease as delineated by identifiable pathognomonic processes, and (c) disorders which are collections of symptoms occurring regularly

together, albeit without identifiable pathognomonic processes. Disorders are of symbolic significance, not to be confused with the signs of disease. And then there are also (d) sickness, to describe the state attributed by VIPs based on their interpretative codes, and (e) predicaments, the challenges resulting from the state (Box 4) (Wilkinson 1988: pp. 37–38). Again these are different logical types, potentially leading to confusing health/dis-ease dialogue depending on perspective if one mistakenly believes them to be necessarily coherent.

Each of these states is related to activation of different memory systems to guide the predictive brain (Clark 2016) towards a helpful activity pattern, so that compassionate empathy trumps emotional empathy and establishes trust through responses that assuage the child’s distress, the child’s need, the essence of intelligent kindness (Ballatt 2020). The greater the mobilised fear in the VIP, child or doctor, the greater the chance that implicit learning, the procedural memory guiding the motor response or perceptuo-affective memory guiding the emotional reaction, will precipitate more impulsive practice. Reflection requires that the doctor is calm enough to integrate information from all memory systems. How a doctor’s tertiary intersubjectivity (Box 2) has formed their anticipatory responses to the needs of others sets them on to one or other sort of alliance with the patient. Using the term ‘client’ is detrimental to this process of achieving a goal-corrected partnership, which instead needs to be built around the subjective discomfort of the patient (etymologically from the Latin for ‘I suffer’), their illness and how the patient’s function is affected, their predicament.

BOX 4 Varieties of ‘dis-ease’: all of differing logical types

Illness: The patient’s subjective discomfort, their personal suffering. Alliance with the patient builds on responding to illness experiences.

Sickness: The state of being sick attributed to the patient by those who have observed the patient’s behaviour given their theory of mind. Restricted to lay perspectives. Alliance with parents is built on responding to their sickness criteria.

Disease: Characterised by pathognomonic signs.

Disorder: Characterised by a collection of symptoms which tend to occur together. Often reified to the ‘status’ of a disease. Currently important for communication between clinicians.

Predicament: Challenges posed by the patient’s ability to function in their social context.

Mindful medicine: reading attachment strategies

Different attachment strategies and their modified effectiveness in the light of trauma, loss and learned helplessness when trying to settle can only be here described with a rather coarse outline. Suffice it to say that there is a major challenge for mindful practice in child psychiatry to avoid overlooking those patients using a type A strategy because their needs are not ‘flagged’ effectively. The caregiving contingencies they experienced led to them becoming as self-sufficient as possible. They often appear to find it a challenge to share their discomforts with strangers, or even have an effective language for doing so. This can result in premature discharge, the classic flight into apparent health. This contrasts with the exaggerated rather flamboyant style of those with a type C strategy in their meeting with health services. For them suffering may be emphasised to ensure a response that they have otherwise found insufficient or unpredictably available in their developmental niche. This group of patients needs predictability of a finite response and the avoidance of interminable treatment, the symptoms nevertheless often returning when discharge is imminent (Wilkinson 2022). The difference between type A and type C patients who cut themselves may show itself by the first group always keeping their cutting hidden and often denied, whereas the second would prefer to use short-sleeved T-shirts and make their bleeding as visible as possible. To develop the practice of more mindful medicine the nuances in these attachment distinctions need to be fully developed in the context of clinicians being aware of their own attachment strategies when under stress. And we must not forget that administrators in the health service, in order to facilitate mindful practice, must also be aware of these interpersonal dynamics and the parts they play indirectly in the treatment dynamic.

The case formulation

In clinical practice these varying strategies for optimal adaptation need to be integrated in clinical formulations to guide treatment. Using a combination of Sameroff’s insights and research into personality (Wilkinson 2022) we can conceptualise the clinician’s case formulation in mindful terms as the transacting genetic, constitutional, neurobiological and biochemical factors in infancy in interaction with the infant’s attachment behaviour and subsequent attachment strategies (Box 5). In true complex system processes, these early attachment patterns feed into the developing brain’s structure, to modify the infant’s dispositions, given their differential susceptibility, and maintain or resolve what could come mistakenly to be regarded as inborn

vulnerabilities. Into these interactions with the attachment strategies of children, we still need to add experience of trauma and loss, and learned helplessness, which have major effects on the execution of attachment strategies, as well as affecting biomedical processes associated with higher mortality and morbidity (see for example Wang 2023 and its commentary, Segal 2023, which provides ideas for clinical responses).

A clinical vignette

When an adolescent was presented by her mother as being in difficulty, the way the girl hid her self-injury rather than make it visible suggested she might be coping with a type A self-managing attachment strategy. She was keeping her struggles to herself, coming to the consultation at her mother’s bidding, while the mother was not able to fathom what might be troubling her daughter. But how might that be, given the apparent competence of her mother, a single parent who was not struggling with economic problems and appeared to have order in her life while running a business? The scenario invited us to adopt a biomedical model in which our focus should only be on the patient. However, a different approach is called for.

The mother

We need to be mindful of the girl’s wish to manage on her own and hide her difficulties; we need information about what has disposed the mother to overlook particular signals from her daughter and perhaps over-emphasise the significance of other behaviour. Maybe the mother has predictably ignored or responded negatively when her daughter had been in distress in her younger years. This information is best addressed through enquiring of the mother’s own upbringing. How were her sensitivities formed in her childhood? What sort of strategies did her parents use to facilitate her development, and how might these processes have formed her awareness and biases when picking up the signals from her young daughter? What mind-reading skills had the mother developed? A three-generation perspective is necessary when understanding mindfully. But beware, we can seldom give reliable information about our own upbringing. We need the observations of others with their mindfulness of those involved.

These developmental processes need to be put beside the current life dilemmas that might have hindered the mother in making use of her resources. Was she distressed or feeling helpless when the patient was younger so that she was potentially less available for the patient? Might there have been predisposing factors that affected the mother’s capacity to be mindful of her young daughter’s needs, regardless of how her initial capacity was formed in her own childhood?

We will be especially interested if the mother experienced events that had the same ‘charge’ as those that seem to have precipitated the daughter’s self-injury. Might these have exaggerated her challenges to be mindful of what her daughter was struggling with? Regardless, that would have been a challenge if the daughter was disposed to try to manage on her own, giving few signals of the ‘trauma’ she had experienced.

BOX 5 An approach to ingredients in a mindful family formulation

- 1 Note the biases in patient information processing that bias the predictive brain's anticipated action plans:
 - (a) influenced by biomedical factors present from first year of life
 - (b) influenced by the interpersonal dynamics of early upbringing
 Points (a) and (b) result in the patient's attachment strategy, and modify which discomforts are shared or kept relatively hidden
 (c) often maintained by responses from VIPs.
- 2 Note the biases in VIP information processing that bias the predictive brain's anticipated action plans
 - (a) influenced by factors present from the VIP's first year of life
 - (b) influenced by the interpersonal dynamics of early upbringing
 Points (a) and (b) result in the VIP's attachment strategy, and modify which discomforts are acknowledged and given importance for the patient.
- 3 Note how 1 and 2 interact.
- 4 Note the context factors triggering the sense of being under threat or in danger. These convert predispositions into vulnerabilities:
 - (a) for VIP, patient and therapist
 - (b) note how these interact with 1 and 2.
- 5 Note previous experience of trauma and loss for all involved, noting at what age they were experienced and whether they were repeated.
- 6 How do the above recursively interact to enrich or perpetuate problems?

'Information processing' covers the way in which interoceptive and exteroceptive stimuli are prioritised in connection with modifying the action patterns being continually initiated in response to incoming information (for links to attachment theory and psychiatric diagnoses see also Bowlby 1980: pp. 44–74 and Crittenden 2002). This is central to the predictive brain hypothesis and has similarities to the backpropagation integral to the development of refined artificial intelligence.

The biases arise on the basis of the historical importance attached to the various stimuli, given the total reading of the context at any moment. Attachment strategies have characteristic biases which have developed over time and reflect how predictable particular responses from VIPs have been when children have been in need. The strategies are interpersonal and are repeated in clinical consultations, especially the initial consultation, when there is maximal uncertainty about how the clinician may respond.

Therapy leads to new learning, i.e. new priorities in information processing, which then take precedence over old learning, even under states of duress.

The mother–daughter dynamic

Diagnosing a depressed, potentially suicidal patient does not, alone, enable us to create a functional treatment formulation that addresses the maintaining VIP–patient dynamic in a compassionate manner. The mother needs as much compassion as the patient to enable them both to come to the sort of mutual support that could help the daughter through the events that had traumatised her. These had led to her cutting the inside of her thighs, which were to be kept hidden from everyone and yet symbolically hinted at the trauma she had experienced. Diagnosing her as having post-traumatic stress disorder (PTSD) or a personality disorder would have encouraged alternative approved approaches, as both trauma treatment and emotionally unstable personality disorder have well accepted approaches, albeit not successful for all patients. These diagnoses can have some of the same symptoms, although we would expect to hear of different predispositions, precipitating and maintaining factors. Regardless, mother and daughter need a mindful approach adapted to their respective personalities, reflecting their illness and sickness perspectives, so their needs can be met within trusting compassionate relationships.

But such an approach might not address a potential maintaining factor in the mother's understanding of how to meet her daughter's needs. An approach is needed which combines the mother's understanding of her daughter with the biases in how the daughter

reads the interoceptive information coming from her body, managed through her cutting and triggered by signals from how her peers misunderstood her false-positive affect, associated with a type A attachment strategy. Hopefully they will be met by a therapist aware of the factors in mother and child and their co-evolution, and having the flexibility to adjust their strategy to meet them both in a mindful way. On this basis classic approaches to PTSD could be added into the treatment mix – and perhaps could also prove useful for relatively unacknowledged abuse of the mother during her upbringing. The mindful therapist would not be acting impulsively through triggers to their own life experiences. Through meeting patient and mother in this single-parent family together the therapist could optimally foster compassionate caring in practice to serve them both for the years to come.

Conclusions

I will adapt a quote from Laing, in *Politics of the Family*, to the health services in which clinicians play their parts: 'We are acting parts in a play that we have never read and never seen, whose plot we don't know, whose existence we can glimpse, but whose beginning and end are beyond our present imagination and conception' (Laing 1998: p. 87). We appear to be dancing to a diagnostic ditty, familiar to all, but origins lost in time. It is time to unravel

the complex systems that make use of international diagnostic classifications for both addressing patients' needs and enabling politicians to distance themselves from human suffering. It is necessary to change political systems and industrial lobbying, which thrive by instantiating psychiatric diagnoses as biomedical products of individual responsibility and minimising the role played by social context. Change in context, both familial and sociocultural, needs to come higher up the treatment ladder. Precision medicine depends on this. Public health is also public mental health. It depends on nourishing the conditions for a healthy society (Marmot 2015). Politicians should not be able to hide behind a biomedical model in which it is the patient alone whose health is failing and who has to make a lonely journey towards health.

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Declaration of interest

None.

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MCQ answers

1 b 2 d 3 c 4 d 5 a

MCOs

Select the single best option for each question stem

1 Attachment strategies develop:

- a as a response to trauma the person has experienced
- b as a result of how the person's attachment behaviour has been responded to
- c in infancy
- d to cope with poor parenting
- e to enable a person to cope with illness.

2 A comprehensive mindful clinical formulation pays no attention to:

- a the clinician's understanding of how sickness has come to be attributed to the patient
- b the patient's attachment strategy
- c what can empower the patient
- d the various dangers experienced by the patient
- e how mindfulness techniques may be employed.

3 Transactional psychology:

- a was developed by Bowlby
- b explores how people interact
- c is consistent with how complex systems lead to emergent processes
- d is in conflict with how attachment theory views adaptation to context in development
- e helps to understand how illness, sickness and disease interact.

4 Diagnostic systems in mental health:

- a to be useful, need to be linked to parental views of sickness
- b are based on categories with clear boundaries that can be used to determine treatment
- c are being reviewed in the Research Domain Criteria project as it looks for an alternative system based on dimensions of human suffering
- d are more or less helpful, not more or less valid
- e need to drop the five-axis diagnostic system of ICD-10.

5 Understanding 'complex systems' is necessary in order to:

- a understand the dynamics giving rise to human suffering
- b predict the form of human suffering
- c understand why disorders and diseases are of different logical types
- d elaborate the connection between diagnoses and the biomedical model
- e understand models of linear causality in mental illness.