Child Psychiatry: White Elephant, Scotch Mist, or Medicine?

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My jokey title, like most jokes, incorporates a serious truth. The truth is that, despite the apparent clinical expansion and academic wellbeing of our subject, the experience of being in a senior position within it is that it is under threat as a medical enterprise. The sense of threat is felt mostly from the stagnation of the retrenchment in the physical and human resources needed to mount a real service, although I grant that consultant numbers have increased. Management will opt for the least costly alternative when they are presented with a broad range of advice of apparently equivalent worth which is available from various professionals within the subject. Indeed, given the degrees of diversity of views that exist, managers might at times wonder what it is that purports to be the subject. It is not difficult for child psychiatry to achieve a negative image within health management since a number of negative stereotypes naturally accrete around people with serious problems of living and coping, or developmental failure, mental impairment, or chronic sickness. Combined with small size, often a single representative in a District, and dealing with small people who suffer lack of political clout, the management case for neglect of child psychiatry when faced by harsh choices may be overwhelming. Further, child psychiatry arose from a triune of social work, psychology and psychiatry and their quite proper individual professionalisation has afforded the possibility of splitting, not only as among psychiatrists but between psychiatrists and other professionals. In the current political climate and faced with resource shortages those splits are likely to accentuate in ways which leave managers rather than practitioners in control.

My title suggests three alternative views; that child psychiatry is a white elephant, an archaism unwanted by the owner but difficult to dispose of; or Scotch mist, a doubtful or illusory phenomenon; or else that child psychiatry might be just another aspect of medical practice requiring the collaboration of many types of skill, medical and non-medical, to make it work as does open heart surgery, or ophthalmology. The other component which makes the basis of child psychiatry questionable is ignorance. Most doctors and health care personnel were trained in an era when, or in situations where, child psychiatry did not exist. Some people have problems in dealing with ignorance and they use projective mechanisms in coping with it.

White elephant

Adult psychiatric services came fully under the management of the National Health Service from its inception in 1948. But many of the child guidance clinics remained under the management of the local education authorities until 1976 when the consultant psychiatrists were incorporated into the Health Service. In parallel with the child guidance clinics, certain hospitals developed child psychiatric services of their own, usually largely for liaison work but also allowing out-patient and even in-patient services. This division of resources and division of emphasis between hospital-based and community-based services has coloured psychiatrists' views about what sort of caseload and what sort of cases they should be seeing and probably influences their therapeutic style. Many child psychiatrists still work partly, and some exclusively, in local authority premises; many were trained in that style. There is, it seems to me, an inevitable sense of being a guest in such situations which might influence the psychiatrists' behaviour, their sense of what resources they require, their relationship with would-be colleagues working in hospitals.

I am uncertain whether the takeover of child psychiatry by the NHS is seen, on balance, as profitable to all concerned. One senses a renewed thrust for child psychiatry to be located 'in the community', which I take to mean somewhere less expensive than a hospital, and I see a danger of its location there as a prelude to hiving it off back to the penurious isolation and the financial whim of the local authority. The poorest authorities, who would also have the greatest number of disadvantaged people, will be the least likely to afford good services. Child psychiatry may be moved in this way since it is the least likely among the specialties to attract private patients. It would be a massively retrograde step, a return to the origins of the subject.

Its origins might be variously construed. Alexander Walk[1] has drawn attention to the existence of young patients in the mental hospitals, and the workhouses would equally have served to contain and confine children. The 'mental hygiene' movement, which manifested itself towards the end of the 19th century, derived from the success of the 'public hygiene' movement. Since poverty was regarded as an heriditable disease and since other persistent plagues and scourges had responded to better planned facilities and decent management, why shouldn't proper habits be taught to the indigent? The movement was much influenced by Clifford Beers' *The Mind that Found Itself*[2] in a way that one saw the influence of Norman Cousins on cancer management quite recently. A psychiatrist was recruited to the Boston Habit Clinic to join what was

essentially a social work venture. These clinics soon spread rapidly in the USA and in Britain. In Europe the movement was matched by the Heilpadagogik and by the special educationalists Pestalozzi and Montessori.

In trying to understand some of the tensions that arise now between management and service and between the various practitioners, we have also to bear in mind the wide variety of other influences which shaped the subject.

Out of the concept of the universal education of children and the more enlightened view of education introduced by Rousseu, there came a need to determine by some means those children unable to profit by normal schooling and hence the issue of psychological testing. Various abuses of this have led to a withdrawal of interest in the concept of 'native intelligence' but the more sophisticated use of testing in a neuropsychological sense is not widespread. Psychologists have been very adaptive at finding other useful roles.

An interest in the family as a structure arose more from anthropology with application to children's issues than the reverse. Families' and parents' accounts of children and the vicissitudes of development also became evident through the rise of paediatrics. The major preoccupation for parents hitherto had been more an issue of survival. In the year of my birth, perinatal mortality was 62 : 1000 (now 6 : 1000) and the death rate in Manchester's children's hospitals was about seven times what it is now from about one third the number of admissions. Human development, the notion of organismal and psychological metamorphosis over time, became apparent to the paediatricians and fitted some of the conceptual issues which arose from psychoanalysis through Freud and the French school.

In this country Donald Winnicott[3] was the prime exemplar of the fusion of paediatrics and psychoanalysis; his textbook appeared in 1931. Leo Kanner's book[4] was prefaced by both the professors of paediatrics and of psychiatry.

The remaining important influences were the rise of interest in adolescence which occurred with the publication of Stanley Hall's massive tome,[5] itself profoundly influenced by Abraham's derivation of stages of a life cycle beginning from infancy, and secondly, the concern with delinquency through people like Healy & Bonner[6] in the USA and Aichorn[7] in Vienna.

Nevertheless, when they were set up the child guidance clinics actually presupposed in their title that they constituted a knowledgeable team, capable of providing guidance to confused or incompetent parents in child rearing and in cases of child disorder.

Scotch mist

Whether child psychiatry and child guidance are seen as doubtful or illusory phenomena will depend very much upon perspective. First an epidemiological view. There are in the North West 14½ District Consultants, two Regional consultants and four university staff. If they had no special responsibilities and were evenly distributed, they would provide for about 1,000,000 under 16s at about one per 200,000 of the population, just half the College view of appropriate norms. According to modest estimates, about one child in ten is seen as significantly disturbed through parents' and teachers' estimates and about one in ten of such children should be seen by psychiatrists, about 10,000 in the Region at any one time. In reality, a hardworking psychiatrist might see 250 new patients per year, thus amounting to 5,000 patients throughout the Region. Discrepancies arise through availability and visibility and idiosyncracies of the referral patterns—some doctors simply never refer cases. Emergencies and severely disturbed patients are rare enough for non-referring doctors to simply forget them when they finally hear about them through other channels.

In terms of efficacy there is no research to support a view that customer satisfaction is any more or less than in other subjects, though there is a tendency to diminish the value accorded to mental health care contacts.

Medicine

The future direction of child psychiatry, the sorts of patients to be seen, the sorts of therapies to be instituted, and the sorts of collaboration with skilled colleagues in other disciplines which are likely to be available, are of intense concern to those of us with the responsibility of teaching the subject. If child psychiatric doctors actually wish to abrogate their medical roles, as it seems at times that they do, and others also wish them to do, I feel that there are likely to be considerable professional and financial repercussions. If, however, the years of medical training are to be put to the service of children and families and to non-medical members of the child mental health team, then that medical training will have to be directed, at undergraduate and postgraduate levels, in a precise manner so that the role of the physician, as contradistinguished from the roles of nurse, psychologist or social worker, can be seen and evaluated.

The medical model, which achieves at times the status of a term of abuse, means to me that when faced with a sickness it is necessary to specify the impairment to the finest level possible in order to allow rational and precise treatment to be given at the least possible human cost to all concerned. It is also necessary to consider aetiologies so that preventive practices can be instituted. I hope to show in that definition how it might be quite possible to have beneficial influence on the experience, or the course of the sickness, in a variety of ways without meeting the constraints imposed by the medical model because no hypotheses about the level of impairment were ever entertained and no knowledge has been or will be gained about aetiology. Thus a patient with neurosyphilis might be persuaded from a tiresome behavioural aberration and enabled to live in appropriately sheltered circumstances and more humanely treated by his family, as an alternative to, rather than as an adjunct to, penicillin treatment if medical aetiologies are not pursued. Not unreasonably, medical people give primacy in their hierarchy of causation to structurally specified abnormalities and to precise therapies.

But there is also a broadly pervasive medical perspective and this derives from an informed view of a number of possibilities that arise from a broad medical, and a specific

psychiatric training. Conventional medical history-taking needs to be much modified for child psychiatry since the essence of the history is more likely to be the history of the reproductive group as a developing system than it is to be the history of the present complaint, but that alternative is ever present in a minor key and may suddenly need to be the major theme. That is not the most common eventuality but it is what the doctor is a doctor for. There are a number of social and psychosocial possibilities thrown up in interviewing a family which need not be construed medically but it depends upon the doctor in the team if there are issues to be so construed. There is a great danger is specifying particular case histories in which understanding medical issues was crucial, by way of justification of this argument, because the examples can readily be set aside as rarities or simply ineptitudes on the part of previous medical personnel. It is the pursuit of the medical model in its broader application, in its more general sense, which I think more persuasive. Progressing through a history in this way, one works through possibilities in genetics, obstetrics, neonatology, paediatrics and child development before turning more formally to the mental states of the parents and the child they present.

The aim is not to pluck triumphantly the missed cerebral tumour from the background noise but rather to make the seeming noise more musical.

> "Every illness is a musical problem
> so said Novalis
> And every cure a musical solution".

Risky or not, as an example, with Dr John Higgs and Dr Elise Rivlin I published in *Archives of Disease in Childhood*[8] a vindication of a model of sickness which was intended to reveal the intense paradox of a medical approach. A girl of five was referred by an ophthalmologist because her nasty habit of eye-rubbing was ruining her cornea. On examination she proved to be mentally handicapped, nearly speechless and multipli-physically stigmatised. Behavioural methods rapidly eliminated her eye-rubbing, but this was undertaken in the context of intensive family work in the course of which, a similarly stigmatised handicapped but behaviourally normal relative was revealed. The very unsatisfactory marriage broke down but this strengthened her mother's capacity to mother and control her child. She was able to accept a more appropriate school and major developmental advances ensued. The translocation trisomy underlying the problem was in one sense by the by, and yet in another, crucial to mother's total reorientation. Many persons, physicians among them, had been involved with the family but it was a medical child psychiatric perspective which recognised the difference between abnormal structures, illness behaviour, and excruciating predicaments while at the same time bearing the relevance of each in mind, which was ultimately successful and which in this instance had major preventive import. The intense paradox of the paper was totally missed since only geneticists showed any interest in it!

Similarly, a boy of 12 soils his trousers and wets by day and night. In a previous admission, at the age of 8, despite his modest intelligence, he learnt clean habits. He has lived with his grandmother, and her daughter, who bore him unmarried and who relates to him only as a jealous sibling. His ageing grandmother cannot cope with his needs and his dirty habits reappeared and made him unacceptable at school. Now older, his vague dysmorphism and multiple minor defects suggested a genetic causation which has now been proved. We have learned of the existence of this anomaly in the population, we can attribute various of his problems to it even though it only heightens their probability of occurrence and cannot be said to be causal until we know more behaviour genetics.

I argue that child psychiatrists should be trained to maintain and deploy physicianly skills so that, in the group of people working in child psychiatry and child guidance, the doctor can bring evident and unique skills which can be respected in the way that the skills of the psychologists, the social workers and other professionals are also evident and respected and different.

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