The College

Child and Adolescent Psychiatry Section

Issues in 1981*

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During the course of the year, the Section has held two major meetings. The first, held in March at the Royal College of Physicians, was devoted to the considerations of Longitudinal Studies, a topic particularly relevant to those working with developing individuals. The second meeting, a residential one spread over three days, was held in Southampton, and the 1982 meeting will be in Edinburgh. Since 1981 was the year dedicated to disabled people, there was a special emphasis on children handicapped by mental retardation or by physical disorders.

At times we have been criticized by other Sections for not participating more actively in the Quarterly Meetings, but the two meetings arranged by the Section are almost invariably over-subscribed. When study leave is precious and expenses by no means always forthcoming from employing authorities, it seems reasonable to attend meetings that are highly relevant to one's work rather than those with only scattered items of interest, but this does make us open to the suspicion of being 'separatists'.

Our Executive Committee meets every two months. Some of the items on the agenda correspond to the preoccupations of the rest of the College. Thus, parasuicide, confidentiality and secure units have been thrashed out in sub-committees and at length by the Executive Committee as a whole; a group representative of the wide variety within the Section, from traditional analysts through family therapy to the 'numbers people' (as those concerned with epidemiology have been described by one of their own offspring). A recent analysis of the Committee found that the members were well spread out geographically, most of the Health Service Regions being represented.

Multidisciplinary work, too, has been an interest of the College as a whole, but has never been so well sent up as by Ezra the Scribe's description of the cricket match, 'Hospital v. Social Services', published in the *Bulletin* some years ago (November, 1977, p. 12). Traditionally, the staff of child guidance clinics resembled the very senior nurses at St Thomas' in those pre-Salmon days when Florence Nightingale was Queen, as they walked three abreast down the wide corridor.

Now, child psychiatrist, educational psychologist and psychiatric social worker vie with each other for 'primacy', pausing in the midst of the jostle only to speak the new Brunel language. They have been joined by a fourth, the child psychotherapist, an urban creature, rarely found beyond the boundaries of NW3. Following the publication by the College of 'The Roles and Responsibilities of the Child and Adolescent Psychiatrist', the others flew back to their parent disciplines, each returning with an equally impressive document on Interdisciplinary Work to be published by a neutral body, the Child Guidance Trust, with an Appendix from each of the four disciplines.

Just as contentious an issue is that of Emotional Abuse. No member of this College needs reminding that cruelty need have no physical component, yet emotional abuse is like the elephant, so easy to recognize and so impossible to define. At one extreme, all of us recognize ourselves as guilty of unnecessarily hard, unwise words, of restricting our teenagers' freedom by keeping their minds on 'O' Levels rather than discos, or of impeding our youngest's autonomy by protecting them too long from traffic or strangers. From this we go to an impotent position in which we leave children in a threatening, callous or bizarre atmosphere because we dare not risk a confrontation in Court. We hope that the recommendations embodied in the Discussion Paper which follows this article (p. 85) will be thought effective to protect children without being intrusive and restrictive in relation to the varied pattern of family life in a multi-cultural society.

Family therapy has grown rapidly over the last ten years and most child psychiatrists are involved to a greater or lesser degree. There are a number of different techniques, another new vocabularly to learn and even upon occasions participating in what seem like charades.

Going forward into the future, child and adolescent psychiatrists recognize that they are children's doctors and have much in common with paediatricians and other specialists concerned with children and young people. Close links are being made with the British Paediatric Association on both academic and practical levels. Many of us feel more at home in the Children's Department of the general hospital than isolated in clinics belonging to the local authority or as a junior branch appearing alongside Psychiatric Departments for Adults.

*The views expressed are those of the author and do not represent an official viewpoint of the Section.

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Liaison is another word pervading the College. Child and adolescent psychiatrists seek to work with all those interested in the welfare of children and young people. Still moving towards improved relationships with those traditionally involved in the same clinics, we are also having to branch out and work in co-operation with all those who have responsibility for the care of children, whether their own or other people's. There are many examples of work done with difficult children in their own schools or their own homes, so that those who have day to day responsibility for them, that is to say teachers or parents, are the ones who provide the direct help to the child. Preliminary results are encouraging, and the parents or teachers are more competent at dealing with the next problem than if the child attends a clinic for some mysterious form of therapy. Sometimes the work can be preventive, such as in advising Family Conciliation Services to help parents who are separating make plans for their children and even to educate the legal profession to prevent the adversarial system from using children as weapons. All this takes time that could indeed be spent on treating individuals. How we arrive at a balance between such preventive work and our own individual sessions with children is something each must work out for him or herself. To lose the essential skills and the clinical experience that communication with individual children brings would mean that we had lost our own souls and had blown up like an outsize vegetable marrow which when cooked is found to consist of a mere veneer spread over a mass of hot air.

Emotional Abuse of Children

This Discussion Paper has been prepared by a Working Party of the Section,* convened to consider the implications of the DHSS Circular LASSL (80)4-HN(80)20-2.2c(ii). A new category is to be included in Child Abuse Central Register Systems—'Children under the age of 17 years whose behavioural and emotional development have been severely affected and where medical and social assessments find evidence of either persistent or severe neglect or rejection.'

Previously the legal framework for considering cases of 'emotional abuse' lay in a section of the Children and Young Persons Act, 1969, where grounds for a Care Order in respect of a child can be 1(2)(a) 'his proper development is being avoidably prevented or neglected, or his health is being avoidably impaired or neglected, or he is being ill treated.'

The Working Party were also asked to attempt to define the concept of emotional abuse and the threshold beyond which concern should be expressed, and to recommend a code of practice for child and adolescent psychiatrists.

Responsibilities with regard to At Risk Register systems

In many, if not all cases of physical abuse of children, there is also emotional abuse, and in some families one child may be physically abused whereas another child is emotionally abused. The new category is potentially helpful in dealing with the wider concept of abuse.

In the period following the inquiry into the death of Maria Colwell, inclusion of children on a register was frequently done in an uncritical way, with no set time limit. The work of the Area Review Committees then led to refinement and limitation of criteria, anxiety diminished, and more effective use of registers developed, with monitoring and with criteria for removal of families from registers. The problems of confidentiality and legal rights of parents as well as children have been openly and constructively discussed. The work of Area Review Committees has been subject to local variations because of differences in their composition and differences also in the communities they serve.

It is not known to what extent child psychiatrists may already be represented on Area Review Committees. If children who are victims of severe emotional abuse are to be helped by at-risk procedures, then active involvement of child psychiatrists in local committees is essential.

Problems of diagnosis

Child psychiatric disorder has a variety of antecedents and there is no picture pathognomonic of emotional abuse. It is necessary for diagnosis to have knowledge both of the child and the family, and establish a connection between the child's state and the parents' behaviour.

'Good enough' parenting

Very few parents, if any, can meet *all* the needs of *all* their children *all* the time or refrain from ill-timed, inappropriate responses to children. Most parents can be expected to achieve parenting which does not impede or seriously damage development. In the vast majority of situations it is clear that a child being reared in his family is faring better in terms of happiness and human development than a child reared in an alternative setting, such as, a children's home.

Parent care and child rearing practice should be seen not as an ideal and needing to follow one particular pattern, but in terms of being adequate for a particular child.

Some children are undoubtedly more difficult to manage by virtue of their temperamental characteristics. Certain other factors may jeopardize a child's status in the family, such as, prematurity, physical abnormalities and chronic

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