Holmes Sutton Routledge 2013

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PAEDIATRICS, PSYCHIATRY AND PSYCHOANALYSIS

I'm a doctor whose job is to try and help by understanding about upsets.[1]

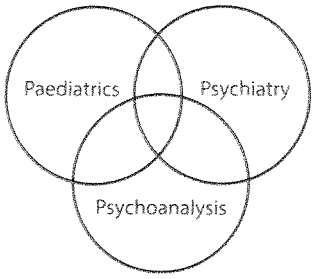


Figure 2

Medical Education has become an academic discipline seeking to prepare students and doctors for life-long learning. It has capitalised on research in 'Adult Learning Approaches' and teaching and learning methods derived from this (see e.g. Merriam, Caffarella and Baumgartner 2007). One such method is *Problem Based Learning* (*PBL*) (see e.g. David et al. 1999). It uses a structure which presents scenarios and defines steps to use in examining them. The aim is for students to describe what they think is happening, discover what additional information and learning they require, and plan responses to clinical situations. Its method involves ensuring a common definition of terms and use of language, brainstorming, hypothesising about possible explanations, prioritising the possibilities and deciding if additional information might be needed to come to a specific conclusion. A key component is that it seeks to mobilise previous learning and experience and to process it in applying it to particular problems in order to further enhance knowledge, skills and attitudes.

Although it is not taught specifically as being a clinical skill, its methods can be extremely useful if confusing or complex situations arise.

Clinical example 2.1

Sixteen-year-old Kyle and his mother had a complex and ambivalent relationship. They were very close but could rapidly become angry with each other. All efforts to improve the situation had been unsuccessful and this was interfering with his medical care for a chronic condition. A fresh opinion was sought.

The descriptions of the professionals already involved were rapidly repeated. Efforts to clarify issues with open questions were not successful in gathering a good history so I decided to ask for very specific details of what had happened that day starting with waking up. Kyle and his mother were able to agree that he had woken up and that he had got up and got dressed. However they adamantly and repeatedly disagreed about whether he had had breakfast or not. It felt like they could have carried on their disagreement all day.

In the spirit of PBL I decided to ask them to define their terms. Mother explained that Kyle had had a breakfast of tea and toast. Kyle agreed that he had had tea and toast but insisted that he had not had breakfast. He defined breakfast as a 'Full English' – egg, sausage, bacon etc.

It subsequently became clear that similar discrepancies occurred in many situations. This did not seem to be born out of any simple wish to be awkward but from some more profound issues about misunderstanding idiom.

Among other things this approach seeks to engender a true spirit of enquiry about one's patients and about oneself in relation to one's patients and other aspects of work and learning. It is a form of enquiry that is shared with the psychoanalytic approach.

Models of medical practice

Paediatrics, psychiatry and psychoanalysis have a common origin in medical practice. Medicine has provided fertile ground for the recognition of children's difficulties and for the needs of those caring for and educating them. It has assisted adults in understanding children, promoting their welfare and responding usefully to their problems. However, what has proven more controversial is the usefulness of different models of practice.

The Medical Model

The *Medical Model* (or *Biomedical Model*) was described by Engel (1977: 130) as:

> The dominant model of disease today, with molecular biology its basic scientific discipline. It assumes disease to be fully accounted for by deviations from the norm of measurable biological (somatic) variables... The biomedical model not only requires that disease be dealt with as an entity independent of social behavior, it also demands that behavioural aberrations be explained on the basis of disordered somatic (biochemical or neuro-physiological) processes.

The debate still continues about whether it has been a constraint or interference rather than a facilitating influence on good clinical practice. It can be difficult to ascertain where the balance lies because it is recruited for the purposes of interdisciplinary dispute as opposed to rigorous examination of its value. Klerman (1977: 221) summarises this:

> To psychologists and social workers in mental health settings, it is a term of contempt to use in the struggle over whether medical degrees are necessary for positions of greater authority or higher salary. To sociologists, learned in 'labeling theory', it refers to the narrow reductionism of conventional psychiatric thinking that refuses to see the social forces in the generation and perpetuation of social deviance. To civil libertarians, it is the basis for the unwillingness of the mental professionals to acknowledge the extent to which mental institutions are agents of social control.

He adds with added relevance to the present context:

> To psychotherapists – medical and nonmedical – it is a synonym for biological treatments, especially 'shock' and psychosurgery, which threaten to destroy the minds and souls of their patients. To biological psychiatrists, proud of the advances in new drugs, it is a summary call to psychiatrists to return to scientific medicine and the mainstream of medical practice.

The Biopsychosocial Model

Engel (ibid.) views the Medical Model as severely limited because it ignores fundamental issues of the art and humanity of medicine. He summarised his objections under six headings:

1 An abnormality may be present, yet the patient not be ill.
2 The biomedical model ignores both the rigor required to achieve reliability in the interview process and the necessity to analyze the meaning of the patient's report in psychological, social, and cultural ... terms...
3 Psychological and social factors are also crucial in determining whether

and when patients with the biochemical abnormality ... come to view themselves or be viewed by others as sick.

4 Rational treatment ... directed only at the biochemical abnormality does not necessarily restore the patient to health even in the face of documented correction or major alleviation of the abnormality...

5 The behavior of the physician and the relationship between patient and physician powerfully influence therapeutic outcome for better or for worse.

6 The successful application of rational therapies is limited by the physician's ability to influence and modify the patient's behavior in directions concordant with health needs... [this] requires psychological knowledge and skills, not merely charisma.

He proposed an alternative model, the *Biopsychosocial Model*, which would incorporate fully the science, art and humanity of medicine. Borrell-Carrió, Suchman and Epstein (2004: 576) summarised this model as:

> a way of understanding how suffering, disease, and illness are affected by multiple levels of organization, from the societal to the molecular. At the practical level, it is a way of understanding the patient's subjective experience as an essential contributor to accurate diagnosis, health outcomes, and humane care... [whose] pillars include (1) self-awareness; (2) active cultivation of trust; (3) an emotional style characterized by empathic curiosity; (4) self-calibration as a way to reduce bias; (5) educating the emotions to assist with diagnosis and forming therapeutic relationships; (6) using informed intuition; and (7) communicating clinical evidence to foster dialogue, not just the mechanical application of protocol.

These authors do not present their arguments in terms of psychoanalytic theory and practice, but their tenets are consistent with psychoanalytic principles. There is a shared emphasis on reflective practice and the central importance of the patient–professional relationship as a diagnostic and therapeutic instrument.

Narrative Based Medicine (Greenhalgh 1999; Greenhalgh and Hurwitz 1998) is another approach which places these factors alongside biomedical evidence in the practice of medicine. *Values Based Medicine* (Fulford, Stanghellini and Broome 2004) also emphasises that practitioners need to be aware of their own perspective and how that influences the view they take of the data and information in the scientific literature, i.e. *Evidence Based Medicine* (Sackett et al. 1996).

What is good medical practice?

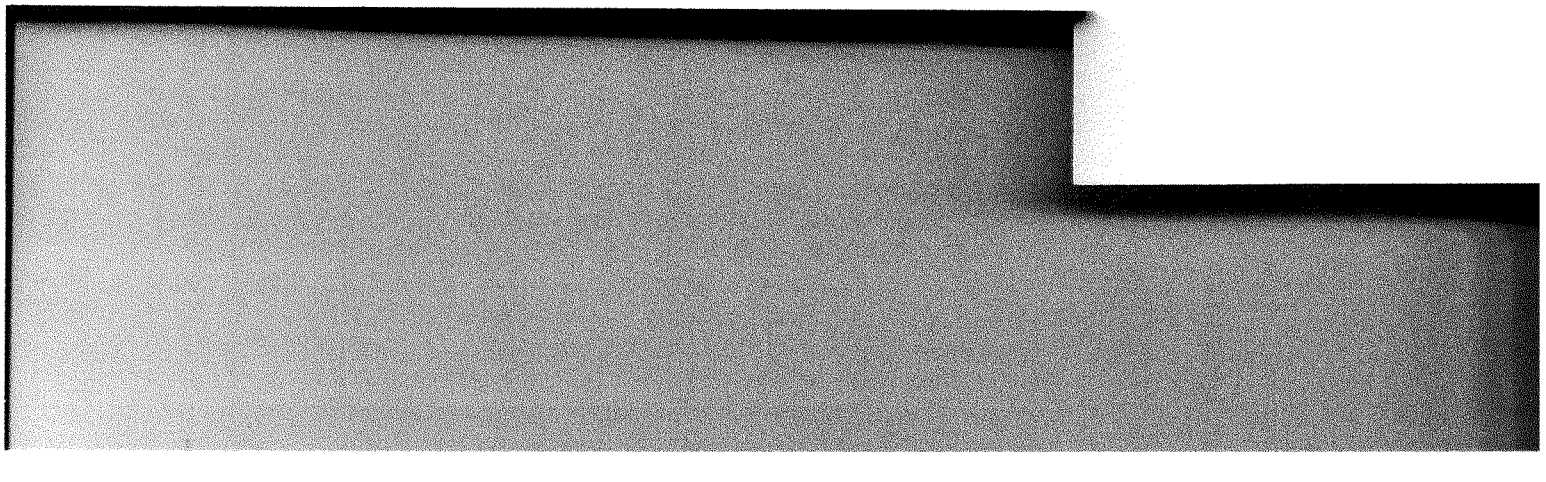
The foundation of clinical practice is the use of the clinical consultation. It provides the opportunity for the doctor to see the patient and the patient

to see the doctor. Through this process necessary and sufficient raw data are gathered. These data are processed and formulated to indicate the likely possibilities in terms of health and illness (the differential diagnosis). It should allow the doctor to decide if further data are needed and what data are required to decide between the different possibilities. Simultaneously it provides a conscious patient with the opportunity to gain a sense of the doctor's trustworthiness, ability, and wish to gain an understanding of their predicament: explicitly it is the doctor making the assessment but implicitly she is also being assessed.

Through this process it becomes possible to proceed with a plan of care which both patient and doctor agree is a reasonable course of action. In emergency, the time-scale may be only the briefest of moments, but in most circumstances there are opportunities for repeated interactions, which may even extend over years. The presence or absence of change can be decisive in establishing the severity and danger of any symptoms or signs, in distinguishing between different diseases, in differentiating health from illness and in deciding on the usefulness of any intervention. Hence, time is an essential clinical tool for both diagnosis and therapy. It is also the means through which both doctor and patient can come to know the ways in which each understands bodily experiences, sensations and functions. Doctor and patient both contribute to the evolution of the clinical picture. Earlier clinical encounters shape the later ones.

The components of the clinical consultation are usually divided into two parts, obtaining a history and the physical examination of the patient. The history consists of information about the patient's immediate concerns, the background to these and the wider context of the patient's health, living situation and any potentially related issues. This provides the opportunity for the patient to say what the current problems are (his *symptoms*) and for the clinician to expand on this to explore anything that may clarify any additional elements relating to the symptoms or their impact. The examination provides the opportunity for the clinician to use their own physical senses and to explore indicators of health and disease, i.e. to elicit the presence and absence of *signs* of illness. This distinction between symptoms, what the patient complains of, and signs, what the clinician elicits, is extremely important.

Paediatrics and psychiatry certainly share the centrality of importance placed on this form of history. In discussions about psychodynamic psychotherapy, different schools may take different positions or emphases. Some may put more weight on the 'here and now' of the clinical encounter as a sufficient source of information; others on the wider emotional and relational context of patients or the historical events and processes of their lives. My position as a psychoanalytic child psychiatrist is that the framework of exploration of the patient's current concerns and predicament and how their relationships and development have unfolded are all essential. This should also include knowledge of the patient's physical health and development.



Psychoanalysis as a framework for practice shares with Narrative Based Medicine an emphasis on the way clinicians become part of the patient's life history: both value subjective experience and are circumspect about claims of 'objectivity'. The form which earlier clinical contacts have taken will shape how the understanding and expectations of health and illness have evolved. In turn, this will shape the form of ongoing and future interactions. A narrative develops in which doctor and patient are both characters.

As described in Chapter 1, what is distinctive about psychoanalysis is the position accorded to transference and countertransference processes as sources of essential information and routes through which comprehensive understanding and therapeutic aspirations can be better realised. Although psychoanalysis may at times appear to place a central importance on explicit interpretation of transference or other factors in unconscious mental life this may over-emphasise intellectual understanding at the cost of experiential and emotional aspects in the psychoanalytic process.

There is a further distinction between the practice of psychoanalysis as a specific form of treatment and the application of psychoanalytic theory in the practice of medicine. In work with children, the possible benefits of specially adapted care may also be underestimated. Winnicott (1953: 115) challenged his paediatrician and psychoanalyst colleagues to consider the place of psychoanalysis as a specific therapy as opposed to a method of informing other types of therapeutic care. In his 1953 Presidential address to the Section of Paediatrics of the Royal Society of Medicine, he presented the case of a boy where he had adapted his involvement to fit with practical constraints:

> Whenever he came to me subsequently he just played with the train, and I did no more psychotherapy. Indeed I must not, unless I had been able to let the treatment develop into a psycho-analytic treatment, with its reliable daily session arranged to last over a period of one, two, or three years... This child needed my personal help, but there are many cases in which the psychotherapeutic session can be omitted, and the whole therapy carried out by the home. The loss is simply that the child fails to gain insight, and this is by no means always a serious loss.

Psychoanalysis as defined by Winnicott was not available for any of the patients described in this book: some of the patients did receive *psychoanalytic psychotherapy*, a less intensive process but still characterised by the relative frequency of attendance and regularity in time and place. Most of the work presented is in fact *psychoanalytically informed therapeutic case management*. But experience and knowledge derived from psychoanalytic psychotherapy and psychoanalytic theory was no less important in the absence of psychoanalytic treatment in its purest form. A psychoanalytically informed approach can help us to understand why things have happened when there is no other

explanation: it may help understand why something has been productive or counter-productive when there does not appear to be a 'rational' explanation. Perhaps even more importantly, it may help us tolerate not understanding at all.

The physical examination

The most obvious manifestation of the physical examination is the laying on of hands – the taking of the pulse, the request to open wide and say 'Ah', the stethoscope on the chest. However the first step is observation. Before laying hands on the patient, the doctor lays eyes on them: before any words are spoken, sounds may be heard; the entry of the patient may be accompanied by a smell.

Observation as a clinical skill is the readiness to take in perceptual experiences without necessarily being seen to do anything. These observational data may direct the clinician's activity and attention immediately: the obvious fracture of a bone, the smell of ketoacidosis, the sound of silence from the patient who has stopped breathing, will direct clinical activity urgently. Raw data need first to be assimilated without awareness of its significance. It requires what Keats (1821) called *negative capability*, 'when man is capable of being in uncertainties, mysteries, doubts without any irritable reaching after fact and reason'.

Examining the patient may include eliciting responses from them by asking the patient to do something or observing their responses, voluntary or involuntary, to requests or intervention. This establishes the base-line from which change can be recognised. Sequential observations over brief or extended periods of time indicate the presence or absence of change over time or in response to any interventions. For that reason there is actually no such thing as a 'negative finding' or 'no significant findings'; there are only 'findings'.

This process includes exploration and enquiry relating to mental functioning. This *mental state examination* is relevant across all areas of medicine and it is the specialist area of operation for psychiatrists. It begins by ascertaining if there is any impairment of consciousness, for example is the patient rousable? Does he know where he is and what day it is, that is, is he orientated in time and place? It includes assessment of cognitive functioning – is the patient able to remember things from the recent or distant past? If there is any impairment is it consistent or variable? Observations and enquiries are made about the patient's perceptual experiences, belief systems and mood. Is he experiencing hallucinations? Does he have delusions? Is his mood depressed, elated, anxious? Just as a surgeon may need to palpate and then exert some pressure in the right iliac fossa to decide if the patient has acute appendicitis, so too does the psychiatrist have to be ready to press and probe despite evidence of pain or upset. The examination is an iterative

process. The clinician must simultaneously enquire and observe deciding whether repetition or elaboration is required in response to the way the examination is proceeding.

What has been described needs to be understood as the *present* mental state. What must also be appreciated is the extent to which this represents the state of the patient over time. Just as a patient whose blood pressure reading is high requires this to be monitored over time to find out what is happening and what it might mean, so too does a patient whose mental state appears abnormal.

Clinical example 2.2

Mary had been admitted to the paediatric ward the previous night after taking an overdose of tranquilisers. When I saw her for initial psychiatric assessment she sat silently and still in her bed. She did respond to my enquiries but only slowly and without elaboration. The circumstances before her overdose had given rise to concerns about her. She had talked about life not being worth living. However, the circumstances around the overdose had not made the clinicians already involved more urgently concerned for her safety.

When I saw her again in the afternoon she was sitting up in bed and talked to me at length about the difficulties she had been having. She cried during this but started talking about ways in which she might try and cope with her circumstances and get on with life.

Initially I did not know if Mary's presentation indicated a profound enduring state of depression or the pharmacological effects of the tranquilisers. By the afternoon it became apparent the latter was the case. If her state had continued to be the same as at that first contact, particular care would have been needed to ensure her safety and further assessment to establish how strongly she was in the grip of depressive processes.

Patterns of consistency or change may be crucial in deciding which specialist is likely to be of most value to the patient. Impairment of consciousness indicates that there is a significant organic process involved and that anatomical, pharmacological or physiological causes need to be investigated. Some common causes are drug or alcohol intoxication and diabetic crises. Less common are specific disorders in the brain or more widely in the body, for example temporal lobe epilepsy, systemic lupus, metabolic or infective disorders. Variability and lability of mental state indicate the need for exploration in the realm of physical disorder. This will be considered in the detailed case presentation of Jenny (*Clinical example 5.2*).

Liaison psychiatry

Recognition of the ways in which people's difficulties emerge and the ways in which this brings them into contact with medical services has given rise to a sub-specialist area of psychiatry: liaison psychiatry. It is:

> the sub-specialty which provides psychiatric treatment to patients attending general hospitals, whether they attend out-patient clinics, accident & emergency departments or are admitted to in-patient wards. Therefore it deals with the interface between physical and psychological health. There is now abundant evidence that medical and surgical patients have a high prevalence of psychiatric disorder which can be effectively treated with psychological or pharmacological methods.
>
> (Royal College of Psychiatrists 2011)

This definition has the advantage of brevity but it does not define what constitutes 'treatment'. Neither does it explicitly include the fact that a process of assessment needs to precede treatment, whether or not it arrives at a 'definitive diagnosis' on which a specific plan of treatment can be formulated and implemented. These points will be considered later in the chapter.

In child mental health practice, definitions of liaison psychiatry often extend to include additional activities which specialists from child mental health contribute, for example teaching, research and staff support. Different models of clinical services are also described:

> – *Independent-functions model*: the paediatrician refers a patient to the psychiatrist who makes an independent assessment of the problem and reports back to the paediatrician. Further action is decided unilaterally by the paediatrician.
> – *Indirect psychiatric consultation model*: paediatrician retains responsibility for the child and the psychiatrist offers advice and suggestions to the paediatrician.
> – *Collaborative-team model*: paediatric and psychiatric professionals work together to provide a comprehensive service for children and their families.
>
> (Engström 2002)

These models do not necessarily represent different *services*: they may describe different *functions* within an overall collaborative team. Hidden in this is also the opportunity to recognise a sub-specialism of 'liaison paediatrics' which assists child psychiatric practitioners in understanding patients' broader health and illness care issues.

This book is in the spirit of the collaborative team model. It describes a core function of child and adolescent psychiatric services as involvement with other health professionals when a child or adolescent has difficulties which involve bodily symptoms or functions. These problems may stem from, or be in conjunction with, identified physical pathology or may remain medically unexplained. Sometimes concerns such as pain, fatigue or loss of function may arise predominantly from the young person him or herself. At other times the reports of problems may preoccupy a parent (or other adult) to a greater degree than the child. The dynamics of these processes emphasise the additional importance of knowledge of the psychiatry and psychodynamics of adults for child health and welfare practitioners.

A brief digression into semantics and metaphor is required and will serve also to illustrate the complexity of this interdisciplinary work and lay the foundations for some of the later content of the book. The Royal College of Psychiatrists' (2011) definition describes liaison psychiatry as '[dealing] with the *interface* between physical and psychological health' [my italics]. But what is an 'interface'? For me it conjures up an image of a boundary with paediatrics on one side, psychiatry on the other. This does not fit with my view of the practice I espouse. The dictionary does offer 'a meeting point or common ground between two parties, disciplines, etc'. Strictly speaking a 'point' has no dimensions whilst 'ground' will have at least two dimensions and perhaps three. 'Common ground' is defined as 'something on which two parties agree or in which both are interested in negotiation, conversation, etc'. Liaison psychiatry does not necessarily bring about agreement but should be on the basis of 'common purpose' and acknowledgement of the professional abilities and resources of each of the practitioners. 'Negotiation' may focus as much on the issue of how action is authorised and by whom – my colleague Prof. Robert Boyd used to ask 'Who should be calling the shots?' Placing the clinicians in context of their usefulness to the patient rather than as administrative configurations of health and illness care services does require contending with greater complexity but it exemplifies a 'patient-centred approach'.

Rather than the relationship being one of 'interface' it is a relationship which needs to be much more in tune with the currents of mental life and their manifestations. As will be considered in the following section which considers the body–mind relationship, simple dichotomies are inadequate in complex systems. The ebb and flow of the different influences and expression of underlying processes are much more akin to the profile of the seashore – sea and sand with an intertidal area which needs to be respected for itself.

Diagnostic dilemmas

The debate between adherents to the Medical Model and the Biopsychosocial Model is reflected in the place of 'diagnosis' in child mental health.

Clinical example 2.3

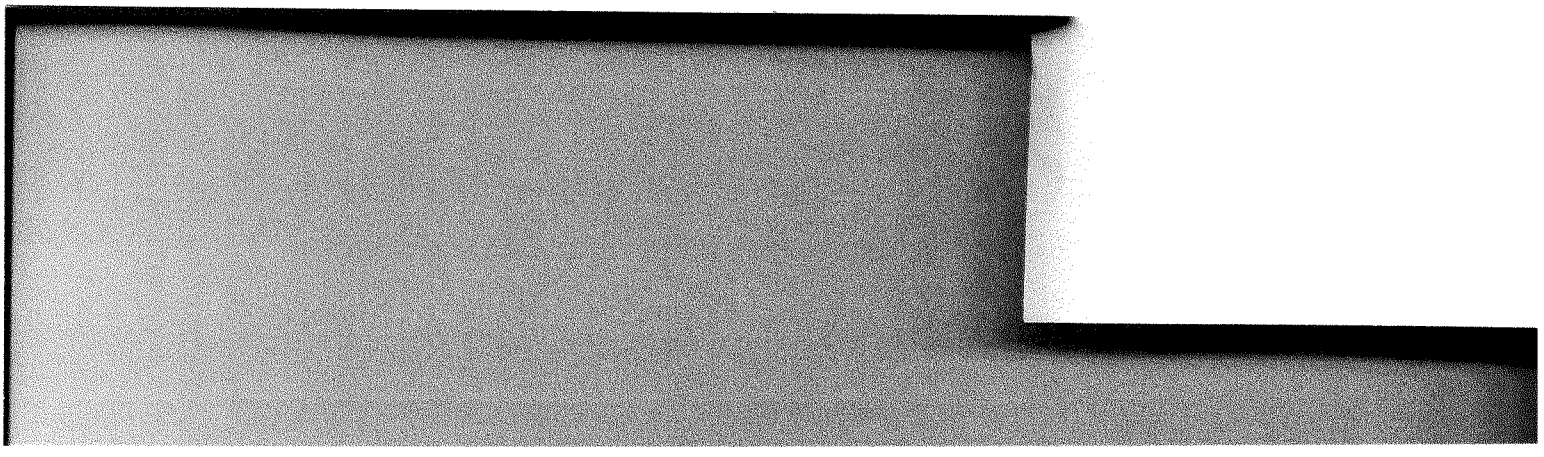
At a case conference, the case presented was that of John, a ten-year-old boy who was brought to see the psychiatrist because he had been persistently pulling his hair out. After comprehensive assessment and clinical debate it was decided that the diagnosis was trichotillomania.

At its extreme in using the Medical Model, 'getting the diagnosis' becomes an end in itself; naming the constellation creates a state of apparent certainty: 'We know what we're dealing with: the patient is suffering from X'. However, as in the above example, a term can be as much a statement of what a patient does not have, for example some other state of being during which people pull their hair out. In fact trichotillomania is a *syndrome* not a *diagnosis*.

A syndrome describes a cluster of symptoms and signs which may have a number of causes: the clinical task involves seeking as much clarification as is possible in order to be properly informed and to properly inform the patient so the best form of action can be decided. The use of the term 'trichotillomania' does not suggest any reason, cause, range of prognosis or possible therapeutic interventions. However, one may find it being used as if it carries much more of the full meaning of 'diagnosis' in these respects. Its use may mask the 'not-knowing-ness' as much as the 'knowing-ness': it can create an image of knowledge and certainty rather than an authentic picture of familiarity, if not from individual professional experience, from the wider medical field. But this may all be another facet of a process which is 'a fiction of the investigator's desire to have simple answers to complex problems' (Blomberg 1996: xiii).

The converse, of assiduously avoiding the application of categories, can be equally unhelpful. It does not acknowledge the simple fact that there are clinical presentations in which common causality, presentation and prognosis have been established. In many of these there are reasonable grounds for recommending particular courses of action and not recommending others. Its use lies in the further recognition of what constitutes reasonable or unreasonable ways of proceeding. This issue of how to seek a language which has enough shared meaning and enough 'room for manoeuvre' in accepting uncertainty is a further essential strand in the fabric of this book.

Attempting to establish a diagnosis is more than simply trying to categorise disorder; it is 'understanding thoroughly what goes on in the mind and the body of the person who presents for care' (Lain-Entralgo 1982). The diagnosis needs to be considered in its relevance and use to the person to whom it is applied. The ICD–10 (World Health Organisation 2007) uses six axes of classification:



- Axis I: Clinical psychiatric syndrome
- Axis II: Specific developmental disorders
- Axis III: General intellectual level
- Axis IV: Associated medical conditions
- Axis V: Associated abnormal psychosocial conditions
- Axis VI: Global social functioning.

In child psychiatry, greater emphasis has been placed on the generation of a *diagnostic formulation* which is a 'working hypothesis'. It integrates the information available across these six domains to express the best understanding of the key factors and influences in the patient's presentation. Events subsequent to any interventions based on it may add weight to the probability that the formulation was correct. However, it may suggest the opposite. It may even allow us to believe *either*, since change in the course of treatment may indicate only that treatment has not prevented change, rather than necessarily having caused or contributed to it. The ability to remain open to new information and its possible interpretation is essential in order to incorporate this into an holistic understanding. 'Old' information must also be open to reinterpretation since change or no change can both constitute *new* information.

Linguistic dilemmas: mental life and bodily symptoms

The debate concerning terminology for problems involving bodily symptoms and mental life reflects the debate around the Medical Model and the Biopsychosocial Model. Lipowski (1984: 167) and Shoenberg (2007: 6) provide historical overviews.

Psychosomatic and *psychogenic* are two words in common usage to describe ailments when the 'mind' is thought to be a significant contributor. In 1984 Lipowski gave these definitions: '*Psychosomatic* is a term referring or related to the inseparability and interdependence of psychosocial and biologic (physiologic, somatic) aspects of humankind'. Psychosomatic medicine is

> a discipline concerned with a) the study of the correlations of psychological and social phenomena with physiological functions, normal or pathologic, and of the interplay of biologic and psychosocial factors in the development, course, and outcome of diseases; and b) advocacy of a holistic (or biopsychosocial) approach to patient care and application of methods derived from behavioral sciences to the prevention and treatment of human morbidity. (This aspect of the field is currently represented by liaison psychiatry and behavioral medicine.)

Shoenberg, 23 years later, succinctly defined psychosomatic illness as 'any physical illness in which psychological factors have played a significant role

in its precipitation and maintenance and, in certain cases, in its causation as well'. In developing the ICD–10 originally published in 1992, the World Health Organisation had decided that *psychogenic* would not be used 'in view of its different meanings in different languages and psychiatric traditions'. It took a similar position in relation to *psychosomatic*. Winnicott (1989, cited in Shoenberg 2007: 1) accepted that sometimes words may fail us in our attempts to be absolutely precise but nevertheless they are the best we have in order to delineate a recognisable form: 'The word "psychosomatic" is needed because no simple word exists which is appropriate in description of certain clinical states.'

This reflects the complexity of 'trying to get one's mind round' the human experience of physical and mental life. It parallels philosophical debate about the nature of consciousness, for example 'Our normal awareness of space and consciousness is not geared to understanding deep theoretical questions about how the two things interrelate, but only to negotiating our world effectively. Looked at from this point of view, it would be remarkable if we *could* solve the mind-body problem' (McGinn 1999: 135–6).

The choice of terminology used sometimes implicitly accepts the practitioners' inability to find a physical explanation for symptoms whilst allowing of its impact on the patient, for example 'functional' to indicate that the presentation and consequence of whatever is happening is an altered ability to perform in the usual way. Other terms used may preserve the veneer of being learned and knowledgeable, using a term the lay person is unlikely to know, whilst implicitly being dismissive and denigratory, for example 'supratentorial'.[4] A major problem is that such terms can tip over into expressions which implicitly or explicitly carry moral connotations, for example 'putting it on', 'manipulative', 'malingering': *moral* judgements are a different species from *clinical* judgements. Clinical terms should carry information that indicates either an 'ordinary' range of experience and function or the acceptance of an altered expressed experience of the body or bodily functions and relationships in which suffering or loss of functioning occurs. The term *medically unexplained symptoms* (also called medically unexplained *physical* symptoms) – 'persistent bodily complaints for which adequate examination does not reveal sufficient explanatory structural or other specified pathology' (National Mental Health Development Unit 2011: 1) is useful because it denotes the clinician's position properly. It does not deny that the patient has a problem but it does also allow that the patient may have other symptoms which are explicable in medical terms.

Psychoanalytic contributions to diagnostic dilemmas

The description given in Chapter 1 is of a general psychoanalytic approach with specific reference to that developed by Anna Freud and her colleagues and successors. This approach is biopsychosocial in its appreciation of the

variety of influences which contribute to children's mental health and the concerns of those responsible for them. Where differences may arise between psychiatry and psychoanalysis is in the emphasis placed on *form* as opposed to *content* in what patients do and say.

Clinical example 2.4

During a train journey with his parents 15-year-old Tony's behaviour and thoughts had become unusual. On arriving at the destination he had told his parents that terrorists were following him. His parents were very concerned and brought him to the hospital emergency department. During the clinical assessment he described other unusual beliefs which had developed during the course of the journey.

I felt his unusual thoughts were delusional but decided to explore whether Tony could think more about them and whether this process might give a better indication of how fixed they were. I asked Tony why he would be of such interest to terrorists. I told him I did not think he was giving me sufficient evidence to convince me.

After a while, he looked at me and said, 'So you're saying that you don't think they are after me. Well, if I believe you I'm going to feel like a right wally!'[5]

In the consultation, I had carefully attempted to delineate the nature of his fears, the possible routes through which they may have emerged, how firmly he held them, and how much they governed his behaviour. In the immediate situation I was not overly concerned with questions of *why* it was the IRA which had become the feared organisation or *why* this fear had arisen at this particular time, in this particular developmental phase of his life. My principal concern was not about the *content* of his thoughts in terms of any possible symbolic significance but their *form*. This was not to dismiss that there may be meaning pertinent to him which could be usefully understood in conducting any treatment. Given the immediate predicament, my approach was to attempt to assess if other aspects of his personal resources and functioning may be 'called upon' to create a safer experience for him. My aim was to try to create a space which was more contained emotionally in which to make reasonable plans for his immediate welfare. I drew on Meltzer's conceptualisation of *modulation* as opposed to *modification* described in Chapter 1.

I hoped to reduce Tony's arousal and anxiety through an approach which used challenge to see if this could help 'empower' his ego strengths to better contain the fears which had broken through. Briefly his strengths achieved ascendancy and there was the possibility of being in two minds, of contending with uncertainty rather than 'omnipotent' explanations of

external persecution. The uncertainty was accompanied by insight into a sense of profound humiliation. Then his primitive mechanisms regained dominance.

Using Meltzer's formulation of modulation and modification there appeared to be a change in Tony's functioning which happened on leaving home. It became more intense and was sustained through the journey and the psychiatric consultation apart from this one brief interlude.

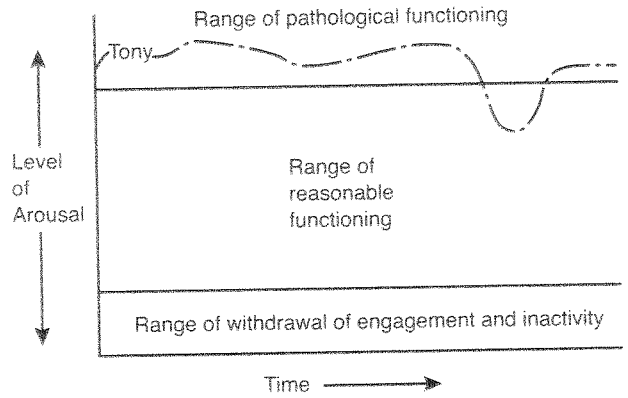


Figure 3

For a few moments Tony came into what I have broadly termed the 'range of reasonable functioning' but this was only sustained briefly. Psychodynamically it was not possible to pursue the idea of 'wally-ness' in its fuller significance to Tony. The balance was between feeling humiliated and feeling in danger from the IRA. The balance tipped back to the belief in an external threat.

This two-dimensional model can be useful but it needs further elaboration. It illustrates that there can be ranges within which different approaches to engagement may be necessary. Identifying these gives the clinician the opportunity to adapt her approach to the mode of mental functioning which is present in the patient and to see which aspects are predominant and persistent. This increases the likelihood of diagnostic accuracy. It also makes it more likely that anxiety or suffering that is driving the problem or secondarily amplifying difficulties can be at least partially or temporarily alleviated (see the discussion of *microtherapy* in Chapter 5).

Tony did fleetingly have insight. What became clear was that other 'forces' within him could override any other contribution that could be made. My position was to attempt to present a 'steady state' through being authentic in my responses – open to enquiry and testing whether or not he could be open to enquiry. I could believe or not believe what he said, maintaining my integrity of

self without it being an attack on him. The affirmation of my own autonomy of thought was not an attack on him. Rather it was an attempt to engage with his. Simultaneously I was carrying out the mental state examination. The nature and manifestations of Tony's fears would be acceptably referred to as 'psychotic' across the field of both psychiatry and psychoanalysis (despite the frequent misunderstanding and even acrimony about this word between practitioners in the two fields). Psychotic states can produce profound countertransference pressures which can adversely affect functioning. Contemporaneously, I had to manage my own concerns about what I was going to be able to do given the resources available to Tony, his parents and to me.

The participant observational stance and perspective of a psychoanalytic approach provide a mental space in which developmental and pathological processes can be recognised and considered in relation to symptomatology. Regressions, fixations and imbalances between different aspects of development can be identified and contribute to the formulation of a more comprehensive approach to care. Psychoanalysis as a specific form of treatment may not be of use or may even be counter-therapeutic for a particular patient. But psychoanalytic understanding can help in directing clinical activity towards adaptations (in the patient, in those around them) generated from a deeper understanding of more realistic expectations and aspirations. This re-emphasises the need to appreciate that aspect of applied psychoanalysis which is a diagnostic process whose therapeutic value lies in understanding better the possibility and probability of dynamic change or developmental progress.

'Going over the top line' in terms of arousal produces a withdrawal from the influences of the outside world in as far as they might moderate some of the self-perpetuating, auto-catalytic processes which maintain or increase arousal and inability to function optimally. A different challenge presents itself when patients 'drop below the line' and enter states of withdrawal from engagement with the outside world and inactivity. These will be explored through Chapters 7–9. The countertransference pressures are very different. But when one enters this world one sees phenomena which again call forward the language of hallucinations, delusions, mood disorder etc.

The situations described all emphasise just how important it is that practitioners monitor and manage their own responses. A psychoanalytic practitioner will describe this function as *containment*. The practitioner's experience and functioning in doing so, or at least trying to, can provide additional and sometimes crucial information about the patient's state of being. Properly managed this can enhance the clinical process, taking it through countertransference to case management.

Demarcation disputes

The Biopsychosocial Model presents a case for integrating knowledge of the personal world of individuals and their relationships into clinical practice.

Medical education incorporates emotional, relational and behavioural factors within the domain 'psychosocial issues'. However, undergraduate and postgraduate curricula are not infinitely extendible so decisions have to be made about the depth and breadth of knowledge and skills required. Part of this is learning when the specialist knowledge, skills and clinical skills of another discipline, profession or clinical service are required.

Historically, clinical services and individual practice have developed out of necessity in the face of clinical demand, personal interest and ability: this gave rise to the establishment of new specialist disciplines, for example child psychiatry. As they evolve, clarification of roles, responsibilities and relationships is necessary. On taking up my consultant post in a hospital which had never previously had a child psychiatrist, a senior colleague told me, 'I think I'm going to be treading on your territory more than you are on mine.' He had developed an extensive, valued practice in both developmental disorder and the physical and emotional consequences of child mistreatment. His comment respected both his own expertise and the fact of there now being a recognised specialist training for child psychiatrists.

Contrast this with a scenario sometimes reported after lengthy consultations in which new, complex information emerges and throws light on the twists and turns which have occurred in a child's presentation. On reporting back, the response may be, 'Well, of course, I just can't have that amount of time to conduct a consultation.' Such a response implicitly denies that the clinical process and assessment owe anything to a difference in specialist expertise, although it does respect the fact that one of the most important tools available to clinical practitioners is time. The information may not be highly technical and scientific in its content and perhaps this is why finding it out can produce a defensive response. However, the knowledge base in knowing what is of greater or lesser significance, the clinical skill in conducting the process of finding it out and the attitudinal stance in integrating the information can be just as complex as those involved in the surgeon's or physician's activities. The shared task is to create a culture of therapeutic cooperation rather than rivalry in the service of patients, discerning where each of the defined areas of paediatrics, psychiatry and psychoanalysis may most usefully be applied for the patient's benefit, singly or collectively.

In considering 'pure' paediatrics, one might consider the child who presents with a rash, severe headache and a raised temperature where it is clear that the immediate need is for someone who can recognise and treat meningitis if it is present. For the child who is developing normally but then has repeated episodes of abnormal experiences including visual hallucinations, paediatric neurologists or neuropsychiatrists may be good alternatives in ascertaining whether this is temporal lobe epilepsy. The 'pure' psychoanalytic practitioner might work in a baby clinic and be available to help where difficulties are arising around sleeping or eating (see, for example, Daws 1989, 1999). A psychiatrist and a psychoanalytic practitioner might see their area of overlap

interface at its clearest where there is a youngster with a history of severe rly deprivation. Ongoing relationship problems and episodes of extreme :haviouraldisturbance can give rise to the question 'Does this child have "diagnosable" condition?' Is this a situation where physical investigations ight provide 'objective' evidence, for example TLE? Might the situation : one in which pharmacological intervention can be beneficial, for example hizophrenia?

All parties may agree that the psychoanalytic practitioner does not need ıe involvement of a medical practitioner when they are treating a child with notional difficulties who is in robust physical health and cared for within resilient family. In the central area of tripartite overlap, there may be full greement about the young person with severe anorexia nervosa needing, r at least, benefiting most when all three contribute. But these apparently imple boundaries may not stand up to closer scrutiny. The breadth of definiions given to child mental health services can be confusing. All children ıave minds and minders (carers, educators, supervisors of recreation, health isitors) so the possibilities of influencing their minds for better or for worse re manifold. Enabling good care, education and recreation is a service to hildren's mental health. But this must not be confounded with what is equired when assessment or treatment is needed. Their service to the child s through their ability to perform within their professional role rather than hrough being seen as another arm of the specialist mental health services. Those other contributors to helping troubled children may themselves benefit in fulfilling their role through the provision of psychiatric liaison services. What brings the professionals together and holds them together is their shared responsibility towards children. There can be many areas of common usefulness for different disciplines, for example the acute assessment of children and adolescents who have attempted suicide where paediatric medical and nursing staff make possible the role of the mental health practitioners through their attention to the care of the child's body.

When considering referral, practitioners may ask how they should decide whether to refer to a psychiatrist, psychologist or psychotherapist. The answer is often more dependent on the ways in which services have emerged and on resources available rather than neat boundaries, defensible fully on solid inclusion and exclusion criteria. In the immediacy of clinical practice it has to be possible to make decisions about who is best placed to accept responsibility for action, for example the dangerously starved anorectic teenager, the acutely psychotic child. But in other situations this may need to be a process which in the past would have been described as 'trial and error' but which, one hopes, will best be described by its replacement term, 'trial and improvement'.

Where there is 'best practice' the process is led by the patient's clinical needs but it may become entangled with other institutional or societal issues and professional or interprofessional dynamics. Different parties may seek

to write themselves or others into a role or out of having a role. Harrison (2009) emphasises how the models which are used on which to practice can be recruited for other purposes, for example financial. In his view, arguments for using a 'Biomedical Model' have influenced not only clinical processes but also the nature of professional responsibility, authority and clinical autonomy. In Chapter 11 I will argue that this may undermine good practice.

A further question for consideration in multidisciplinary practice is 'How well equipped are practitioners to recognise when they are presented with something beyond their expertise?' Mrs T (*Clinical example 1.2*), who is considered in detail in Chapter 3, presents a good example. In the course of the child psychiatric treatment it became apparent that Mrs T had had a classical puerperal psychosis after the birth of her daughter. Might these signs have been recognised if there had been a psychiatrist available (child psychiatry training in the UK requires substantial experience in the psychiatry of adulthood)? Her child's behaviour at two years old led a paediatrician to suggest and consider a 'trial of medication' of anticonvulsants. I was able to offer an alternative diagnostic formulation which was accepted and stood the test of time. This meant drug treatment was not instituted and its possible adverse effects (physical, psychological and sociological) were avoided. The recommendations for the treatment of attention deficit hyperactivity disorder in the UK (National Institute for Health & Clinical Excellence 2009a) state that the expertise for deciding when this should happen resides in some paediatricians and in child psychiatrists. Yet their trainings and ongoing collegiate work situations are very different. There may be major overlap in 'biomedical' terms but in 'biopsychosocial terms' there are major differences. The complex institutional and psychodynamic processes involved can provide very fertile ground on which enactments of unconscious processes can take root, grow and thrive. So it needs to remain an open question as to how much confidence should be placed in different doctors or other practitioners to know when alternative or additional factors may come into play in producing the clinical picture or in providing the best help to the children.

In practice it can be difficult to know how best to advise other practitioners how they should choose between referral to different disciplines within a child mental health team. This stems, at least in part, from the tradition in which I have trained – a biopsychosocial model strongly influenced by psychoanalysis both in the practice of medicine generally (Balint 1957) and in psychiatric practice. In addition to the influences indicated in Chapter 1, the influence of D. W. Winnicott has also been powerful. He was a paediatrician who trained as a psychoanalyst and developed his practice as one of the pioneers of child psychiatry in the UK alongside his psychoanalytic practice with children and adolescents. This exemplifies how child mental health as a specialism within the UK National Health Service, in contrast to Educational and Social Welfare Services, emerged as a function of individuals from different areas of medicine having the necessary opportunity, drive and interest. They also had

the freedom to direct themselves into areas of practice, the need for which they recognised but which had not at that time been more widely recognised.

Do we need doctors to do the work described in this book?

The roles and responsibilities for which child psychiatrists are trained in the UK are described by the Royal College of Psychiatrists (2008). In fact the document defines more that other people have roles and responsibilities which psychiatrists need to know about rather than specifying the role of the psychiatrist. In reviewing these it has to be asked 'Do we need people who have undergone a *medical* training to fulfil these?' There is no neat, straight line which can be drawn between the knowledge and skills that are required to fulfil the General Medical Council requirements for preliminary registration as a doctor and the requirements for child psychiatry. The same is true for many areas of medical practice, including 'medical management'.

The challenge is whether other professionals trained at much less expense may be able to fulfil some or all of these roles and responsibilities. Some child psychiatrists have suggested a much narrower remit for consultant child psychiatrists (e.g. Goodman 1997). It could be argued that such a delineation is a 'retreat' into a Medical Model in contrast to maintaining an holistic Biopsychosocial Model. My own pragmatic position is that in everyday clinical practice the demand for the services of child psychiatrists as well as other child mental health specialists has continued to be greater than the resources available to respond. There also continues to be unrecognised unmet need. There does seem to be a significant belief from outside that medical practitioners have value in child psychiatry.

Simultaneously there can be persisting significant ambivalence about the speciality and towards psychiatrists. I was contacted by a lawyer for advice. She wondered if I could suggest the name of a suitable psychologist who could assess a child. I asked for details and she described a child whom I thought could very appropriately be referred to a child psychiatrist. I checked that the lawyer was clear that I was a psychiatrist. I then asked why she wanted a psychologist rather than a psychiatrist. She told me it was not good for children to be referred to psychiatrists because of the stigma. I asked why she had contacted me. She explained that I had been recommended because of my positive contribution in seeing a child for another case. She good-humouredly accepted my suggestion that she needed to examine her prejudices.

Some medical and surgical colleagues raise concern about too much 'touchy-feely stuff' at the expense of anatomy, physiology, pharmacology etc. in clinical practice and medical education. Their concerns need to be taken seriously if we are properly to balance the different elements of the bio-, psycho- and social of a biopsychosocial approach. Child mental health teams need readily available access to a base-line knowledge of organic conditions and this can be well-supplied by psychiatrists. We also need to ensure

that the literal touch and feel of patients is in the experience of members of child mental services even if the practitioners are operating only in the area of metaphorical touch and feel. We need people who have handled bodies, healthy bodies and sick bodies which produce unpleasant sights, sounds, smells. We need people who have had to do unpleasant things to patients. We need clinicians who have been with people as they die. Working alongside other colleagues with different experiences, I believe can help build a culture for child mental health services which is fundamentally based in the unavoidably psychosomatic nature of humanity.

Summary and conclusions

The underlying theoretical framework which clinicians use can have profound implications for the clinical process. It contributes to the shaping of the clinical contact with children, their parents, colleagues and the wider professional, organisational and societal framework. It can make the difference between raw data being noticed and noted or unnoticed and un-noted. The emergent forms of understanding of the clinical picture cannot be separated from the clinician's viewing point and their ways of relating to data and relationships.

The tools we have at our disposal to communicate about our experiences personally and professionally can be simultaneously sophisticated and inadequate for our task if we think that task involves absolute certainties in understanding health and illness. The models we use professionally are tools which can help orientate us to our place in other people's lives alongside other professionals. Their usefulness is constrained by the extent to which we are able to know that we are using them and why we are using them.

Similarly, the distinctions between different professionals in their roles can be difficult to ascertain. This may sometimes relate to the fact of there being an inevitable lack of clarity derived from the nature of clinical presentations and the available resources. It may also be difficult because of the different qualities that individuals bring to clinical work from their professional origins, experiences and, not least, because of their personal qualities. This builds a complex picture of clinical practice with people in vulnerable situations full of uncertainties and the interaction of conscious and unconscious processes. The possibilities for unproductive and even counter-productive activity are manifold. Fulfilling their roles and responsibilities relies on institutions and organisation incorporating mechanisms to protect the central task of health and illness care.