Paediatrics and child psychiatry

The case for collaboration

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Interdisciplinary liaison in the field of child health is not a new theme. It was championed 20 years ago, for example, by Winnicott (1953), 6 years later by Mildred Creak in her Charles West lecture (1959), and more recently by Pinkerton (1972a). The need, if anything, has become increasingly urgent because of rapid advances in paediatric technology which threaten to overshadow the child as a person. It would be ironic if expertise were to be gained at the expense of the patient as a whole. How best, therefore, to obviate this danger and how does it arise in the first place?

'The trouble with child psychiatry', said the professor of paediatrics at an American medical school, 'is that you ask for an opinion and they send you back a book.' 'The trouble with paediatrics', retorted his psychiatric colleague, 'is that they want some kind of instant child psychiatry; but how can you condense human relationships into a single sentence?'

This exchange, overheard during a recent American lecture tour, epitomizes the gap between the two disciplines.

One difficulty is that we are not comparing like with like. Traditionally, the paediatric province has been the acutely ill child, requiring urgent treatment based upon precise diagnosis—much the same position as in adult organic medicine. The young child, to be sure, is not a miniature adult, nor must he be regarded as such in terms of treatment. But the pattern of pathology is virtually the same, as are the basic body responses. Few misconceptions are therefore likely to arise, as between paediatrics and adult medicine, because they share this common language of professional terminology.

How different is the position of clinical child psychiatry. Here, the unit, both of diagnosis and treatment, is no longer the child, but the family as a whole. The same might be claimed for paediatrics,

and certainly this applies to particular areas of practice, e.g. genetic counselling, the battered child, or the child with terminal illness. In psychiatry, however, it applies quite literally in every case; and not just for the duration of a specified course of treatment.

Nor is the scope of treatment the sole distinction. The entire therapeutic time scale is different, both in its duration and its pace. Hence the turnover of material is necessarily slower, the complement of new cases smaller, staffing needs greater, and waiting lists inevitably longer. Moreover, more involvement is demanded of the doctor as a person, in the course of which he operates a radically different treatment technique. Small wonder there is scope for misinterpretation.

All this adds up to a difference in *approach*, as between the standard paediatric formulation and the broader psychosomatic construction. A study of the same case from these two different aspects will illustrate the point (Lazare, 1973).

First the *paediatric model*.

John. Aged 9, asthmatic since infancy; attacks on average every 2 to 3 weeks, lasting 1 to 2 days. Serious impairment of ventilatory function (FEV_1/FVC 48%) with marked growth retardation. Average loss of schooling 60%. Despite confirmed sensitivity to dust mites and animal fur, response to hyposensitization disappointing. Similarly, poor response to disodium cromoglycate. Regular steroid therapy has proved the only effective treatment. Nevertheless, he remains prone to chest infection leading to repeated hospital admissions. Cushingoid changes were noted before the introduction of beclomethasone aerosol. Relative improvement thereafter, but has remained steroid-dependent.

One sister aged 2; no evidence of asthma to date. Mother has seasonal hay fever; maternal family history of asthma. Father is marine engineer; no evidence of allergy. Frequently absent from home at sea. Son's

asthma noticeably more troublesome during father's shore leaves. Attributable to excitement of father's homecoming. Overall prognosis guarded.

Now, by contrast, the *psychosomatic model* (Pinkerton, 1972b).

John. Aged 9, asthmatic since infancy etc. etc. Superficially stoical and uncomplaining, but found upon inquiry bitterly to resent his handicap. Persistently plays down symptoms and denies disablement, though manifestly unwell. Mother sympathetic and protective. Father unsympathetic and rejecting of invalid image. Openly expresses preference for robust asthma-free daughter. Scornful of 'tainted' maternal stock, and secretly disappointed to have a weakling for his son and heir. Repeatedly exhorts the boy to fight his asthma, try to do without drugs (including steroid) and thereby harden himself. John desperately tries to comply, but taxes his ventilatory reserve in the process. Overall prognosis governed by response to chemotherapy but also by prospects of modifying father's attitude and John's self-image.

Essentially, the second model differs from the first by taking cognizance not only of the lesion itself but of family attitudes to it, i.e. *how* the child and his parents respectively view the problem. There is evidence that over and above definitive measures, both overall prognosis and therapeutic response may be significantly affected by attitudinal factors. This is certainly so for childhood asthma (Pinkerton, 1969) and comparable considerations apply to other areas, e.g. congenital heart disease (Linde *et al.*, 1966), juvenile diabetes (Crain, Sussman, and Weil, 1966), cystic fibrosis (Tropauer, Franz, and Dilgard (1970)), and the study of haemophiliacs (Husek, 1964).

Nevertheless, the emotional contribution to paediatric disorder is still woefully misunderstood. Three aspects in particular seem difficult to interpret. They are (i) its exact nature, (ii) how it may best be elicited, and (iii) what are its implications?

What does 'emotional' mean?

Too many paediatricians still believe that 'emotional' either means 'neurotic' or indicates gross social pathology—overcrowding, the broken home situation, abandonment, or delinquency. In any event it certainly means 'nonorganic', and as such, not strictly within the paediatric province. To be sure, neurotic overlay *is* encountered—frequently, children *are* abused, and become disturbed in consequence. Does this incidentally make them any the less deserving of our attention? But just as often, problems arise not through over-reaction to stress, but to dangerous denial that it exists at all.

This is potentially a much greater hazard, the more so in that it is so easily overlooked.

Consider the case of John, the asthmatic. Far from showing neurotic traits, he refuses to acknowledge major handicap at all, despite objective evidence of ventilatory impairment. He is in a sense 'super-stable' or counter-neurotic. The risk of course is that in his efforts to retain paternal approval, he will push himself beyond his limitations and thereby court a fatal outcome (Pinkerton, 1971). That risk is all the greater if he is misguidedly exhorted to manage without steroid. Yet in the past, there has been a tendency among 'no nonsense' doctors to applaud this kind of 'spirit.'

Further difficulty derives from the widespread prejudice that such personality assessments are purely intuitive, i.e. based upon inadequate 'hard' data. On the contrary, within the asthmatic series studied by Pinkerton and Weaver (1970), a small subgroup was isolated by Schubert (J. Schubert, personal communication, 1968) on the basis of a detailed Rorschach analysis. These cases could be identified by the factor of 'constriction' which characterized their projective test performance.

All the children showed lack of imagination in their school work; and in their interpretation of the Rorschach 'ink blots', they ignored the usual symbols both of anxiety and aggression. There was a marked discrepancy between their level of IQ (always higher than average) and the limited yield of projective responses. In all this, they contrasted sharply with the neurotically disposed asthmatic subgroup in the study, whose responses were high, both for aggression and anxiety.

In short, the Rorschach profile indicated a severely constricted personality, with marked repression of emotionally charged material—the prototype of the uncomplaining stoic.

When these data came to be checked against the clinical findings, the 'constricted' children proved to be among the most severely affected in pathophysiological terms.

Over the past decade, comparable studies have been reported in certain other disorders, each with the same kind of personality profile. Kissen and Eysenck, for example, in a study of male lung cancer patients (1962), described a pattern of restricted emotional discharge, as measured by the Eysenck Personality Inventory, compared with noncancer subjects. Brown (1967), in his study of eczematous patients, used the same instrument to isolate a similar type of personality, which he designated 'super-stable' (Table). This group of skin patients yielded low neuroticism scores and seemed disinclined to abreact emotional tensions. They

TABLE
The super-stable personality

Disorder	Lung cancer	Eczema	Essential hypertension	Bronchial asthma
Personality features	Diminished outlet for emotional discharge	Super-stable; low neuroticism score	Emotional overcontrol	'Constricted'; limited projective imagination
Test procedure	EPI	EPI	EPI	Rorschach
Authors	Kissen and Eysenck (1962)	Brown (1967)	Davies (1973)	Schubert (personal communication, 1968)

EPI, Eysenck Personality Inventory.

tended instead to develop eczema in response to self-imposed restrictions, compared with a more unstable control group who reacted with eczema to restrictions imposed from outside.

Similarly, Davies (1973), seeking an association between raised blood pressure and personality characteristics, produced evidence to suggest that hypertension is linked with suppressing strong feeling, as opposed to expressing it, either openly or through neurotic channels. Again, the Eysenck Personality Inventory was utilized.

Admittedly, these studies were undertaken with adult patients, and it may not be wise to extrapolate too far in respect of paediatric material. Nevertheless, their relevance to the concept of self-image in juvenile disorder represents an attractive area of aetiological speculation.

Personality profiles of this calibre are not based upon subjective judgements, intuitive in nature, but represent serious attempts at objective psychodiagnostics. As such, they could be complementary to other paediatric data in advancing our concepts of disease patterns.

Eliciting the emotional contribution. The clinician, however, may want to make his own assessment, at consultation, before having it confirmed more formally. Therein lies a further distinction, because the basic tool of child psychiatry is the interview (Creak, 1959), rather than the physical examination, additional to the history.

The trouble is that on the surface this seems too much like routine social converse. Hence, the comment at a recent British Paediatric Association conference about a tape, presented for clinical illustration, 'sounding too contrived—not at all like ordinary people talking.'

That is precisely the point; it was *not* an ordinary conversation but a professional exercise designed to elicit certain data and put them to therapeutic use.

That it does not seem as technical a procedure as (say) cardiac auscultation, is part of the problem. Nevertheless, it *is* a skilled technique governed by certain principles, just like listening for a cardiac murmur. Both involve recognizing what to listen *for*, and *how* to listen for it; both take time and training to acquire; the one is no less skilful than the other.

Important though it is to formulate the problem, it is just as important to listen for what may lay *behind* it. Sometimes, it is not so much what is said, but how it is said, or equally, what is left unsaid, which gives the clue to parental attitude or the child's self-image. Consider again the case of John, the asthmatic.

The *paediatric version*—focusing mainly upon details of the illness—is constructed on the basis of precise and direct questioning, traditional to medicine at all age levels. Not so the *psychosomatic version*, where direct confrontation is contra-indicated. In trying to unravel the subtleties of underlying attitudes, an oblique approach is preferable.

But this takes time—time to uncover and time to crystallize; partly because the subjects themselves may not be fully aware of the problem, but partly also because there is reluctance to voice it until rapport has been built up with the doctor, and more confidence established.

Thus, John's father was initially reticent about the critical views he held, and only felt free to express them as he gained an understanding of his pressurizing role. Similarly, John himself was unwilling to open up until he too could feel more trusting. Not only are time and monumental patience involved, but the capacity to wait for the dawning of insight, and the willingness to give a little of oneself; to become involved as a person, over and above one's authority as a doctor (Balint, 1957). For those of us unable to achieve this shift in orientation, exploration in depth is likely to prove

unrewarding. This is perhaps yet another area of contrast between the two disciplines.

Therapeutic and prognostic implications. If so much effort is involved in evaluating the emotional factor, is it really justified? What stands to be gained by adopting the psychosomatic model other than purely academic interest? In practice, the advantages are twofold—therapeutic and prognostic.

Reference has already been made to prognostic significance in childhood asthma, citing John as a prototype. In a series specially reviewed in the search for significant pointers, parental challenge, echoed by a noncomplaining attitude of denial by the child, was found to have characterized the majority of fatal cases (Pinkerton, 1971).

A particular risk in these cases is that improvement achieved in hospital may well be misconstrued by an already critical parent, as a challenge to his or her adequacy of management of the asthma at home. Further strain is thereby imposed upon the parent/child relationship, and one way of trying to resolve it would be an unconscious pact of mutual denial regarding the severity of symptoms—with potentially fatal outcome. The obvious moral is to avoid competition as to which can achieve the greater benefit for the patient—treatment in hospital or management at home. The ideal is a therapeutic partnership between the two.

Comparable considerations, based upon evaluating the emotional climate, apply to disorders like diabetes and cystic fibrosis (Burton, 1973), especially during the phase of teenage turbulence. The rebellious adolescent is particularly liable to sabotage his treatment as a deliberate gesture of perversity, thereby affecting prognosis adversely.

The implications for therapy hinge upon the concept of a causal sequence, rather than a single aetiological factor. Thus in asthma, though the basis is an immuno-physiological substrate of enhanced bronchial lability (Jones, 1971), additional factors are required to induce an actual attack. These include exposure to certain allergens in appropriately sensitive subjects; intercurrent chest infection if ventilatory function is already depressed; and on occasion, the prevailing aura of parent/child interaction. In other words, what is being invoked is the principle of *summation*.

It follows therefore that by *subtracting* from the cumulative build-up at any stage in the sequence, therapeutic benefit should result (Pinkerton, 1974).

Thus, in the case of migraine, excluding tyramine-containing foods may significantly reduce the likelihood of an attack; while in the asthma/eczema

complex, desensitization against known allergens could just as favourably influence the clinical outcome.

Alternatively, the sequence may be interrupted by the blocking action of specific drug therapy, e.g. ergotamine in migraine; anticholinergic drugs in peptic ulceration or spastic colon; topical steroid in atopic eczema; or disodium cromoglycate in asthma.

By the same token, benefit may accrue from the correct interpretation of self-attitude and family attitudes; because this makes possible effective psychotherapy at a further stage in the cumulative build-up, thereby counteracting the clinical progression. In other words, in line with all these other factors, successful intervention on the emotional 'front' may have equally significant impact.

It is of course in no sense a substitute for pharmacotherapy, but it can reduce the dosage schedule needed to maintain stability, and this may be important. Thus in John's case, improving the parent/child relationship and scaling down the boy's own physical fitness aspirations (and those of his father) did permit a valuable reduction in the level of maintenance steroid without clinical detriment.

While, therefore, the demonstration of a patho-physiological substrate in disorders such as asthma seems to rule out any suggestion of primary psychogenesis, emotional considerations are no less pertinent for being secondary.

As in other spheres of overlapping responsibility, the respective contributions of paediatrics and child psychiatry to the treatment of childhood disorder are complementary rather than mutually exclusive.

Conclusion

The reorganization of health services in 1974 will aim at closer liaison between the various agencies concerned with the welfare of children. In particular, the trend away from hospitals and in favour of community paediatrics, must mean increased involvement of the family as a whole. This will call for deployment of the very skills and insights lately discussed. Could there be a more convincing argument in favour of professional collaboration?

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