

General article Γενικό άρθρο

Reflexions on the identity and the practice of child Psychiatry

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The issue of the professional identity is salient for any medical discipline but especially for these, like child psychiatry and perhaps psychiatry, where the professional is the principal “instrument” in the assessment and in providing interventions. The Ericksonian view on identity implies self-sameness, continuity and synthesis which the child psychiatry as a specialty and child psychiatrists as professionals are to achieve more or less successfully. As a professional, the child psychiatrist is directed to the prevention, diagnosis and treatment of psychiatric disorders and associated problems in children and adolescents viewing children as developing biopsychological entities being in ongoing co-influencing interaction with their immediate and wider societal contexts. As a discipline, child and adolescent psychiatry needs to integrate developmental biological and psychological aspects, and holistic child-centered and family-focused perspectives. Child psychiatry is to integrate not only various aspects of the child as individual and of his environments as they are, but also in their diachronic dimension. As child psychiatrists, in my view, we must keep integrated in our professional armamentarium the consideration for intra- and interpersonal processes. In that perspective, of special value is the appreciation of setting, of timing, and of interpersonal processes in their interaction with intrapersonal ones. In addition, being both child-centered and family-focused, we need a systemic literacy to look at the families and of children as part of them. Apart from evidence-based information and clinical skills, we need some mature attitude to helpfully use our knowledge and skills. This attitude can transcend the state of the art professional algorithms; rather it integrates and not just imitates them. It cautions against too much enthusiasm in following the pendulum. It implies awareness of some reasonable limit to the urge to change the children and families. In fact, many developmentally and behaviorally disabled children need not only attempts to correction, but also some help to live and develop more successfully with their handicaps. Here, if not everywhere, a facilitating discovery and building on patient’s personal assets professional approach is needed. The international integration of “child psychiatries” of different countries and world’s regions is valuable, and not only with reference to elaborating on and further developing child psychiatry as a theory and practice, but in the view of international co-support, which being almost everywhere under-served child psychiatry and its potential patients-children, adolescents and families-necessitate.

Key words: Child psychiatry, child psychiatrist, professional identity, integration, continuity

Being with the profession of child psychiatry since 1985, the problem of reconsidering the issue of the professional identity of child psychiatrist and of child psychiatry as well as the different ways to be a child psychiatrist is, as I feel, timely for me. I also believe

that topic to be important for any helping profession like child psychiatry.

I strongly believe that we need routinely to look at and reflect of ourselves despite the heavy stone of everyday preoccupations and duties, to be like

Theseus who succeeded to lift a stone to find the token placed under it including his father's name.¹

For years, I have led multi-disciplinary teams in child psychiatry and have been routinely engaged in teaching to and discussing with medical students, residents in psychiatry and child psychiatry, and students in psychology. All these experiences have recurrently raised the question of what the distinctive features of our discipline are and could be.

Undoubtedly, the professional identity (or identities) of child psychiatrists is reflected in what and how they do or abstain to do in their practice, what they say and write about it, and how are they influencing the public perception of them. Being an active participant in the professional field in Bulgaria, I saw the extent to which the practice and ideas can change not only as following the unavoidable pendulum, but as influenced by the leaders in the field and the politico-societal contexts. So, the future of our discipline also depends on our attitude and conscious efforts in that direction. While working with patients, we are also agents in the society, and are responsible for the image of the profession, its definition, its real and perceived utility, and its future development.

In my view, a (possible) definition of the child psychiatrist as a professional can be stated as a "medical doctor directed to the prevention, diagnosis and treatment of psychiatric disorders and associated problems in children and adolescents as developing biopsychological entities in ongoing interaction with their immediate and wider societal contexts". Here, I mean the child as developing individual with a given genetically potential, being brought into existence and consequently shaped by the environment while at the same time influencing it; and psychiatric symptoms, signs and disorders, of course their precursors, taken in clinical and developmental perspectives. The developmental focus of Child Psychiatry, indeed, may be distinctive feature,² a hallmark of our discipline.

Here, I may add the major for me characteristic of our discipline – its integrative aspect. In my belief, it can precise the specialty of child psychiatry as an independent one. At least, child and adolescent psychiatry integrates developmental biological and psychological aspects, and holistic child-centered and family-focused perspectives. The former distinguishes it from the general psychiatry and the later from the pediatrics or child neurology. Thus, like unicorn, "a fabulous animal that combines many attributes in a

single creature" the child psychiatry "has its qualities as well as virtues and one is obliged to report both".³

Undoubtedly, our discipline is to integrate not only various aspects of the child as individual and of his environments as they are, but also the past and the present – as they apply to our patients, generations of patients and to us as a succession of individuals and an evolving discipline. Historical as well as developmental process is not a linearly and uniformly positive one. There are assets in danger to be left in the past. The child psychiatrists of the beginning of the 21st century are to seek to combine "the best of both worlds, the old and the new".⁴ As witnesses and agents in different times of the ever evolving profession, the senior professionals may transmit the need for necessary historical synthesis and embody it.

Wherever as a specialty and profession we go and whatever the contexts we live in impose on us, I believe, we must continue to try to keep integrated in our professional equipment the consideration for intra- and interpersonal processes. For me, when working with children and families, of special value is the appreciation of setting, of timing, and of interpersonal processes in their interaction with intrapersonal ones, and in their diachronic and synchronic aspects. Furthermore, in the days of the expansion of neurobiological and basic research and of collecting evidence-based facts about disorders and interventions (i.e. information) we may overlook that all we do with patients is relationally mediated (i.e. process). Apart from information and discrete clinical skills, we must have some personal maturity and thus capacity to helpfully use our knowledge and inter-ventive requisite. Also, being family-focused, we need a "systemic eye" to look at the families. The importance of family assessment is exemplified by the existence of a separate AACAP's Practice Parameter.⁵ Considering the child as belonging to family subsystem(s) and being more or less at his right place in a given family at a given time, or as sometimes subjected to aberrant familial processes like triangulation or parentification, or perceiving the family as more or less flexible in adapting to constitutionally "difficult child," turbulent developmental transitions, or stressful events, are all matters of importance.

With respect to relationship's quality and unfolding, we must be constantly aware that the act of medication, a prominent part of our therapeutic armamentarium today, is also in the matrix of relationships. As Sprenger and Josephson state "medication noncompliance typically suggests family issues".⁶

Perhaps health insurance systems and case loads will keep to impel us to act rapidly and superficially in a work, where out of emergent cases or even in them after the emergent phase, we need a time for unfolding of the relationships with the child and the family to appreciate the right time, kind and focus of intervention(s). Often, in integrating interventions we need to sequence them and intervention sequencing needs time. Apart from managed care exigencies, the "western attitude" to act and induce changes, and some "voyeuristic" pressures of the mass culture today may leave out underdeveloped the attitude to look at inside, at ourselves as participants, influencing the interpersonal processes and their outcomes. In my view, this attitude towards consideration of our own input into relational domain and relational outcomes has to be transmitted to trainees, as something valuable to their work with patients.

When immersed into a given topic or trend, or a thematic content, we are running the risk to overvalue and extend it. Knowing the brain as an organ to the extent that the current knowledge permits us, for example, is necessary but not sufficient. On slightly enlarged ground, the information only is not sufficient. At least, we need a tridimensional professional armamentarium – attitude (more or less aware, we always have it), information and skills. In addition, each of these is acquired predominantly by different processes. Clinical skills, for example, as Jellinek⁷ points out, are learned by "apprenticeship requiring time, experience and supervision." Viewing the individual professional formation in Eriksonian⁸ terms at the beginning there is preponderance of identification (in selecting information and building practical skills), perhaps mainly with trainer(s) but also collateral, lately comes the personalization of what is acquired and thus a more stable individual professional identity begins to emerge.

Too much ardor to apply the state of the art knowledge or fashionable professional thinking and algorithms, or too much enthusiasm to follow the pendulum at its extremes, may be (dangerously) misleading. The "wild" application of psychoanalysis in cases of childhood autism with "all blame to mothers" consequences is one of the striking historical lessons. Another one are the histories of psychological treatment of individuals with Tourette's syndrome long practiced before recognizing it as a neurobehavioral disorder. Nowadays, one of the dangers may be applying medication more (as indications, dosing, combina-

tion) and earlier than justified, as a sole interventive modality, or at the expense of other interventions.

Some reasonable limit to the urge to define, to prove and to change, may be justified. Perhaps, it is helpful to remember that another, more eastern philosophic approach to the world exists, where accepting the truth as given and trying to find a balance is sometimes needed. In fact, many children (and their families) with some disorders (such as Tourette's and ADHD) need not only medication, but also help to can live, function and develop more successfully with their more or less medication-controlled handicaps. Not only correctional, but facilitating discovery and building on patient's personal assets professional approach is needed.

The international integration is valuable for the profession and its cross national identity but it remains somewhat more difficult for poorer countries like mine. Here we need to create more opportunities for sharing with each other and for exposing and critically discussing the implication of biological and psychosocial aspects of child mental health and illness, individual and relational focus, research and clinical wisdom, quantitative and qualitative approaches to assessing and describing reality, and integrating the present and the past beyond the current conjuncture of professional fashion. In my view and regrettably, the leading journals in child psychiatry, like "the Orange Journal" of AACAP, are currently publishing almost entirely quantitative research articles omitting some topics and type of articles they previously had been publishing.

This international integration and co-support are especially valuable for a discipline like child psychiatry. For various reasons, including economical ones, it continues to be not so attractive for the majority of the graduating medical students, remaining one of the least chosen. It can hardly compete with the major medical specialties for funding and for public attention. More the national health system in market-oriented, less chances child psychiatry has to survive and develop successfully. There is, though disproportionate, a shortcoming of child psychiatrists almost everywhere in the world and as a consequence the mental health needs of many children remain underserved. Because our specialty needs to be an object of special governmental interest and a State child mental health policy, the potential role for achieving this goal of the international organizations like IACAPAP and ESCAP is considerate.

Προβληματισμοί για την ταυτότητα και την πρακτική της Παιδοψυχιατρικής

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Το ζήτημα της επαγγελματικής ταυτότητας είναι ουσιαστικό για οποιαδήποτε ιατρική ειδικότητα, αλλά κυρίως για ειδικότητες, όπως η Παιδοψυχιατρική και η Ψυχιατρική, όπου ο επαγγελματίας είναι το βασικό «εργαλείο» για την αξιολόγηση και την παροχή παρεμβάσεων. Η άποψη του Erickson σχετικά με την ταυτότητα συνεπάγεται αυτο-ομοιότητα, συνέχεια και σύνθεση, πράγμα που η Παιδοψυχιατρική ως ειδικότητα και οι παιδοψυχίατροι ως επαγγελματίες επιχειρούν να επιτύχουν, με άλλοτε μεγαλύτερη και άλλοτε μικρότερη επιτυχία. Ως επαγγελματίας, ο παιδοψυχίατρος ασχολείται με την πρόληψη, τη διάγνωση και τη θεραπεία των ψυχιατρικών διαταραχών και των συναφών προβλημάτων σε παιδιά και εφήβους τους οποίους αντιμετωπίζει ως βιοψυχοκοινωνικά αναπτυσσόμενες οντότητες που βρίσκονται σε συνεχή αλληλεπίδραση με το άμεσο και το ευρύτερο κοινωνικό τους πλαίσιο. Η Ψυχιατρική παιδιών και έφηβων καλείται να ενσωματώσει βιολογικές και ψυχολογικές αναπτυξιακά πτυχές, και να υιοθετήσει μια ολιστική παιδοκεντρική και οικογενειο-κεντρική προσέγγιση. Επιπλέον, η Παιδοψυχιατρική καλείται να λάβει υπ' όψιν της όχι μόνο τις διάφορες πτυχές του παιδιού ως ατόμου και του περιβάλλοντός του, αλλά και τη διαχρονική-εξελικτική τους διάσταση. Ως παιδοψυχίατροι, οφείλουμε να ενσωματώσουμε στην επαγγελματική φαρέτρα μας τη συνεκτίμηση τόσο εσωτερικών όσο και διαπροσωπικών διεργασιών. Στο πλαίσιο αυτό, ιδιαίτερη αξία έχει η εκτίμηση του παισιού, του χρόνου, και των διαπροσωπικών διεργασιών σε αλληλεπίδραση με τους εσωτερικούς. Επιπλέον, έχοντας παιδοκεντρική και οικογενειο-κεντρική προσέγγιση, χρειαζόμαστε μια συστηματική πρακτική για να εξετάζουμε τις οικογένειες και τα παιδιά ως μέρος αυτών. Εκτός από βασισμένες σε αποδείξεις πληροφορίες και κλινικές δεξιότητες, χρειαζόμαστε κάποια ώριμη στάση, ώστε πρόθυμα να χρησιμοποιούμε τις γνώσεις και τις δεξιότητές μας. Αυτή η στάση μπορεί να ξεπεράσει τους τέλειους επαγγελματικούς αλγόριθμους, ενσωματώνοντάς τους στην κλινική πράξη. Συνεπάγεται επίσης την οριοθέτηση μιας λογικής στην παρόρμηση που μπορεί να υπάρχει για να αλλάξουμε τα παιδιά και τις οικογένειες. Στην πραγματικότητα, πολλά παιδιά με αναπτυξιακά και συμπεριφορικά προβλήματα έχουν ανάγκη όχι τόσο προσπαθειών για βελτίωση, αλλά κάποια βοήθεια για να ζήσουν και να αναπτυχθούν παρά την αναπηρία τους. Η ενσωμάτωση του τρόπου με τον οποίο ασκείται η Παιδοψυχιατρική σε διαφορεές χώρες είναι πολύτιμη, και όχι μόνο για την περαιτέρω ανάπτυξη της Παιδοψυχιατρικής ως θεωρία και πράξη, αλλά για την εξυπηρέτηση της διεθνούς συνεργασίας και στήριξης η οποία στον χώρο μας βρίσκεται σε εμβρυϊκό επίπεδο.

Λέξεις ευρητηρίου: Παιδοψυχιατρική, παιδοψυχίατρος, επαγγελματική ταυτότητα, ολοκλήρωση, συνέχεια

References

1. Welvaert SR, Bowman L. *Theseus and the Minotaur*. Capstone Press, 2005:15
2. Schowalter JE. Trying to predict the future of a nascent discipline: Whaddya got? *J Am Acad Child Adolesc Psychiatry* 2011, 50:966–968
3. Philips I. Child psychiatry perspectives: If you see a Unicorn you are obliged to report it. *J Am Acad Child Adolesc Psychiatry* 1997, 16:340–346
4. Kestenbaum CJ. How we shall treat the children in 21st century? (Presidential address). *J Am Acad Child Adolesc Psychiatry* 2000, 39:2–10
5. American Academy of Child and Adolescent Psychiatry. Practice parameter for the assessment of the family. *J Am Acad Child Adolesc Psychiatry* 2007, 46:922–937
6. Sprenger DL, Josephson AM. Integration of pharmacotherapy and family therapy in the treatment of children and adolescence. *J Am Acad Child Adolesc Psychiatry* 1998, 37:887–889
7. Jellinek MS. The outpatient milieu. *J Am Acad Child Adolesc Psychiatry* 1994, 33:277–279
8. Erikson E. *Identity and Life Cycle*. WW. Norton & Company, 1980

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