

The view from the bridge: bringing a third position to child health *

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Introduction

A mental health presence in hospital paediatrics adds an extra player to the medical partnership with patients and families. Now there are two contrasting kinds of opinion about children and their health disorders, and they are not always compatible. The tension created may cause divisions between staff, but it can also lead to a more three-dimensional view of the patient's predicament.

The ability to take part in triangular relationships is an emotional and intellectual achievement for the developing mind. As the psychoanalyst Ronald Britton put it “a third position comes into existence [that] provides us with a capacity for seeing ourselves in interaction with others and for entertaining another point of view whilst retaining our own” (Britton, 1989, p. 87)¹. Likewise it is an enrichment of child health practice when necessary differences between paediatrics and child mental health add depth and perspective to the clinical picture.

A clinical example

Alex is 11 and has asthma. He keeps getting admitted to the paediatric hospital ward from the emergency department (A&E) with dangerous attacks of wheezing. This had happened ten times during the year preceding his referral to me, the trigger for which was a concern about his mother's attitude to his illness. She is obsessed with it, keeping detailed notes of every wheeze.

Together with the referring paediatrician I meet the two of them. Mother explains that doctors in A&E always ask *her* about Alex's symptoms when they should be

* chapter in (eds.) Sarah Campbell, Roger Catchpole & Dinah Morley, *Child & Adolescent Mental Health: new insights to practice*. Palgrave Macmillan, 2016.

¹ 'If the link between the parents perceived in love and hate can be tolerated in the child's mind it provides him with a prototype for an object relationship of a third kind in which he is a witness and not a participant. A third position then comes into existence from which object relationships can be observed. Given this, we can also envisage being observed. This provides us with a capacity for seeing ourselves in interaction with others and for entertaining another point of view whilst retaining our own, for reflecting on ourselves whilst being ourselves. I call the mental freedom provided by this process triangular space' (Britton, 1989)

asking *him*. The trouble is that he would usually say that he was ok even when he was really ill. It's clear that there is a breakdown of trust between mother and the paediatric team.

In the first consultation she is rather prickly and self-righteous both with me and with the paediatrician, but becomes more interested as she follows a conversation between us that reveals our different clinical perspectives. I ask her about Alex growing up and she says 'please not!', which opens up another aspect of their relationship, not about asthma. He is leaving childhood and she does not like it. I suggest they are an 'asthma couple', enmeshed by his illness and her anxiety about it. This uncritical observation seems to make sense to both of them. We hear that Alex's father does not live with him but visits and stays at weekends.

I offer to meet him with them (from then on without the paediatrician) a few weeks later. Father is a big man and looks unusual. It turns out that he is part descended from central Asian people, which explains Alex's appearance – his dark straight hair – which we talk about with enthusiasm. I get the impression that none of this has been discussed in the family, and we enjoy doing so now. Father had never attended an outpatient appointment with his son before, so this consultation brings a third perspective for Alex, now seeing himself in interaction with each parent, and them with each other. Mother is clearly the primary parent, while father is not expected to do much extra. But he is keen to get involved. His entrance at this point in Alex's life is crucial for his development as a soon-to-be adolescent. Once mother's anxiety about the prospect of Alex growing up has been acknowledged the atmosphere in these consultations becomes warm and humorous, and her thoughtful intelligence shines through.

We meet for several further reviews (father only attending once more) at widely spaced intervals during the next 18 months by which time mother has thrown away her notebook. Having already tailed off soon after the first two meetings, Alex's emergency admissions had stopped altogether.

While the reason for this referral was wheezing, its timing² was partly determined by Alex's impending adolescence; an alarming prospect for mother and son. Even if neither of them was thinking about it, both were anxious about what comes next. Here is one triangle repeated on the vertex of another. Paediatrician and psychiatrist see the problem

² An experienced paediatrician reflects: '...asthma and migraine prove to be symptoms, not diseases; translations of the clinical history into medical shorthand. We are left to find out why this child experiences recurrent attacks of wheezing and that one recurrent headaches' (Smithells, 1982, p. 135).

differently, as we are bound by training and temperament to do.³ As mother and son witnessed us working together it became easier for them to take their own positions alongside ours. When father joined us, more room for change was opened up within the family.

Since most of the anxiety had been carried by his mother, it would have been much less productive for me to see Alex on his own. This kind of intervention is essentially a part of paediatric practice and not a separate mental health treatment.

Location of the problem: Where is it really?

A serious difficulty in making the case for mental health teams in paediatrics is that many patients with complex medical presentations do not appear to have mental problems. Rather than being 'all in the mind' it's all in the body. Even when very ill, Alex was always cheerful. The predicaments that lead paediatricians to seek our support are often confusing.

If, unlike Alex, a young person presents with mysterious physical symptoms with *no* pre-existing paediatric diagnosis there is an urgent need to find one. A 14-year-old girl is referred by her GP to a consultant paediatrician because of dizzy spells and intermittent hearing loss. The paediatrician does her assessment, including a variety of tests, and finds no abnormality. During the next few weeks she gets neurological and ENT (ear, nose and throat) opinions, both of which confirm her findings. The neurologist also adds that in his view this is a psychological problem, which she is beginning to think too. What is the paediatrician to say?

Imagine you are this patient with your mother in the clinic. The doctor has a hunch that is supported by a more specialist medical colleague, but it takes her out of her comfortable expertise. She begins, 'we have done all the tests but found no explanation for these symptoms'. You hear this and think 'What's wrong with me then?' As medical uncertainty increases so does the anxiety in the room. She goes on: 'I think this could be due to some stress or worry that you are having...' Your silent rumination continues: 'she thinks that this is all in my mind, that I'm just making it up! (The only stress I have is from my

³ 'Paediatricians view childhood more positively than do child psychiatrists [who] rated their own parents as less caring than do paediatricians' (Lawrence and Adler, 1992, p. 82). Enzer et al. (1986) showed how psychiatrists see childhood as a time of struggle, powerlessness and conflict. In a more recent British study, Glazebrook et al. (2003) found that paediatricians missed the need for mental health attention in three-quarters of their patients whose SDQ (Strengths and Difficulties Questionnaire) suggested they should have been referred.

giddiness)'. Your and your mother's faith in this doctor is shaken; she has failed to find a proper cause, and is now telling you the symptoms are not real.

Although there will be a number of parents or children who are greatly relieved to hear it, the suggestion of a psychological origin for so far unexplained symptoms often creates offence and the risk of humiliation; it both exposes what appear to be the doctor's limitations, and implies that there is something wrong with the child's family. 'The temptation for professionals, unable to diagnose a physical cause, is to blame the child and/or the family as the cause of the problem' (Carter, 2002, p. 38). 'Medically unexplained symptoms' (MUS) has become a category in its own right as if it defined a problem in the patient, like psychosomatic disorder. Though more inclusive than somatisation the term fails to neutralise the stigma of non-medical causes.⁴ This is despite the unconscious irony embedded in the phrase, which clearly does not refer to anything in the patient at all. What MUS describes is a problem in the doctor's mind, not the patient's. By her awkward manner she transfers her frustration – tinged perhaps with shame at not seeming to be a clever enough paediatrician – to the mother, who then feels that she is not a good enough parent. 'Even the most caring physician can be perceived as guilty of an empathic failure when the patient and family believe they are being told that "nothing is wrong" after weeks or months of symptomatic distress and several hours in a waiting room' (Campo and Fritz, 2001, p. 469).⁵

The implications of ascribing a mental origin for a physical symptom introduce an entirely new dimension to the clinical picture.

Body and mind

'Physical disorders are seen as "real" and patients are seen as victims, whereas psychiatric disorders are seen as "not real," and patients are seen as partly responsible for their problems' (Hatcher and Arroll, 2008, p. 1124).

⁴ 'Although "medically unexplained" is scientifically neutral, it had surprisingly negative connotations for patients. Conversely, although doctors may think the term "functional" is pejorative, patients did not perceive it as such' (Stone et al., 2002). However, neurologists prefer the ambiguity of 'functional' (Kanaan et al., 2012).

⁵ Campo and Fritz go on to give the following advice – a counsel of perfection – 'Given the pervasive nature of stigma, it is especially important to avoid communicating any sense of embarrassment regarding the diagnosis of somatoform disorder or other psychiatric disorder because this can contribute to treatment resistance and a patient's wish to perpetuate the search for traditional disease. Avoid mind-body dualism by discussing the relationship between mind and body and the false dichotomies presented by our current health care system' (Campo & Fritz, 2002, p. 470).

Where does this idea come from? Of course not all referrals face such resistance but the peculiar experience of taking the step from physical to mental is familiar to all of us. It opens up an enormous, disconcerting field to explore. Since at least the European enlightenment⁶ the body has been perceived as material; a living thing, but subject to deterministic cause and effect. The mind, on the other hand, is where thoughts, wishes, beliefs, desires, anxieties and dreams are located along, most crucially, with choice. This distinction is most often associated with the philosophy of René Descartes. ‘The Cartesian doctrine of the immaterial unextended soul served to open up a space for human freedom which would have been precluded ... if the soul were material’ (Wright and Potter, 2000, p. 4).

Descartes’ intention was to allow mental events to be detached from physical ones; to show that mind exists without body and to remove any hint of mentality from physical objects (Skirry, 2005). He set out to be more scientific about matter, for example not to ascribe the falling of a stone to its desire to reach the centre of the earth. The body is material, like a machine, but the mind is moral. Many philosophers before Descartes, such as Plato and St Augustine, struggled with various possible relationships between the two, but what they shared is a concept of mind, however connected to it, as a separate entity from the body (Wright and Potter, 2002). This is still the case. We know a lot more about the brain now, including how mental content, such as belief, can have an effect in the body. Good examples are the placebo effect (Mayberg et al., 2002)⁷ which, like psychotherapy, alters the brain (Abbas et al., 2014). We always knew that sexual fantasy has bodily effects, and science has caught up with ancient knowledge that you can die from a broken heart (Tennant and McLean, 2001). The interdependence of each domain is no longer challenged. Besides the effects of toxins or drugs on consciousness there are interesting correlations (while not the same as causes) between somatisation disorders and changes in the brain (Spence, 2006). Yet despite scientific advances we stubbornly hold on to a largely unquestioned assumption of the separateness of mind and body, comparable to that between the sexes. As with male–female so with mind–body; you are either in one or in the other. The impact of this tradition on clinical thinking is that we are inclined to see a medical condition as a fault in the machine, while a mental disorder is subject to free will, entailing choice.

⁶ Long before Western philosophy there was an understanding of mind–body unity, which still finds expression. Gregory Bateson (1979) follows a line of thinkers – from the ancient Egyptians and pre-Socratic philosophers to, in our time, Iain McGilchrist (2009) and others who see more continuity between mind and matter. Descartes’ contemporary Baruch Spinoza said ‘Mind and body are one and the same thing’ (Spinoza, 1951, p. 131).

⁷ ‘While comparable brain changes were seen with both drug and placebo administration, drug response was not merely the same as the placebo effect’ (Mayberg et al., 2002, p. 731).

To add to the size of the moral landscape revealed, in paediatric practice the problem is now not only seen to be in the child's mind. Responsibility for it extends into the family and beyond. From the point of view of the players in our clinical scenario this is a massive step to take. In a study of paediatric staff's experience with patients who have medically unexplained symptoms Furness et al conclude 'Making the transition from physical to psychological care was perceived as one of the most difficult stages in the professional-carer relationship because of parental resistance to giving up the notion of an identifiable, treatable physical cause for the symptoms in favour of an approach addressing psychological and social issues' (Furness et al., 2009, p. 579).

The stigma of mental illness is usually ascribed to prejudice about madness as a dangerous affliction. But in paediatric liaison the principal anxiety is the sudden prospect of having to consider someone's responsibility, even blame, for physical symptoms where none existed before. Doctors tend to think that emotional disorders are not real illnesses because there is no lesion (afflicted tissue) to explain them. Actually mental health practitioners think the same, but usually have better skills in working out where the affliction is to be found, outside the body. *The reality is somewhere else*: often – though not evident in Alex's case – contained in a narrative of intergenerational sorrow, grievance or loss.⁸ The fact that neuroscience and immunology can show altered tissues in mental disorders (White et al., 2012; Davison, 2012) might ease the transition, but it does not fully explain them. The binary disjunction between dimensions remains. Psychological therapies only exaggerate it; if there is a mental way out of the problem does that not suggest there was a mental – even wilful – way in?

The development of health professions in modern times has faithfully reflected prevailing notions of mind and body. Whatever integration and 'parity of esteem' we may wish to see between them, the difference between a paediatrician and a psychiatrist is only too real. It would take a cultural revolution of the kind envisaged by Iain McGilchrist in his magisterial text, *The Master and His Emissary: The Divided Brain and the Making of the Western World* (2009), to make the barrier more permeable.

⁸ As in any setting a crucial quality of effective mental health intervention in paediatrics is the absence of blame. While family members may blame one another it is a clinical obligation not to take sides, but instead to make sense of the story. Therapists work hard at being 'non-judgemental'. 'This is not the absence of judgement, but the absence of blaming. The psychoanalyst Wilfred Bion (1897–1979) spoke of the need to abandon 'memory and desire' (1970) when with a patient. Later Gianfranco Cecchin (1932–2004), one of the original Milan group of family systemic therapists, said one must be trained to achieve neutrality, 'to see the system, to be interested in it, to appreciate this kind of system without wanting to change it' (Boscolo et al., 1987, p. 152). From this position problems seem different already; they move from a fixed location to where they may be more easily observed by all players' (Kraemer, 2006, pp. 242–3). Where systematic lying or criminal abuse is part of the picture, non-blaming neutrality may have to be modified.

Creating a third position: The true meaning of MUS

The history of the relationship between paediatrics and child psychiatry shows conflict between them from quite early on. In 1931, the Chicago paediatrician Joseph Brenneman wrote 'there is a menace in psychologizing the school child, psychiatrizing his behavior and overorganizing his habits and his play' (Brenneman, 1931, p. 391). A similar antipathy was also evident in British child health. The great paediatrician Sir James Spence (1892–1954)⁹ was firmly against the development of child psychiatry as a profession in its own right. In a biographical review written 20 years after his death, Donald Court (also a distinguished paediatrician) wrote '...his intuitive understanding of people made him unwilling to recognize the extent and complexity of mental ill health in children and resistant to the development of child psychiatry as an independent discipline' (Court, 1975, p. 88). Though Spence had been a pioneer in providing room on the wards for mothers to live in with their sick babies, and was clearly sympathetic to the loneliness of child patients in long-stay hospitals (Spence, 1947), he was quite dismissive of the efforts of John Bowlby and James Robertson to show that children in hospital were significantly affected by separation from their parents.

In 1951 Robertson was invited to present his observations to the British Paediatric Association. As soon as he had finished Spence was on his feet, asking 'what is wrong with emotional upset?' (Brandon et al., 2009). Robertson records his discouraging discovery that 'the myth of the Happy Children's Ward that has sustained the hospital professions for several decades was very resistant to what I had to say' (Robertson and Robertson, 1989, p.19). With Bowlby's support, he decided to make a scientific film. When *A Two-Year-Old Goes to Hospital* (1952) was shown at the Royal Society of Medicine in November 1952 'in the discussion which followed, the first reaction of the audience seemed to be a frank refusal to admit that the child was distressed' (Lancet, 1952). Spence was clearly not alone. The paediatric establishment, including children's nurses, was affronted. Three years later, shortly after the first showing of Robertson's film in Scotland, the child psychiatrist Fred Stone was offered a research grant by his colleagues at Glasgow's Royal Hospital for Sick Children to 'disprove all this Bowlby nonsense' (Karen, 1994, pp 80, 81)¹⁰.

⁹ The *James Spence Medal* is the highest honour in British paediatrics.

¹⁰ Stone's study had a surprising outcome. Despite furious resistance from nurses in particular, a paediatric colleague opened one of his wards to unrestricted visiting while keeping the other limited to the usual minimal hours. Before any results could be obtained, within several months all the paediatric wards has opened their doors to parents (Karen, 1994, pp. 80–81).

Yet there were pioneering efforts in the United States and in Europe to get paediatricians and psychiatrists working together. The child psychiatrist Leo Kanner (1894– 1981)¹¹ writes in strikingly familiar terms about impediments to these ventures. In 1930 a planned ‘psychiatric workshop’ for paediatric trainees and staff in a clinic at Johns Hopkins hospital ‘did not work out too well’ (Kanner et al., 1953, p. 394) largely because the doctors were too busy with acute medicine to find the time. He takes an even-handed view of the cultural gap keeping medical and mental apart:

The community child guidance clinics have made great contributions to the understanding of children’s feelings and parental attitudes. They were set up as ‘teams’ of psychiatrist, psychologist and social worker. Paediatricians were left out of the arrangement. ... Insult was added to injury when paediatricians, kept at a distance from all that went on in the clinics, were blamed for their alleged lack of comprehension and interest. Only recently, after about 30 years, have the child guidance clinics begun to show a desire to break through the walls of their isolation from medicine ... Obviously, paediatricians could expect nothing from the pontifical attitude of the community child guidance clinics. (Kanner et al., 1953, p. 394)

Other attempts to introduce mental health skills and knowledge to paediatricians also petered out. There were a variety of reasons for this failure, largely due to the far greater time and emotional pressures on doctors trying to treat behavioural and emotional disorders, but also to ‘such puzzlements as how to help parents accept the suggestion that a child be seen by a psychiatrist’ (Kanner et al., 1953, p. 396). This remains a problem: ‘... referrals to psychologists and psychiatrists were perceived by parents as labelling their child as ‘mad’ or as ‘obviously making it up’ (OT; Nurse), and could permanently damage the relationship between practitioner and family’ (Furness et al., 2009, p. 580).¹² Hinton and Kirk (2016) note that ‘referrals to child and adolescent mental health services are often a last resort when other approaches have failed’.

My colleague who was looking after Alex, the asthmatic boy presented above, told me afterwards that she had only been able to refer him to me once she had become quite

¹¹ Leo Kanner wrote the first textbook of child psychiatry in the English language, published in 1935, and was the first to describe the syndrome of infantile autism.

¹² ‘Sometimes, although the news came initially from doctors, ward staff would be left with the burden of dealing with the family’s confusion or resistance: The family sits there nodding, but as the doctor goes away, then they sort of talk to the nurses and they automatically think it has been made up. They can’t accept that the child has actually got psychological problems (Health Care Assistant)’ (Furness et al., 2009, p. 580).

exasperated by his mother. Her wish to keep on cordial terms with the family was trumped by a fear that her patient could die. Despite her good working relationship with me, resistance to crossing the body–mind boundary was great. Without our collegial friendship the referral might well not have taken place at all. In view of the evident strengths in the family and their exceptional responsiveness to therapeutic consultations, that could have been tragic.

In many parts of the world, there are now thriving partnerships between paediatricians and mental health specialists (Pinsky et al., 2015;¹³ Edwards and Titman, 2010). Some well established in centres of excellence, but they are in a minority (Slowick and Noronha, 2004; Woodgate and Garralda, 2006).¹⁴ Liaison teams in general hospitals are less secure, easily broken up when committed enthusiasts move on. In Britain there are special interest groups of mental health professionals working in paediatrics but their collective voice is weak in a National Health Service driven by contracts and outcomes (and intimidated by shrinking budgets) rather than by service and patient needs. The trend towards highly regulated training and evidence-based practice has kept us apart in our different professional bodies; paediatrics, psychiatry, psychology, child mental health nursing, individual and family psychotherapies in particular. In none of these disciplines is paediatric mental health a mandatory element in training. Just as in the United States 80 years ago community child and adolescent mental health clinics in Britain now are relatively exclusive (and overworked) organisations with preoccupations far from hospitals and child health. Meanwhile (with honourable exceptions), the paediatric establishment has largely dedicated itself to what most people expect it to do, which is to focus on the diagnosis and treatment of physical disease.¹⁵ Despite many official working parties and recommendations over the years,¹⁶ there is little sign of a national

¹³ ‘...the key features of quality consultation will remain unchanged. The consultant will continue to bring to the multidisciplinary medical team the combined expertise of psychodynamic understanding, psychopharmacology, a developmental perspective on the meaning of illness, adaptation to trauma, knowledge of psychiatric conditions, behavioural interventions, and CNS influences in medical illnesses and as a result of medical treatment’ (Pinsky et al., 2015, p. 596).

¹⁴ ‘Over 80% of paediatricians perceived access as a frequently encountered difficulty ... Paediatricians were frustrated with the current provision of consultations and some tried to manage by themselves as they did not expect any additional help from their local CAMHS.’ (Slowik & Noronha, 2004). ‘...formalised liaison services were rare (provided by only one-third) and dedicated specialist CAMHS liaison services even rarer’ (Woodgate and Garralda, 2006).

¹⁵while taking a more active part in the safeguarding of children in their care, no doubt due to a more urgent need to prevent harm, even death, befalling them.

¹⁶ Kraemer, S. (2015, unpublished) *National Guidance on Paediatric Mental Health Liaison*
<http://www.sebastiankraemer.com/docs/Kraemer%20National%20Guidance%20on%20Paediatric%20Mental%20Health%20Liaison.pdf>

understanding of this complex story: 'Repeated exhortations for cross-agency collaboration are faithfully incorporated into national guidance and protocols but have not had much impact on commissioning. Institutional resistance does not disappear because documents say it should... It is as if child mental health practice had opened a previously unknown room in the paediatric house to reveal quite new kinds of anxiety and sorrow in the complex lives of children' (Kraemer, 2009, p. 571).

An 'institutional blind spot' remains (Kraemer, 2015). A critical mass for creating joined up working has not yet been achieved, leaving the child health professions in a collective state of ambivalence. In too many places paediatricians have been disappointed by the lack of readily accessible mental health colleagues to work with. They have had to manage on their own or beg for help from hard-pressed local CAMHS. Given high thresholds for access to these services, children referred to them with puzzling medical symptoms may be given a low priority – with a long wait and little chance of a joint consultation – or not be accepted at all, as happens to many children referred.¹⁷

Without first-hand experience of an effective partnership – likened to a marriage¹⁸ – paediatricians are in no position to spell out to colleagues, managers and commissioners what they need. Neither frustration nor ignorance is a sufficient basis for designing new services. Kanner's prescient observation from the 1950s about the paediatrician in need of a mental health opinion for a patient is still valid:

There is a choice between 3 possibilities: one is that these needs are disregarded or handled clumsily to the patients' detriment. Another possibility is that these children are sent away to be treated elsewhere;¹⁹ this deprives the pediatricians of valuable experience. A third alternative presents itself in the form of a psychiatric unit in the children's hospital. (Kanner et al., 1953, p. 397)

To return to our harassed paediatrician with the deaf and dizzy patient; clearly the best choice is Kanner's 'third alternative'. Once she has explored the medical options she can then discuss the patient with the mental health team to work out a strategy for referral. In

¹⁷ 'One fifth of all children referred to local specialist NHS mental health services, are rejected for treatment' NSPCC, 12 October 2015 www.nspcc.org.uk/fighting-for-childhood/news-opinion/1-in-five-5-children-referred-to-local-mental-health-services-are-rejected-for-treatment/ (Accessed 10 February 2016).

¹⁸ 'There has been a long and desultory flirtation between [paediatricians and child psychiatrists] but it is high time they were married – if only for the sake of the children' (paediatrician John Apley (1908–1980) cited by Hersov, 1986).

¹⁹ Kanner could have added that sending a paediatric patient away to be treated elsewhere – such as CAMHS – is unlikely to appeal to the child and family unless they have already agreed that the primary problem is a mental or emotional one.

a case of this kind, letters or emails tend to screen out the most revealing and useful information; a conversation is required. This can be in the corridor (as happened in this case), in a visit to the mental health team's own meeting, or in the weekly multidisciplinary meeting of all staff where there is space to reflect on complex cases. It is easier to say than to write 'I was pretty sure this is psychological; there was something about the way the mother and child interacted which made me feel uneasy, as if mother was somehow encouraging her daughter's problem.' The paediatrician decided that she would say to the girl and her mother: 'I am puzzled about these symptoms. We have done enough tests for now, so I am going to need some help to look at this a different way. I have been talking to my colleague X who is a specialist in this kind of problem. I want him to join me to help me work out what's needed here'. The moment of truth is the mention of X's profession which may include the terms 'mental' or 'psycho-' in it²⁰. Some families will bristle even at this diplomatic proposal but it helps that the doctor, while introducing a third point of view, is taking a one-down position. She makes herself part of the problem; the true meaning of MUS. At the same time she demonstrates that she knows and trusts this new kind of specialist and will not abandon the family to yet another consultation where they have to tell the story all over again. Speaking in 2010 at the launch of his report on the needs of children in the NHS Sir Ian Kennedy said 'no 21st century health system should require parents and children to go from place to place or even worse to go to multiple appointments to tell the same story' (Kennedy, 2010).

If it is to have a chance of success the vital feature of this step is that it is not done in parallel with any other search for help. Asking for a further expert opinion at the same time clouds the moment. If not distracted by yet more medical tests the view from the fragile bridge between body and mind can open the minds of all players to something new and provisional. 'The development of a third position ... is a necessary preliminary to the sceptical position' (Britton, 2015, p. 81).

Conclusion: Liaison is an end in itself

There is no doubting the need for a mental health presence in paediatrics. Epidemiological studies show that children with chronic disease and/or medically unexplained symptoms have higher rates of mental disorder than the general population (Meltzer et al., 2000;²² Hysing et al., 2007;²³ Garralda and Rask, 2015).²⁴ There is a large

²⁰ 'Family therapy' is less off-putting-

²² 'Having any physical complaint (compared with no physical health condition) increased the odds of having a mental disorder by 82%' (Meltzer et al., 2000).

²³ 'The estimated prevalence of a psychiatric diagnosis among children with reported chronic illness was 10%, almost twice the rate found in children without chronic illness' (Hysing et al., 2007).

literature of psychological interventions for children of all ages with unexplained symptoms, with and without underlying physical illness²⁵. Neither neuroscience nor philosophy play much part in this knowledge, most of which depends on a developmental view of children's and parents' experiences of illness, anxiety, pain and disability. A clue to the origins of somatisation (Rask et al., 2013) may better be found in the normal state of a human infant who has never heard of Descartes, one whose mind and body have not yet been partitioned.

Once a mental health colleague is engaged it is often possible (as in Alex's case) for the patient and family to continue consultations without the paediatrician, but she still carries overall responsibility for the patient's care. She remains in the mind of the mental health clinician who is all the while providing a service *both to the family and to the paediatric department*. This triangular set up is a necessary condition for good liaison. Modern health services have difficulty promoting partnerships of this kind, preferring 'patient pathways' which risk prejudging the intervention required (and a premature entrance through the wrong door) rather than reflecting on it. Disintegration of comprehensive services for the sake of contracting does not do justice to the actual experience of a child and family in confused clinical situations. A passing opportunity to enlist a mental health point of view is easily lost by thoughtless adherence to protocols.

Though it is essential to collect clinical activity data, the quality of the resulting service cannot be judged by measurable outcomes alone. The liaison relationship is an end in itself. Having evolved in the context of multiple caregiving (Hrdy, 2016) all humans are programmed to monitor relationships between significant others. Our survival as small children depends on trusting partnerships amongst caregivers. Supporting Britton's formulation in the laboratory, Fivaz-Depeursinge et al. (2012) show how acutely attentive infants are to the way their parents are getting on. Likewise, patients and families are attuned to the quality of professional discourse in a paediatric department, for example the extent to which clinical staff can entertain multiple explanations for child health problems. This capacity is fostered in regular multidisciplinary meetings where colleagues are free to speak their minds (Kraemer, 2010) to get a sense of a child's experience of illness from all sides. Another voice resonating from the past is that of Sir Harry Platt (1886–1986), the orthopaedic surgeon who chaired the report on the welfare

²⁴ '...high levels of comorbid anxiety and to a lesser extent depressive disorders in childhood, functional somatic symptoms and somatoform disorders' (Garralda and Rask, 2015).

²⁵ Kraemer, S. (2016, unpublished) *Paediatric psychology/mental health liaison: selected references* <http://www.sebastiankraemer.com/docs/Kraemer%20Liaisonrefs.pdf>

of children in hospital usually named after him: ‘What, after all, is it really like to be that child in this hospital, at this moment?’ (Platt, 1959).

As it did for Alex, the inclusion of mental health in paediatric practice can reduce hospital admissions and unnecessary investigations. It may save money too, but neither of these is its primary task, which is to hold together in one place otherwise incompatible accounts of disease.

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