A foothold in paediatrics [*]

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The Child Guidance Training Centre started life in Canonbury in 1929, but after the second world war it migrated through three places until finding a home in 1967 on the first floor of the newly built Tavistock Centre. The Tavistock Clinic's larger Department for Children and Parents was on the second floor, entirely independent of CGTC, whose identity was thus rather submerged. It was not an ideal location for one of the very first child mental health clinics in the country [(1)]. From the mid 1970s onwards there were many discussions about moving back to Islington where there was a greater need for child mental health services. Although the Whittington Hospital had been seriously considered, in the end no place could be found.

In parallel with this story there was a very small scale mental health innovation in that hospital. In 1960 a determined young child psychiatrist, Dr Dora Black, needed to get some experience in paediatrics and persuaded the eminent consultant paediatrician, Dr Sam Yudkin (1914-1968), to give her unpaid experience working alongside him in his outpatient clinic at the Whittington Hospital. He was so impressed with what she could do that he decided a few years later to appoint a consultant child psychiatrist, Dr Margaret Collins, to join him, giving up two of his sessions to pay for her. Dr Collins had been on the staff of CGTC since 1954 and arrived at the Whittington [(2)] a year or so before her clinic moved into the Tavistock Centre.

I was appointed to a consultant post at the Child Guidance Training Centre in 1980 which included Dr Collins' sessions – now increased to three - at the Whittington Hospital. The appointment committee took place while I was in the middle of the annual Tavistock Institute Leicester Group Relations Conference. These are extraordinary ordeals, from which lifelong learning about oneself in organisations can be gained. My performance at the interview was undoubtedly affected by a state of heightened consciousness. I had trained in paediatrics before starting psychiatry but had no experience of working as a psychiatrist in this specialty. While the child guidance sessions I took over were part of a

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[1] The decision to put it there was probably due to financial pressure in the NHS from the looming devaluation crisis of that year.

[2] When Dr Collins retired in 1975 a distinguished and also retired psychiatrist Dr Jack Kahn (1904-1989), father of Dilys Daws, occupied these sessions as a locum until 1980.

well-established clinical organization, the place of psychiatry in the Whittington paediatric department remained fragile, barely a foothold. I knew this was a single handed post but arrived at the hospital to find that, besides having no mental health colleagues, I also had no secretary, and had been allocated a room with no windows. This tiny outpost of CGTC was all that was left of its yearning for a return home. Shortly after my appointment the search was abandoned. Five years later CGTC was no more, having been absorbed into the Tavistock Clinic to create the newly minted Child and Family Department. I knew none of the history at the time. I was very pleased to get this job and thought it a good opportunity to apply what I had learned as a trainee at the Tavistock Clinic in the preceding four years.

Passing the test

Though he had no vote on the appointment committee the head of the paediatric department Dr Max Friedman (1931–1987) was keen to have a colleague with a paediatric qualification, which probably got me the job. The first case he referred to me was a girl with abdominal pains who had stopped eating. I saw her with her parents on the ward, which seemed to resolve the symptoms quite quickly. I felt I had passed a test. In those days there were few emergencies so that it was possible to focus on patients with what are now known as medically unexplained symptoms (MUS). The most immediately useful clinical preparation for this was my training in systemic family therapy, under the ambitious leadership of psychiatrist Dr John Byng Hall (1937-2020) and social worker Rosie Whiffen (Papadopoulos & Byng-Hall, 1997). Building on a relatively modest interest in therapy for families from the 1930s onwards, these pioneers carved out a significant space for it in the Tavistock Clinic during the 1970s. They set up an intensive training for internal and external clinicians, while forging inspiring links with then world leaders in the field such as Dr Salvador Minuchin (1921–2017), Marianne Walters (1930–2006) and Harry Aponte from Philadelphia, with Lynn Hoffman (1924-2017) from New York, Drs Gianfranco Cecchin (1932–2004) and Luigi Boscolo (1932–2015) from Milan. All made several visits to the clinic to supervise and teach us. These were revolutionary times. The 'family therapy programme' became within a few years the now thriving Systemic Psychotherapy training and service with its own distinct profession [3].

It is significant that when he took over the leadership after the war John Bowlby renamed the Tavistock children's department 'the Department for Children and Parents'. With little antecedent literature or practice to go on he was already interested in families as clinical entities. Virtually inventing it from scratch he started doing family therapy (Bowlby, 1949). At the same time he set up the first training in child psychotherapy but as his energies

[3] The establishment of the systemic discipline in the Tavistock & Portman Trust was supported by Margaret Rustin when she was chair of the professional committee around the turn of the century.

became diverted towards attachment research, family therapy did not develop as much as child therapy [4]. By the time Bowlby retired from clinical work in the early 1970s the prevailing ethos in the department was psychoanalytic child psychotherapy, along with infant observation, work discussion and group relations training. These were also core aspects of training in child and adolescent psychiatry at the time, which is how I began mine. Only a few of us were later drawn to the still new, and very different, approach to therapy with families. An immersion in both systemic and analytic thinking turned out to be a good preparation for the hospital challenge.

Where is the anxiety?

The system around a sick child includes not only her family, but also the doctors and nurses responsible for her care. When early on I asked a paediatrician who had referred a patient to me if she could join me in the family consultation, she said afterwards "I see what you are doing", which surprised me, because I had not quite seen it myself. She realised that I was not going to take over the clinical care of her patient but instead, through shared consultations, wanted to enhance what she was already doing. There the families could witness our liaison relationship – *a therapeutic process in itself*. This is not what other specialists, such as neurologists or gastroenterologists do, because they are, rightly, more concerned with children's symptoms than with their experiences.

A doctor confronted with MUS is inclined to think that there must be a mental problem in the child. Actually the problem is in the mind of the doctor herself, who should therefore be included in any attempt to solve it. Children with inscrutable symptoms are distressed by these symptoms, rather than by any emotion behind it. Psychoanalysis began with this predicament but in children, troublesome anxieties may more easily be found somewhere else in the family (Minuchin, 1979; Kraemer, 1983). Neither paediatric patients nor their parents are likely to see any sense in an appointment with a psychiatrist. They might even be offended at the suggestion. A better strategy for engaging one is for the paediatrician to say to the family that *she* is the one who needs help. 'I am puzzled about these symptoms. We have done enough tests for now, so I am going to need a colleague to look at this in a

[4] In an interview with Alice Smuts recorded in 1977 Bowlby recalled the arrival of his gifted trainee, the Canadian psychiatrist, Freda MacQueen (subsequently Martin). "She quickly adopted a joint interview technique [Martin & Knight, 1962] and as she progressed to senior registrar and staff status had a powerful influence on several members of staff. Although I gave her every encouragement and what help I could, as did Molly Mackenzie, I had too much else on my plate to make any further contribution myself." John Bowlby, cited by Duschinsky and White (2019, pp 208-9). Dr Freda Martin (1932-2019) later became the chair of the Department for Children and Parents. She wrote elegantly about the interface between family and individual approaches (Martin, 1977) but left in 1975 to return to her native Canada.

different way. I want him to join me to help me work out what's needed here' (Kraemer, 2016, p. 75). A therapeutically useful system is thus created [5].

Within a few years the hospital saw a need for more mental health sessions and found money for another part time consultant, and Dr Peter Loader, from Great Ormond Street Hospital, was appointed. From his research on psychosomatic families he could see that with our limited resources we should focus on paediatric patients only, and stop accepting referrals from outside the hospital; thus a dedicated paediatric liaison team was born. By the 1990s the mental health presence in the department had been enhanced by several more gifted colleagues, all part time. Dr Jane Roberts, replacing Peter Loader (both were also family therapists), a consultant psychotherapist, Maggie Cohen, who worked in the neonatal intensive care unit and was also a trainer at the Tavistock, a child protection expert, Carol Edwards, a senior psychiatric trainee from the Tavistock Clinic on placement each year, and a (full time) local authority social worker, Annie Souter (1953-2014). Annie's leadership provided a third boundary, alongside medicine and mental health, for the department. This containing triangle played a significant part in the success of the Whittington paediatrics as one of the most popular places in London for doctors and nurses to train. Throughout these years the head of department was the fearless paediatrician Dr Heather Mackinnon who led the way in cross disciplinary collaboration with social services and mental health. She regularly demonstrated the necessity of robust disagreement between colleagues in complex child protection cases.

A bigger system

Problematic cases are shared not only in clinical consultations but in departmental discussions. Before I arrived Dr Friedman had already established a weekly multidisciplinary group of ward and clinic staff and trainees, of which I became a regular member, rarely missing a meeting over the following 35 years. This group originally crowded into a tiny room where people sat on a table or the floor but after a few years, when the ward had moved to a new building, we met as the 'multidisciplinary team' (MDT) in a larger space with seats for everyone. The meeting was always chaired by the consultant paediatrician on duty. Those attending were a number of other consultant paediatricians and juniors, senior ward and specialist nurses, social workers, safeguarding leads, mental health staff, hospital specialist teachers, play specialists, physiotherapists, speech and language therapists, nursing and medical students (and, in earlier decades, the

[5] what the early group and family therapist Dr Robin Skynner (1922-2000) called 'the minimum sufficient network'.

hospital chaplain), plus any visiting colleague, such as a social worker or health visitor who was involved in the care of one of the patients being discussed.

Having a senior paediatrician in the chair – as there had been already before my time – made it clear to everyone that this was proper medical business, and not a marginalised 'psycho-social meeting' which important people need not attend. In Tavistock terms, the MDT had to have a *primary task*. After many years, and much debate, our 'terms of reference' were formulated thus:

> "The aim of the MDT is to provide a weekly space for reflection on complex or troublesome cases and on themes arising out of these. The discussion is intended to be facilitative, supportive and educational to all those working in the wider team. There are no rigid criteria for the types of cases to be discussed but they will always include: Non accidental injury/safeguarding, serious/life threatening illness, deliberate self harm/acute mental health, complex cases involving many teams and agencies, *or any case in which the child or member of family is generating curiosity, anxiety or concern in any staff however unclear this may be*." (*italics added*)

This is a disconcerting setting for medical and nursing staff. A typical ward round is a hierarchy of decision making, with a consultant at the top and students at the bottom. The principle that everyone in the MDT, including visitors, student and trainees had an equal voice in the discussion needed regular reinforcement: "hang on a minute, I think our visitor has something to add". The task is to make observations, not decisions. To encourage people to speak their minds no minutes were kept. Meetings would often start late, and the discussion be waylaid by exciting distractions, but over the decades the MDT served its function well enough.

Joining a paediatric department in this way was a form of participant anthropology. Through our daily visibility on wards and in clinics mental health staff became domesticated. We wanted to change the culture to one of inquiry, to slow down rapid-fire – often competitive – diagnostic talk and ask in conversations about puzzling cases, 'what is happening here?', and how the way we were behaving with each other could be related to the case we are caught up in (Mattinson, 1975; Britton 2005). This kind of thinking is routine in the Tavistock, where it had grown out of wartime experiments in leadership and group dynamics (Bion & Rickman, 1943), but is quite alien almost everywhere else in public services. Its fundamental premise is that any contribution, however inarticulate or even offensive, reflects a significant aspect of the case, and should be given equal value to any other, possibly more carefully formulated, contribution. In work discussion "there is not one "right" way to do whatever is being studied; instead there are some facts that can be viewed in many different ways, yielding new lines of enquiry" (Rustin, 2009, p. 12). Note that the mental health team's comments were not made from the privileged position of a

group consultant but as regular members of the MDT, who had to present and discuss our own clinical material along with everyone else.

In contrast, we gradually set up facilitated staff groups. In the neonatal unit Maggie Cohen started a work discussion group and asked me to join her. Alongside her remarkable observations of premature infants, she wrote about these meetings in *Sent Before My Time* (Cohen, 2003). We also ran regular groups with junior paediatricians, and with the consultants in the department (Kraemer, 2016). Only many years later - now working with Maggie Cohen's successor Judy Shuttleworth - was it possible to maintain a group with ward nurses, set up by an enthusiastic nursing tutor. "We don't know any psychology" they said, to which I replied "that's fine. Tell us about your patients". The discussion that followed showed how natural – yet how unusual in a busy timetable – it is to talk honestly about ones clinical experiences (Kraemer, 2018).

Canaries in the mine

Since the turn of the century the number of consultant paediatricians grew rapidly and there were smaller developments in what was now called the Paediatric Mental Health Team, but the most dramatic change affecting the whole department was the number of emergency admissions, mostly of teenage girls following suicidal self-poisoning. [6] This epidemic has made the need for mental health in paediatrics more visible to policymakers, but has not helped them to understand the basic principle of our working in partnership. Poisoned people need doctors to assess the damage before any mental health help can be provided, but it is real collaboration – by which I mean conversations of some kind – between physical and mental health care that has the most profound therapeutic effect.

Infant observation, both in analytic training and in the laboratory (Fivaz-Depeursinge, et al., 2012) shows how attuned babies are to the relationship *between* the adults who look after them and how disturbing it is when they undermine one another. It seems that this capacity has survival value; that it is, so to speak, "wired in". It should be no surprise, then, that people of any age who are in a vulnerable state will be affected when physical and mental clinicians show little respect for each other. Though often concealed in warm words this antipathy is still prevalent in health services. The therapeutic function of an emergency medical assessment is destroyed if patients are then deposited on a paediatric ward, waiting to be seen by a psychiatrist who is unknown to the hospital staff, and takes days to arrive (Kraemer, 2019).

[6] Badshah, N. (2018) Hospital admissions for teenage girls who self-harm nearly double. *Guardian,* 6.08.18

To manage the anxiety stirred up by the most troubling admissions it was necessary for the ward to have access to out-of-hours emergency psychiatric consultations. In 1998 I watched in admiration as Jane Roberts summoned senior managers from UCLH, Royal Free Hospital, Whittington Hospital and the Tavistock Clinic to advise them of their obligation to organise and fund a rota of specialist trainees in child and adolescent psychiatry, and the serious dangers of not doing so. One trainee would cover the three hospitals each night and each 24 hour day of the weekend, always with phone access to a consultant psychiatrist from whichever hospital their patient had been admitted. This service, largely invisible to managers and day time staff, strengthened the bond of good faith between paediatric and mental health colleagues.

Paediatric wards everywhere are under unprecedented pressure from emergencies. This has been building up throughout this century as young people see their prospects for secure homes and jobs – even for a habitable planet - dwindling. Such considerations are beyond the grasp of a technocratic health service. Without a deeper view of the developmental origins of mental and physical illness the NHS will be overwhelmed.

At the foundation of the NHS the Tavistock Clinic had bold new ideas for early intervention. Staff would engage the population from the beginning of life in "Infant Welfare Clinics, Obstetric Units, as well as … such organisations as a Nursery School and a Juvenile Employment Agency"(Dicks, 1970). This compulsion to reach out is still a proud part of the Tavistock ethos, as several chapters in this book show. The postwar pioneers discovered, as we did at the Whittington, that it is possible for teams to do good work on a certain scale. What we have now witnessed is the danger that small creative organisations can easily be washed away by tidal social forces which can only be contained by political change. Compared to the 1940s we are equipped with a much richer understanding of human needs and behaviour, waiting to be woven into social policy.

Mental health in paediatrics is a fragile thing. Like a good marriage, it depends on tolerable degrees of conflict, which are not usually encouraged in public services. The whole point of liaison is to hold together in one place otherwise incompatible accounts of disease. This is more than diplomacy; it is professional friendship, which when it works well is always evident to patients and families. Many innovations that have extended the scope of child health have their origin in fortuitous meetings, such as between Drs Black and Yudkin 60 years ago.

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References

Bion, W., & Rickman, J. (1943). Intragroup tensions in therapy: their study as the task of the group. *Lancet,* 2, 678–681 *reprinted in* 'Pre-view' in Bion, W. (1961) Experiences in groups (pp. 11–26). London: Tavistock.

Black, D., McFadyen, A. & Broster, G. (1990). Development of a Psychiatric Liaison Service. *Archive of Diseases in Childhood, 65*:1373-1375.

Britton, R. (2005) Re-enactment as an unwitting professional response to family dynamics, In M. Bower (ed) *Psychoanalytic Theory for Social Work Practice: thinking under fire*. Abingdon: Routledge

Byng Hall, J., & Papadopoulos, R. (1997). *Multiple Voices: Narrative in Systemic Family Psychotherapy.* London: Duckworth.

Bowlby, J. (1949). "The Study and Reduction of Group Tensions in the Family" *Human Relations,* 2: 123 - 128, 1949, *reprinted in* E. Trist & H. Murray (Eds.), *The Social Engagement of Social Science: A Tavistock Anthology, Vol 1: the Socio-Psychological Perspective* (pp. 291-298). Philadelphia, University of Pennsylvania Press, 1990.

Cohen, M. (2003). *Sent Before My Time: A Child Psychotherapist's View of Life on a Neonatal Intensive Care Unit (Tavistock Clinic Series).* London: Karnac.

Dicks, H. V. (1970). *50 Years of the Tavistock Clinic*. London: Routledge & Kegan Paul, p. 143.

Duschinsky, R . & White, K. (2019). *Trauma and Loss: Key Texts from the John Bowlby Archive.* London: Routledge, pp. 208-9.

Fivaz-Depeursinge, E,, Cairo, S., Scaiola, C. L., & Favez, N. (2012). Nine-month-olds' triangular interactive strategies with their parents' couple in low-coordination families: A descriptive study. *Infant Mental Health Journal, 33*(1): 10-21.

Kraemer, S. (1983). Who will have my tummy ache if I give it up? *Family Systems Medicine, 1*: 51-59.

Kraemer, S. (2015). Anxiety at the front line. In: D. Armstrong & M. Rustin (Eds.), *Social Defences against Anxiety: Explorations in a Paradigm (Tavistock Clinic Series)*. London: Karnac.

Kraemer, S. (2016). The view from the bridge: bringing a third position to child health. In: S. Campbell, R. Catchpole & D. Morley (Eds.), *Critical Issues in Child & Adolescent Mental Health:* London*:* Palgrave Macmillan p.75.

Kraemer, S. (2018). Stop running and start thinking. *Child and Adolescent Mental Health, 23*(4): 381–383.

Kraemer, S. (2019). Deliberate self-poisoning by teenagers. *Archives of Disease in Childhood, 104***:** 728-729.

Martin, F. & Knight, J. (1962). Joint interviews as part of intake procedure in a child psychiatric clinic. *Journal of Child Psychology and Psychiatry*, *3*: 17-26.

Martin, F. E. (1977). Some implications from the theory and practice of family therapy for individual therapy (and vice versa). *British Journal of Medical Psychology, 50*: 53-64.

Mattinson, J. (1975). *The Reflection Process in Casework Supervision* (2nd. Edition, 1992). London: Tavistock Marital Studies Institute.

Minuchin, S., & Fishman, C. (1979). The psychosomatic family in child psychiatry. *Journal of the American Academy of Child Psychiatry. 18*: 76-90.

Rustin, M. (2009). Some historical and theoretical observations. In: M. Rustin & J. Bradley (Eds.), *Work discussion: Learning from reflective practice in work with children and families* (pp. 3–21). London: Karnac.