Introduction

"Child Psychiatry is a wonderful field. Those of us who are in it are very privileged. Patients (both children and adults) trust that their life stories of courage, despair, love and hate will be respected rather than judged by us and will be put to use to help them achieve their optimal state of well-being. … Learning to understand better the complexity of children and their families never stops and this is what makes our field eternally exciting." (Gaby Weiss[1732])

Is There Art in Child Psychiatry?

"It's a contradiction," says one of our daughters. She says this book isn't art at all: it's just facts. She's partly right: it's not about visual or verbal beauty, but about beautiful *ideas*. Few outsiders see the art in psychiatry. Many see it as an authoritarian, biologically driven field, blindly medicalising social problems, and usually missing the point. We hope this book changes those views a little – especially about child and adolescent psychiatry (CAP), a small branch of the field of psychiatry.

The book focusses mainly on another meaning of the word *art*: skilled practice, or *craft*. An inpatient CAP, who faces many difficult decisions, told us recently that her craft is not often based on treatment guidelines. She makes perhaps a hundred clinical decisions a day, of which she says only 10% have any published evidence.[2000] She is one of hundreds of clinicians who think and debate and formulate and treat. In this most accessible of all medical fields, such forays have lessons for everyone.[2001]

The book draws on the core CAP evidence base, but it is more about our other decisions. So we don't have one chapter on each diagnosis. Instead, the book is divided into three volumes: Assessment, Treatment, and Systems. In every chapter, we find tension and balance: between theory and practice, populations and individuals, feelings and rationality, quality and quantity, anxiety and exploration. The book is extensively cross-referenced to avoid repetition, because the same thinking patterns come up often, whether in children, families, teams, employers, or ourselves.

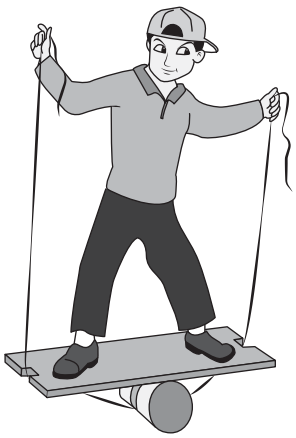
We hope general readers will enjoy this book, as a peek into psychiatry. Managers, adult psychiatrists, psychologists, and many others will find ideas relevant to their work. In all these areas, the best practitioners we meet rely on their thinking skills when dealing with nonstandard problems. We have tried to capture many of those skills in this book, for people who must do a lot of their work off-piste, guided not by a protocol but by values, intuition, general knowledge, and careful thinking.

A Dynamic Art

What is the art of CAP like? We sometimes find ourselves captivated by introspective, ethereal, poetic beauty, but CAP needs art that is more substantial. CAP should be both modest and practical: more bridges than equations, and more footbridges than Golden Gates. Some psychiatrists love art that is spontaneous, florid, or self-indulgent. But personally, we are drawn to methods that are reproducible, unexpected, and as simple as possible.[2002] Those characteristics make this art useful.

CAP is a dynamic, kinetic pursuit, almost like a sport. Consideration of a particularly beautiful sport, sailing, may explain what attracted us to the topics in this book. CAP has many parallels with sailing, not just the need to cooperate, and to have everything to hand when you need it – and to remain buoyant.

A central theme of this book is *balance*. "Balance is an alien concept in today's world. It wants opinions that are certain and are made fast."[148] But we have to weigh patients' choices and hopes versus professional and societal requirements.[287] We judge the needs of family members and classmates. We balance competing opinions, scientific findings, protocols, ethics – and resources. Balance also includes *dynamic* adjustment. We are constantly considering the family's response to



what we say – and both old and new treatments, with their short- and long-term effects. And keeping an "even keel" ourselves.

Unexpected effects are captivating: the sailboat that makes progress *against* the wind; the hydrofoil that rises out of the water, balanced on a rod. In healthcare, paradoxical interventions bring similar awe.

A more important parallel with sailing is the need for a gentle hand on the tiller. No sailboat moves on tracks; instead, it is jiggled or tossed back and forth, without losing direction. Every child psychiatrist will recognise the need to be flexible in the face of changes in the child's inclinations, the family's mood, the availability of staff, and so on. But of course there are firm rules, too.

When should we pass on the wrong side of the buoy? As modern clinicians, should we simply obey protocols and meta-analyses? The balance is crucial, because if we overshoot with control, patients are denied the "art of individual expression from each caring doctor; but undershoot, and patients play dice, gambling that this particular doctor [is] up to date, accurate and precise."[131]

Getting something for nothing – simply, effortlessly – is always intriguing: the magic of the sailboat, completely unshared by the motorboat racing past. Clinically we have careful waiting, and gentle turns of phrase. The spontaneous drawing that reveals ID is much more exciting than the same result obtained via an IQ test, even though the latter shows more careful craft.

We all love sudden clarity: the view when the clouds lift, or the sail snaps taut, catching the wind and making good speed. Clinically, we have Eureka! moments, when bits of the story fall into place, in an unexpected way, and the formulation suddenly makes sense. Perhaps each parent had a part of the story, and they fit like jigsaw pieces; or you realise the child in front of you has a condition you had only read about in books.

What the Book Isn't

It is not a textbook. We had hoped to produce an inspirational, easy read, but that turned out to be too hard. We also tried to make a catalogue of rules, or a list of instructions, but (being CAPs) we didn't like being so directive. We ended up with a wide-ranging compendium of ideas and quotations.[2003] The book is long, because the job is complicated.

But the book is not complete. We have intentionally omitted diagnostic criteria, epidemiology, and protocols, as they already have numerous authors. We exclude most specific medicines and laws as they vary around the world, and will date rapidly. We can be aware of only a small fraction of what has been done, and we exclude most ideas that we have not personally seen or tried. Rather than summarising what is *well known*, we have organised the chapters to cover the big questions in clinical practice. So the short chapters discuss topics where we have not found much to say.[2004]

The book has almost no overlap with our previous book, *A Handbook for the Assessment of Children's Behaviours*. Both books address gaps in the CAMHS

literature: this on the Art, the other on differential diagnosis. That book is about what is happening in the child, whereas this book is about what is happening in the clinician. That book encouraged a particular way of thinking, whereas this book gives options.

The book is far from perfect. Every expert will find oversimplifications; every researcher will regret a missing reference; and some protocol-lovers will find the very idea of the book preposterous. We wish our descriptions of the ideas could be as elegant as the ideas themselves. We feel absurdly pretentious in trying to summarise "the Art," but it needs to be done and no one else is stepping up to the plate. In any case, while writing the book we have enjoyed trying to be artists: "It is better for an aim to exceed one's grasp than for one to aim too low or too narrowly." (Howard Gardner[576])

Navigating around the Book

The book is not intended to be read straight from start to finish! Wherever you start, if you follow the links, you could eventually cover the entire book. Or you could read just the vignettes, and follow any links that interest you.

If you want to find a specific topic, the table of contents is a good place to start, with related chapters nearby. If not, the index should point you to the right place. Some topics appear throughout the book, in many different contexts. To find these, the longest index entries are most likely to be helpful. They include general topics such as philosophy, science, creativity and ethics (plus of course art), with more serious topics such as management and economics.

The following tables offer a way to find concepts that apply to many types of people or groups. You could work across a row, or down a column.

In this book, *child* is usually shorthand for both children and adolescents. 'DSM' is used as a shorthand for several diagnostic systems (p.173). Abbreviations can be found in the index. The vignettes are chosen to illustrate successes and errors we have made or seen.[2005] They are shorter than those in many clinical books, to protect anonymity and to save space. All the names and locations have been changed, and all the

	Main Source ▼	Learning	Irrationality, Heuristics	How to change	Failure	Risk
Main Source ►		788	533	365	283,810	271-288, 86
child	5-59	761,89		339,365	189,766	450-477
parent	108-131	356	126	262,255	469	155,69
CA psychiatrist	496-504	510, 803	949	468,551	323	288,271,516
team	595,670	674,658	670	666,613	676	670
organisations	625-694	796	636,637	663	749	276,35
regulation	422-439	440	693	701	439	285
CA psychiatry	180-218	849	883,174	857	172	814,285

	Ethics	Complexity	Words	Innovation	Competition, Selection	Quality
Main Source ►	564-578	522	247	810	867	422-439
child	370	17,522	24	350	626	23
parent	131,583	108	122,69	389,811	836	127
CA psychiatrist	175,273,572	523	249	810	702,164	422-433
team	675	625,670		666,672	679,748	603,673,679
organisations	578	760,636	251	857,664	633	423
regulation	442,29,32	817,[2694]	252	925	442	435
CA psychiatry	31,575	522.872	137,174	853,841	872,[2042]	866

stories altered. If they match a real person, that is a coincidence.

Citations are numbered from 1–1999, and endnotes from 2000 (underlined if the endnote contains something to read; grey if it has only an external reference). Many of the endnotes draw parallels between CAMHS and nature, which may seem barely relevant, but these strands are brought together in the final chapter.

Painful Topics

Psychiatrists deal with people in terrible situations, and some of them do terrible things. It would be absurd to omit these, producing a book of "vanilla psychiatry". We have agonised over how to present painful topics. Realistic details make the vignettes more interesting, but where possible we have excluded vivid details that could upset readers. We have obtained advice from sympathetic people in several professions, and usually followed it. But we can't exclude all painful topics: dealing with them in a considerate way is one of the core skills of the CAP. Indeed, a quick search through the book shows that almost every page contains a topic that could offend, but which we cannot omit.

Some readers may be disappointed that we describe immoral behaviours without commenting on how reprehensible they are. In fact, we believe this non-judgmental stance is crucial for full clinical effectiveness, especially when working among people who are ethnically or religiously or developmentally diverse.

CAPs usually speak to each other in a professional telegrammatic way – much like casualty nurses, for example. In addition, most CAPs develop a slower, more sympathetic way of talking to the families themselves, constantly listening to ourselves and observing the reactions. To keep the reasoning clear, and the book a manageable size, most of the writing has to be in the briefer style. With patients we are often intentionally vague or euphemistic, but in the book, we must be much more direct. We hope the reader hears our voices as if in a clinical discussion, striving for accuracy and effectiveness. This may grate, both with academic readers used to formal writing, and with non-clinical readers used to sympathetic doctors. We hope readers will accept the reasons for this and not think us careless or disrespectful.

Normality

"The only normal people are the ones you don't know very well." (Alfred Adler)

"The older I grow the more I realize how terribly difficult it is for people to understand each other, and I think that what misleads one is the fact that they all look so much like each other. If some people looked like elephants and others like cats, or fish, one wouldn't expect them to understand each other and things would look much more like what they really are." (Ludwig Wittgenstein[1350b])

"It seems for success in science and art, a dash of autism is necessary." (Hans Asperger, 1944[2006])

Normality always seems obvious, so we don't think about it much. Many factors influence what you judge to be normal. Perhaps the biggest factor is who you are used to seeing (p.553). Another is who you are – your culture, your background, and your training, each with its associated prejudices. Compared with CAPs in the UK, those in America are far more likely to diagnose disruption as ADHD rather than conduct disorder[1312] – in other words, more likely to take a medical view than a moral one. Countries even within a single continent differ widely in the behaviour that is judged acceptable – and also in what is judged to be a mental health issue.[1151]

There are some more subtle influences on you, too. One is whether you want it to be normal (p.51). Another is what group you are considering someone to be part of. For example, children with specific learning disabilities are likely to be extra tired when they get home from school – so they are extra resistant to homework. You don't need another explanation for the tiredness or the resistance. They are normal in the context of those disabilities.

Definitions

Normal: Common or expected, "nothing much to worry about."[1681] The word *normal* often needs exploration. It can mean common for the country, for children with this diagnosis, or for this particular child. When parents ask, "Is this normal?" they mean, "Is it culturally acceptable – healthy – average – what you would expect?" Many fathers ask this.

Norms: Standards, expectations. Don't use your class, culture, or background as a norm.

Normative: Relating to what is correct: what *tends* to be or what people think *ought* to be (p.211).

"Because the psychiatrist learns a good deal about normal psychological functioning as well as abnormal functioning he may well involve himself in the management of those who, by such pure criteria, are not truly mentally ill. Many people with sexual problems, marital unhappiness, drug dependence, or social difficulties are seen and advised by psychiatrists although it would be difficult to classify such patients as suffering from mental diseases. Doctors in general medicine, it is worth remembering, do not confine themselves to the physically ill either: the pregnant woman, the woman in labour, the person undergoing an examination for a life assurance policy, the airline pilot having his yearly check-up are not necessarily suffering from physical disease yet are properly considered as falling within the physician's area of interest and competence."[276] This is part of the sensible argument for the involvement of psychiatrists in the screening of people who have self-harmed (p.456).

Spotting Abnormality

> "Every day we experience, at least momentarily, three emotions we don't like: anxiety, depression and anger. These same three emotions, when out of control, cause most 'mental illness.' … Each emotion of the dysphoric triad bears – no, *is* – a message – insistent, uncomfortable, hurting – goading us to change our lives."[1488]

Some problems are absolutely clearly abnormal *and* need to be taken seriously. They are uncommon, but when they appear we need to recognise them and their importance. Physical signs of severe starvation are an important example – which we will miss if we don't weigh the patient or examine her properly. Severe weight loss is also important – it is certainly not "normal" for the weight to drop across two centile lines on a standard growth chart, even if the child is still overweight. Also important are hard neurological signs,[1754] such as upgoing plantars which indicate physical disease.

Vignette 1. From One "Abnormal" to Another

Sam 16, was gradually getting better. In January he had been floridly psychotic, hearing the voices of gangsters wanting to kill him. With regular olanzapine he was settling. Each month he was a little more settled and we inched the olanzapine down, finally stopping it in July.

At the September review appointment, off all medicines, he was so bouncy, so intrusively in-your-face, that I worried he was becoming psychotic again. His mother reassured me: "No, this is him, it's lovely to have him back to normal, he's fun, he's enjoying life again, now he's off the medicine."

He was attending school again, a school for teenagers with behaviour problems. Some new staff requested an emergency psychiatric assessment on the grounds that he was obviously ill: loud, aggressive, illogical, and sometimes violent. We saw Sam with the deputy headmaster, who fortunately had known him for a few years. He explained that this was normal for Sam. Yes, he's a handful, but he's not dangerous at all!

He remained over-excited (some would say hypomanic) when off medication. Unfortunately, the next year he had another paranoid psychotic episode. He became very distrusting of me and his family. He muttered angry things under his breath, though it wasn't at all clear whether he was hearing voices. We restarted the olanzapine that had helped the year before.

The olanzapine didn't help and we approached an inpatient unit about a voluntary admission. They assessed him and were quite certain that he wasn't psychotic at all. They felt his unwillingness to communicate, in the absence of hallucinations, was probably due to autism, especially given his difficult birth. They even went to the extent of putting this in writing, thoroughly confusing the family, before they were told that his current state was not the "real him." (Such diagnostic errors are common in inpatient units that have little experience of autism.)

The moral of the story is that a diagnosis based only on a patient's current state has little meaning – and even less if his usual state is not standard.[2007] In an assessment we need to work out his normal self – his baseline – and how he is, at this moment, different from that. Only in this way do we have a chance of identifying the processes involved – that is, the causes of his problems. An added complication in Sam's case was that his state *while off medicines* changed: in general, the calming effects of antipsychotics continue reducing for about 2 months after stopping them (p.401).

Vignette 2. Healthy but Violent

"A thirteen-year-old boy had been bullied and teased at school. Through his therapy he began to gain self-esteem and inner strength. In one session he reported, with pride, that he had beaten up a peer and thrown him down a flight of stairs. [The therapist later wrote:] 'I felt a deep distress that I had helped him discover resources for self-assertiveness and use of personal power and that he was using those strengths to attack and injure others, that he was pleased and even bragging and gloating at his successes. We grappled with these issues for a while and he became increasingly angry with me. … Sneeringly, he told me I did not understand the ethics of teenage life or society. He terminated the therapy with the support of his parents, who were pleased with his new strength and ability to conquer others in his everyday world.'"[2008]

The moral is that normal is not necessarily nice. It varies between cultures, subcultures, and individuals. Should we aim to please an Italian dad who loves his son's hyperactivity? Abnormality in one area can protect against abnormality in another. For example, permanent hypomania protects one child against teasing for her mild ID – while in another child the same abnormalities lead to major problems (vignettes on pp.566,395). A very timid girl didn't cause problems for anyone – but relieving her anxiety revealed her ADHD and made her stroppy. Mum then needed new parenting skills (p.770).

Are Patients Normal?

Don't assume, on the basis of the referral and your observations in the session, that you have a good overview of the child's long-term or short-term functioning. They are referred at their worst point – at an abnormal time – and you see them in an abnormal environment. The two most common errors in this respect seem to be (a) assuming that the child is having a temporary response to recent difficulties (p.480); and (b) conversely that the cause of the problem is permanent and within them (the fundamental attribution error, p.536). More often, the truth is a combination of these.

Borderline Intellectual Functioning (BIF)

From 12 to 15% of the population have BIF. This term describes the 14% of children whose IQ is from 70 to 85 (or 80: see figure, p.9). They have much in common with children with mild ID,[478] but they are taught in mainstream classes, and receive very little extra help. Most teachers will describe them as normal. These children's cognitive difficulties are often unrecognised (e.g. memory problems, NVLD, severe dyslexia – or simply low intellectual capacity) and even when recognised they do not typically reach the threshold for significant extra help in school. A child with IQ 73 who is given a diagnosis of "no global intellectual disability" is likely to have a worse outcome than his peer with IQ 69 who has "mild intellectual disability," because the latter is given much more help (a boundary / threshold effect).

Each 15-point decrease in IQ increases diagnoses by 25%.[629] Overall, children with BIF account for 40% of child mental health problems, such as depression, self-harm, and suicide. In a study of three CAMHS units in Norway, the mean IQ of referred children was 85.[1068] The IQ of referred children traces roughly a normal distribution: it is left-shifted by 10–15 IQ points in comparison with the whole population.[2009] This means that half of all our patients will find school a major struggle. They are exposed to other difficulties too: mothers of children with BIF "exhibited less positive and less sensitive parenting than did other mothers"[504] perhaps, in part, because BIF is often inherited (contrast p.657).

"Almost a quarter of young offenders were identified with learning difficulties (IQ<70), while a further third had borderline learning difficulties (IQ 70–80). However, this finding must be taken in context, in that a number of these young people had missed education. Commonly used psychological measures cannot easily differentiate those with intrinsic learning difficulties from those with low IQ scores secondary to lack of education."[721] In the same study, the mean IQ of young offenders was lower for males than for females: 77 versus 84. There was little difference in IQ between offenders in custody versus those in the community.

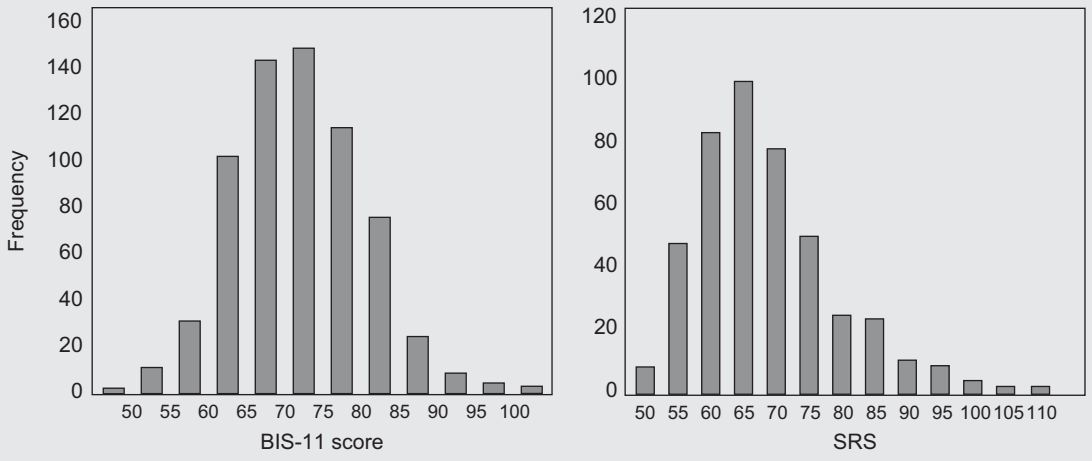
For children with BIF, more than with any other large group, there is an appropriate natural tension between the "universal" education service efficiently teaching the *multitudes*, and the health service advocating for extra support for *individuals*, often on the basis of medical diagnoses and emotional needs. This advocacy role is most effectively performed by specialist neurodevelopmental staff who are in day-to-day contact with special schools and with cognitive testing, rather than by mainstream CAMHS staff (p.651) Detailed cognitive testing results can sometimes be used to obtain extra provision, and to guide the teaching methods used with the child: adaptations at school and home are often more useful than interventions in the clinic.

Normal Variation

"I'm fine, you know: Freaked out, Insecure, Neurotic, and Emotional." (*The Italian Job*)

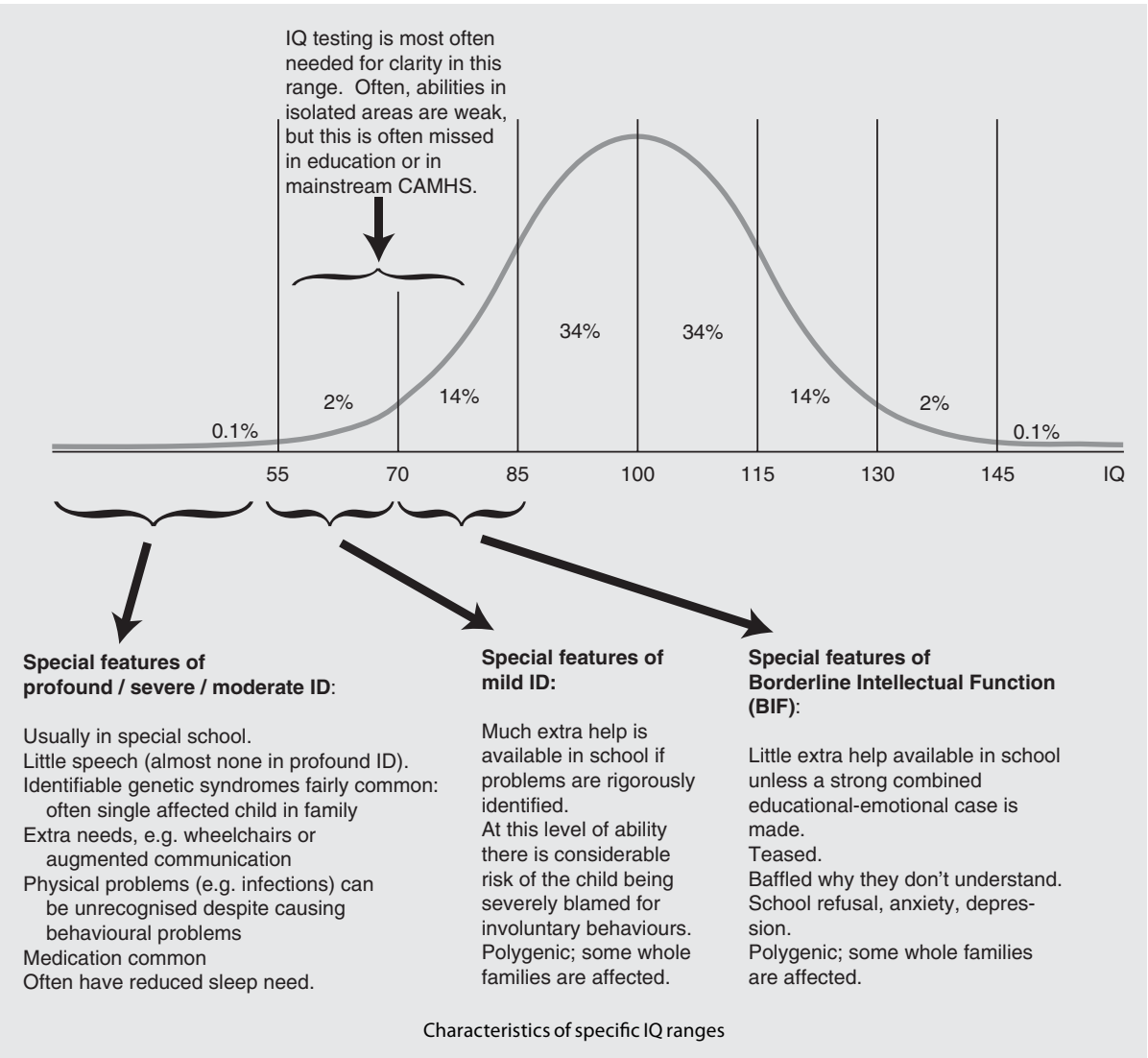
"There is no society known where a more or less developed criminality is not found under different forms. No people exists whose morality is not daily infringed upon. We must therefore call crime necessary." (Émile Durkheim)

Most human characteristics follow something like a bell-shaped curve, or normal distribution. Here are three examples:



Bell curves

(*left*, distribution of Barratt Impulsiveness Scale; *right*, Social Responsiveness Scale.[2010] Note that the graphs are skewed differently, probably due to properties of the test, not the population.)



Characteristics of specific IQ ranges

Which lifestyle choices are abnormal and within our remit, and which are abnormal but a matter for social services? For example, staying home from school is generally ignored in 17-year-olds but would not be in 10-year-olds. Are the grounds on which the child makes his decision based on a health problem (i.e. is he sick)? Should we call his dependent or avoidant personality a "disorder"? If he just has a different view, is he entitled to make a decision for himself at the moment? Are we right to impose a value system on him? Are we right to make a moral judgment such as "He doesn't contribute to society"?

These are questions for society, not for medicine, with the partial exception of whether he is sick or not. Is this appropriate territory for a psychiatrist to be involved in? Anorexia nervosa is clearer: it is also a lifestyle "decision" but it's a dangerous one; whereas preferring not to go out of the house isn't dangerous (see vignette, p.532).

The Poetry of Life

"Nothing will sustain you more potently than the power to recognize in your humdrum routine, as perhaps it may be thought, the true poetry of life – the poetry of the commonplace, of the ordinary man, of the plain, toil-worn woman, with their loves and their joys, their sorrows and their griefs."[2011]

"In all things of nature there is something of the marvellous." (Aristotle[417])

"And I would think back on conversations I had had in a similar way, really. A great part of my work has been listening to people, in that particular intense privacy of confession, or at least unburdening, and it has been very interesting to me. Not that I thought of these conversations as if they were a contest, I don't mean that. But as you might look at a game more abstractly – where is the strength, what is the strategy? As if you had no interest in it except in seeing how well the two sides bring each other along, how much they can require of each other, how the life that is the real subject of it all is manifest in it. By 'life' I mean something like 'energy' (as the scientists use the word) or 'vitality' and also something very different. When people come to speak to me, whatever they say, I am struck by a kind of incandescence in them, the 'I' whose predicate can be 'love' or 'fear' or 'want,' and whose object can be 'someone' or nothing' and it won't really matter, because the loveliness is just in that presence, shaped around 'I' like a flame on a wick. … To see this aspect of life is a privilege of the ministry which is seldom mentioned."[1374]

"No, Charles Tansley would put them both right in a second about books, but it was all so mixed up with, Am I saying the right thing? Am I making a good impression? that, after all, one knew more about him than about Tolstoi, whereas, what Paul said was about the thing, simply, not himself, nothing else. Like all stupid people, he had a kind of modesty too, a consideration for what you were feeling, which, once in a way at least, she found attractive. Now he was thinking, not about himself, or about Tolstoi, but whether she was cold, whether she felt a draught, whether she would like a pear." (Virginia Woolf[1788])

Poetry of life