

Child and Adolescent Psychiatry in France, Viewed from Outside

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Our observations about child and adolescent psychiatry in France come not from direct clinical experience there, but we consider them as "a view from outside": It comes from contact with a number of clinicians and professors in Child Psychiatry in France, and from our awareness of the scientific literature published in French and in other languages, mainly English.

We hope to offer some observations about the nature of French language contributions to the field of child psychiatry as it appears to us from the U.S. We offer a view from practicing child psychiatrists and would like to address some differences between the traditions and practices in the US and what we see from France and other French speaking countries.

Impact of francophone contributions in Child Psychiatry.

In the United States, French-language publications in child psychiatry have a limited impact, except for a few authors who may publish material in English (e.g. Serge Lebovici, Colette Chiland, Antoine Guedeney, Bertrand Cramer, etc.). This has to do with limited circulation of journals like *La Psychiatrie de l'Enfant*, *Pediatrie* or *Devenir*, as well as the French language journal *PRISME* published in Montreal (from the Hopital St. Justine). Even if the journals were available in medical libraries here, they would have limited impact on professionals, as clinicians are often unfamiliar with the French language.

Indeed, when reading material in the field of Child Psychiatry published in the journals available in USA, there is a great predominance of literature references in English, and very few or none in any other languages. It would appear that American authors have mostly access to articles written in English, and these are the main references cited, as if other work were not as significant. A number of scientific journals, notably from Scandinavian countries, and from Israel have resorted to publishing their material in English. In this way, they assure that abstracts and articles will have a greater impact and readership.

The preeminence of English, is also noticeable in many international conferences, in which translation is no longer offered to other languages, and every presentation and materials are written in English, which has become the usual official language. This used to be different even a decade ago. English seems to have become the "lingua franca" of recent times in many academic disciplines.

It would appear that French language publications in the field have a greater impact in several European countries, Africa and to a limited extent, in Latin America. Additionally, there are translations of French works into other languages. For example, several francophone authors are well known in Latin America through Spanish translations of their work. One example is the multi-volume treatise *Traite de Psychiatrie de l'enfant et de l'adolescent* edited by Serge Lebovici. The textbook written by J. De Ajuriaguerra, the writings of François Dolto and others are well known, published in translations mostly in Mexico or Argentina. This may be part of a longstanding tradition in Medicine in Latin America. Even a few decades ago, most medical texts and study materials were published in French, where physicians searched for sources to study in most areas of Medicine, including Psychiatry. French textbooks of Anatomy, Physiology, Pediatrics, Internal Medicine, etc. were greatly influential in Latin America, as well as the "French school" and methods of approaching patients, of diagnosis and treatment. During the past three or four decades this has changed greatly and now the most influential sources are written in English and come from the United States and to a lesser degree from the UK.

Child and Adolescent Psychiatry in the United States

In the scientific literature in the United States there are several journals that cover topics in Child and Adolescent Psychiatry or mental health (*Journal of the American Academy of Child and Adolescent Psychiatry*, *Archives of General Psychiatry*, *American Journal of Psychiatry*, for example). Journals tend to give preference to studies and articles that verse on topics like neurochemistry, neuroimaging, the effects of medications, genetics and biochemical markers of disorders. There are a few epidemiological studies.

Recently, several journals have started accepting single case descriptions based on clinical material, when a case is unusual or has features that are particularly illuminating. These contributions are usually left in a very small space and are quite brief.

The general tenor of the articles published in the most influential journals have bias toward nomothetic issues and refer to groups of patients, sometimes very large groups and are oriented toward empirical and numerical parameters. Standardized set of measures or instruments are preferred to validate diagnoses and to test treatment outcomes. There is a general salience given to numbers, statistical parameters and empiricism (Greenhalg , 1997). Indeed, in many areas of medicine, including psychiatry, there is great deal of interest on evidence-based approaches.

What does francophone Child Psychiatry have to offer?

We concur that the advancement of our field does depend to a large extent of continuing to address neurochemical, psychopharmacological, imaging and biological issues in general. An empiricist and nomothetic approach is necessary to compile information on numbers of patients and learn about the onset of disorders, their clinical course and response to treatment. Also, evidence-based diagnostic tools and treatment approaches are necessary and welcome. Indeed, it appears that this tendency is being increasingly adopted in many countries, including France. There is however, a danger that this may be the only view of children and their emotional suffering, of families and their problems. We suggest that an exclusive interest in those issues would develop the field in a deformed and unbalanced way and that other points of view are necessary.

What appears as pure science may have several important drawbacks. This is evident in several aspects of child psychiatry as it is practiced in many centers in the US. For instance, the actuarial approach to studying emotional and behavioral disorders can easily be misused to classify people and to constrain resources for diagnosis and treatment. In the US, terms that are directly borrowed from industry and line production can easily be transferred to the practice of the art and science of psychiatry. For instance, "productivity" can mean that the clinician who uses the least amount of time to diagnose patients, or to treat them in the briefest possible time is the most "productive". Based on statistical techniques, an adolescent who is suicidal may be "authorized" to remain so many days (usually very few) in hospital, as otherwise the case would be considered an "out-lier" and the psychiatrist who does not discharge the patient very shortly after admission, to be an "over-user" of benefits. These are but a few examples of trends that tend to limit the practice of medicine and child psychiatry and tend to constrain it to a set of standardized procedures and techniques applicable to all patients in a uniform way.

In this, we see some of the strengths of the traditional approach that clinicians from France and other countries have to offer to our discipline as a whole. We propose to highlight a few of these strengths.

The importance of phenomenology and inner experience.

Judging from our exchanges with francophone colleagues, scientific presentations and publications, clinicians have a great deal of interest in the experience of the patient, his or her problems and the inner life of the individual, a child or even an infant. Traditionally French clinicians have been interested in very detailed observations of patients and their accounts of inner experience, perceptions and emotions.

There is a fair representation of this in case vignettes and in the description of the patient's difficulties. The individual experience is analyzed carefully and given an important role in understanding the situation. This tendency may seem rather trivial to the French speaking clinician, however, for psychiatrists from the U.S., this may be surprising. For many young child psychiatrists in the US., emotional disorders are mostly a collection of symptoms (diagnostic criteria) that patients have, and which lead to a diagnosis and a treatment prescription. Gradually, the interest in the inner life of the child patient and the depth of clinical understanding of the uniqueness of individuals is easily lost, as well as the human suffering in the child and the family. In the U.S. many child psychiatrists are trained in child psychiatry programs in which all the emphasis is placed in diagnosing conditions according to the nomothetic rules, of the Diagnostic and Statistical Manual of Mental Disorders (e.g. DSM IV). So, the clinician develops an overarching interest in whether a given patient " meets criteria" for a diagnostic condition. Many child psychiatrists are not trained in conducting interviews along the lines of a conversation with a child about their inner experience, and are only interested in symptoms, their severity, frequency and coexistence with other symptoms.

Once the clinician feels reassured that a patient has a specific disorder, he or she can feel comfort in prescribing a certain treatment. The diagnostician may quite easily lose sight (or not take into consideration) his or her own reactions to the patient and

the family (or countertransference, which is not mentioned in the training, let alone used in the understanding or treatment of the child).

In contrast, in many contributions from the French speaking world the individual child or adolescent matters a lot, his or her unique experiences and perceptions and the particulars of how he or she arrived at the present situation. This is something that should be valued and preserved, not seen as "noise" or purely anecdotal information. Single cases often are the clue to understand new phenomena, new combinations, unique turns in the psychopathology of the patient. If psychiatry only consisted of collections of patients who are all "the same" it could not advance in discovering new phenomena, which are often encountered when a careful observation and history are undertaken from the individual patient.

One example of this might be the work of Lenore Terr. Prior to her discoveries, it used to be thought that children were relatively "immune" to traumatic experiences. Interviewing a small number of patients (e.g. the children of Chowchilla) (reference), listening to their own experiences in detail, without statistical methods, she described the phenomena of posttraumatic phenomena in children, which were unknown until then.

Psychodynamic perspective and what is unconscious.

In a recent interview with Dr. Serge Lebovici (Infancy Matters, 2000), he was asked what it meant to be French and its impact on his work. His answer was that being French was very important, because, in his words, the French had kept alive the spirit of psychoanalysis. Psychodynamics may appear as trivial to a francophone child psychiatrist. However, for many other countries, and particularly in the US, that perspective is increasingly rare and at times difficult to understand.

It is clear that representatives of psychodynamic psychiatry or psychoanalysis in the past made numerous claims that have turned out to be false. Also, there were many claims that appeared universal and applicable to every patient. This approach was wrong and misleading and should have been abandoned a long time ago. However, it appears that in the interest of the more "scientific" or empirical approach, everything psychodynamic was almost abandoned. This is very unfortunate. In the U.S. some psychiatrists are only interested in treating patients, including children and adolescents, in a reductionistic way, as if they only had a brain disturbance or some sort of imbalance that should be corrected with medication. While it is true that all conditions have a substrate in neurotransmitters and the brain, the person is still there. French psychiatry has not abandoned this important element. In centers where all psychodynamic psychiatry has been abandoned, colleagues only know to treat symptoms (not the person) and only with a very limited set of tools, with no training in psychotherapies or hardly any psychological approaches.

If the claims made in the past by psychoanalysts about certain disorders and phenomena (e.g. autism, psychosomatic conditions, the role of the mother in causing mental disturbances in children) were false, one should not discard everything psychodynamic. Defense mechanisms of children, even very young children and infants (Freiberg, 1987), the concept of internal conflict in causing suffering, and the importance of relationships and attachments (Bowlby, 1951, 1969. Holmes, 1983. Montagner, 1988. Rutter, 1985. Zeanah, Mammen and Lieberman, 1983) are crucial psychodynamic concepts that help understand children and families. Themes like the transgenerational transmission of unresolved issues (Lebovici, 1993. Lebovici, Barriguete et Salinas, en presse), fantasmatic interactions (Kreisler and Cramer, 1981. Lebovici, 1994) and the importance of early experience (Kennel and Klaus, 1998. Stern, 1993. 1995) are crucial to the understanding and clinical work with children and families. These themes are gradually being lost, and as noted, in many training programs in child psychiatry, they are never taught or used. Clinical work and accounts written by numerous authors, many of them French, keep these themes alive and further the development of our discipline.

Public Health and Social Perspective

It appears that in France child psychiatry is still practiced in the public sector, or in centers partly financed by private funds, but not primarily for profit. Therefore, the impact of economic and market forces on this field of Medicine has been less negative or not as severe. In the U.S., public child mental health is limited and in constant search for more economic, brief and practical interventions. Disciplines like consultation-liaison child psychiatry are very limited by economic pressures, and mostly consist of seeing patients only after a severe disorder has become manifest, rather than as an ongoing collaboration with other medical specialties.

Much of child psychiatry is practiced under the funding provided by private insurance companies to patients, and this dictates a number of practices. The need to "document" a diagnosis based mostly on observable behaviors and statements made by the patient. The need to provide very brief therapeutic interventions with clear behavioral and measurable goals. Most of

psychiatry/mental health makes emphasis on a traditional model of seeing patients once they have manifested a more or less severe dysfunction (that is at a secondary or tertiary level). Given those economic issues, there is very limited activity in prevention, promotion of mental health or early detection of difficulties.

Many children are un-insured and therefore have no access to mental health services (Geltman et al, 1996. Smith et al, 2000). Many children and adolescents in these situations, when they exhibit violent behavior or dissocial conduct, are dealt with in the juvenile justice system rather than in the mental health system. The juvenile system focuses mostly on confinement and punishment, and very little in rehabilitation (Haller, 2000).

In short, it appears that child psychiatry in France enjoys some "luxuries" that should be preserved, and that should continue to be based in values like the importance of the individual, the family, the right to health, and the obligation of the social system to provide services for its most vulnerable citizens.

Perhaps also due to the cultural diversity in France and many other countries, attention is paid to the child's social and cultural circumstances(Moro and Nathan, 1995). Authors are interested in this "additional" dimension of the patient, his or her social and cultural context. They do not tend to limit themselves to an account of the patient as an isolated individual, but tend to look readily at the social and cultural milieu of the child.

What are some of the problems?

Having pointed out what we see as some of the strengths and greater contributions of francophone authors and colleagues, we would like to explore some possible drawbacks or problematic features.

Exclusively anecdotal accounts.

Paradoxically, one of the very strengths of a predominantly clinical perspective is also a drawback. An immediate question is : what can one obtain from a series of anecdotes? If a majority of written contributions refer to highly unique situations, how can one then extrapolate and derive knowledge from a number of very unique situations?

If one does not ever sacrifice the uniqueness of each individual to examine data from numbers of patients, and treating these data as though they were uniform (e.g. symptoms, psychosocial impairments, quality of life, etc.) then the field could not advance in the characterization of certain things, like the "typical" age of onset of a disorder, or its usual clinical course, response to treatment. Such studies would be impossible and each time, with each patient, the clinician would be facing an entirely new phenomenon. In our opinion taken to the extreme, this position is undesirable. Data from epidemiological studies, from groups of patients, do help the clinician faced with the individual patient. These data can guide the clinician and help in his/her explorations and treatment recommendations. While each patient is truly unique, there may be enough similarities with other patients, to be able to assume that there are characteristics in common in groups of patients, and that one can learn from studying such groups.

Narrative style

The style of many articles is highly narrative and detailed: so the articles may be quite long and some could be boring. Clinicians in the U.S., as in many other countries, are extremely busy and may wish access to quick information and make a small investment in time to obtain a maximum of information or knowledge. A narrative style, for instance, without "bullet points", brief sentences and crisply organized may put off a potential reader. The reader is asked to invest precious time to gain an unknown amount of knowledge. Indeed, many journals in the U.S. and others written in English make it a requirement to use a particular style of writing (e.g. American Psychological Association, Chicago style, etc.). This usually means conciseness, short sentences and an organization of the material in an easy to read format. A more traditional style- of narration and detailed accounts- does not fit very well in this model (incidentally, one wonders if Freud's detailed account of the "Rat Man", would have ever been published in one of the English language journals with the greatest publication impact). In short, a style of writing that is evocative, elegant, descriptive and detailed may not be very practical for the busy clinician who may want to quickly get to the point of the article and find out what the article has to say before deciding whether to read it thoroughly or not.

In our opinion it would be undesirable that all scientific journals and articles had the "same writing style", the same format and the same "bullet points". However, it is also true that there should be room for conciseness, a clear account of the claims made and an

easy to read style.

Claims to knowledge based on individual cases

This is another area of potential weakness: the belief that one "knows" about a certain disorder, based on individual clinical experience. A close correlate of this practice is the "certainty" based on inference, as well as the conviction that one knows why a patient does or feels something, i.e. interpretation of the meaning of symptoms and of their etiology. In principle, these inferences and speculations about a particular patient or set of patients should be provisional tools and ways of understanding something in a preliminary way. However, inferences easily become "truths" because they provide a sense of certainty and of not having to deal with the unknown and with ambiguity. The empiricism practiced in the UK or the US would take the position that one does not know "why" a patient does this or that, or why he/she has a given symptom. One cannot answer the question until the issue is researched. In psychodynamic psychiatry there is a long tradition of making speculations into "truths" that cannot be easily falsified. Not long ago, if a student of psychoanalysis questioned an instructor or challenged the professor about certain claim or statement, the student might get a response indicating that he or she was asking the question due to inner unresolved conflicts, rather than based on any objective reasons. Until recently, it was widely believed in psychodynamic circles, that all symptoms represented psychological defense mechanisms that the patient created for a reason and the goal of treatment was not ever elimination of symptoms. Indeed, it was considered dangerous to remove symptoms because this would lead to worse difficulties in the patient.

Without empiricism, the field would be entirely at the mercy of professors that perhaps could not be questioned or challenged. They "knew" why something happened and what the symptoms of the patient meant.

The contribution of the child to the problem and the role of parents

One final point we wish to make is the bias toward inferring that the difficulties in a child are often rooted in the parent's inner conflicts or in pathological interactions vis a vis the child. Even today, in several recent publications in French, the position is taken that autistic disorder in children is the result of a massive defense mechanism on the part of the autistic child, and caused by a sense of rejection by the mother (Golse, 1995). This position is an example of the bias toward etiological thinking (knowing why things are the way they are) and also toward minimizing the true nature of the child's difficulties. In several exchanges with colleagues from France, we have been impressed with their minute observation of parental ambivalence, coldness, or even rejection of the child. It is less natural for them to think about the child's contribution to these interactions. That is, can it be that a parent is less empathic or less patient when a child is very difficult, aggressive, defiant, inattentive? The etiological thinking at times obscures observation (Maldonado-Duran et al. 2000). If one observes a parent being less sensitive to the child, this is thought to have caused the child's problems. However, a more complex model of causality would take into account interactions, and the role of the child in the situation. The focus on the child is not only interesting to "assign blame" to either parents or child. It is important in order to truly understand the challenges some children face to be content, to focus, to have positive interactions, or to cooperate with others. If this is more accurately appreciated, then the therapy might be more focused toward helping the child overcome certain obstacles (and also on helping parents to help their child overcome them, without feeling guilty or responsible).

Conclusion. Can a synthesis be possible?

We have attempted to point out a few of the strengths and weaknesses of child psychiatry schools and ways of practicing in different countries and cultural backgrounds. An important question is whether different "schools" and traditions can learn from each other. We believe they can. One vehicle is the sharing of experiences and studies, ways of thinking and mutual critiquing during these exchanges. It is important that members of different schools treat each other with respect and value the uniqueness and strengths of the other's model and ways of working, taking what might be missing or be weaker in one's school. Traditions are very important and uniformity or dominance by one school of thought is undesirable. However, mutual fertilization and learning are desirable in that context of sharing and learning from each other.

We also would hope for more bilingual publications, where authors can be exposed to alternative points of view. Many colleagues in the US would be anxious to be exposed to the French authors and points of view.

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