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COMMENTARY

Commentary: The King is Naked – a very subjective look at child and adolescent psychiatry

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Abstract

There is a great crisis in child-adolescent psychiatry, but we will not solve it just only by increasing the number of psychiatrists or psychiatric wards. The young patients described in Agnieszka Wlazło's editorial indeed should not end up in a psychiatry department, but that does not mean they do not need any institutional support at all. In this commentary I would like to add two simple but important remarks: we need a serious discussion of the consequences of childhood trauma and mental problems in adolescence and also a well-functioning prevention system to avoid them.

Keywords: Poland · healthcare · crisis · adverse childhood experiences · prevention

Citation

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Dear Editor,

I read with great interest the Invited Editorial by Agnieszka Wlazło in the latest issue of *European Journal of Translational and Clinical Medicine* [1]. As a psychiatrist who also works with children and adolescents, I share the main observations made by the Author. Indeed there is a great crisis in child-adolescent psychiatry, but as the Author rightly emphasizes, we will not solve it just by simply training more psychiatrists or increasing the number of psychiatric wards. The young patients described in Agnieszka Wlazło's editorial indeed should not end up in a psychiatry department, but that does not mean they do not need any institutional support at all. In this commentary I would like to add two simple but important remarks: we need a serious discussion of the consequences of childhood trauma and mental problems in adolescence and also a well-functioning prevention system to avoid them.

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When the prevalence of suicide attempts and the incidence of mental disorders increases nationalwide [2-3], this is a problem that goes far beyond the psychiatrists' offices. What does this say about the condition of our society and our way of life? Do we really know what we want to teach our children? Do we work in partnership with them to shape their future or do we just want them to be "who they should be"? One half of all serious adult psychiatric disorders start before the age of 14, however the treatment often does not begin until 6-23 years after onset [4]. Thus, child psychiatry is not limited to child issues, because problems that arise at this age often last long into adulthood. There is a term Adverse Childhood Experiences (ACEs) that includes child sexual abuse, physical abuse, verbal threats, living with alcoholic parents etc. A significant group of the patients we work with in child psychiatry clinics and departments have such history. Indeed, a systematic review on ACEs shows their correlation not only to several mental disorders and suicidal behavior but also to physical health consequences and risk factors: obesity, smoking. cardiovascular disease, chronic lung disease, headaches, autoimmune disease and sleep disturbances [5]. It has been suggested that ACEs can also be linked to an increased risk of premature death during adulthood [6].

A large prospective study of 1.420 participants observed from 1993 to 2015 showed that childhood depression has a wide variety of consequences in the subsequent stages of life [7]. The authors found that any episode of childhood/adolescent depression was associated with higher levels of adult anxiety and illicit drug disorders and also with worse health, criminal, and social functioning [7]. A depressed child is then very often an adult with depression. Depression in a parent contributes significantly to a child's emotional problems [8]. In this way, mental disorders seem to be passed down from generation to generation [8]. Therefore, waiting for the children to "grow out of" their problems (and if that does not happen, treating them) is the worst possible option.

Instead of taking this discussion seriously, we would simply like the child and adolescents suicidality crisis to end, psychiatric departments to end beds shortage and everything else to remain the same. It is a bit like the situation where the parents consult a child/adolescent psychiatrist because they wish to "fix the child" and yet refuse to take a closer look at the entire situation and their possible role in the roots of their child's problem/s.

Where is the problem then? The problem is that we don't have much to offer children and their parents to prevent ACEs and mental disorders. Unfortunately, due to frequent lack of other, non-medical forms of sufficient support, parents of a child who is "difficult" or from a "difficult background" receive a request from teachers at kindergarten or school "to go to a psychiatrist." What is missing between everyday life and medicine is a well-functioning social support system. It is easier to refer a child (and its parents) to a psychiatrist or psychologist to start treatment/therapy than to strengthen the systemic (e.g. social or educational) support for families and children in crisis. Many elements of such support are beyond the field of medicine e.g. increasing the number of family orphanages, providing more classes adapted to the needs of children with difficulties, further developing the system of early development support and re-thinking the system of foster care. One of the roles of schools should also be to help young people get to know themselves and their emotions, and teach them to cope with life's difficulties. In addition, it is impossible to talk about child psychiatry without the context of parents and guardians. Last but not least, support should apply not only to the child itself, but also to their caregivers. According to research, Polish parents are burned out more than those from other countries [9]. In a large analysis from 2018-2019, the average level of parental burnout in Poland was higher than in 40 other analyzed countries and very clearly correlated with the intensity of individualism, assessed as loosening of social ties and lack of social support [9].

These examples are as important, if not more important than increasing the number/availability of psychiatric services. In fact, we are already over-medicating even the youngest children, e.g. with antipsychotic drugs, which is also shown by Polish study [10]. As in other fields of medicine, prevention should be the key direction of child/adolescent psychiatry. The World Health Organization also devoted a lot of space to the prevention of mental disorders, with great emphasis on children and adolescents [11]. There is also growing evidence that a large proportion of mental disorders are preventable (e.g. depression, anxiety or substance abuse) but effective strategies are often neglected [12-13].

The reform of child and adolescent psychiatry is currently taking place in Poland and, at least in theory, it takes into account some of the above tenets [14]. The reform put a major emphasis on aid at the community level (e.g. psychologists and community therapists), directing strictly medical issues to higher levels of support when necessary. It also places emphasis on effective communication and cooperation between support levels [14]. The assumptions are important, but in practice, everything can break down at the level of financing from the state budget. It is definitely too early to judge its effectiveness, however it is worth keeping our fingers crossed.

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Conflicts of interest

The author declares no conflict of interest.

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