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American Pediatrics and the Transition from Mental Health to Illness Since the 1960s

Abstract: American pediatricians are now bearing the brunt of massive increases in demand for treatment of mental illness in children and adolescents, areas in which many pediatricians have not been well trained. It would be logical to encourage policy measures to increase pediatricians' expertise in this area to improve access to care. But the expanses in demand for services are about much more than increased incidence of biologically-based illnesses. Instead, pediatricians are caught juggling between their traditional focus on health and prevention and a rapid rise in broad socially, culturally, and economically mediated distress among young people and their families. This article explores the historical context of pediatricians' engagement with mental health and the hazards of the push toward treatment for mental illness. The historical perspective can help us develop policy more directed to broader goals of improving the mental health of our nation's children and adolescents.

Keywords: child psychiatry, reimbursement, medications, medical model, behavioral pediatrics, child development

In June 2013 at the National Conference on Mental Health, President Barak Obama spoke out on the topic of health policy progress in the area of child mental health. While his predecessors in the previous century had discussed prevention and the importance of supporting American children in their

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healthy development, Obama's call was for better awareness of the medical nature of mental illness and increased access to health care to treat it.[1] In Obama's message, he addressed one of the biggest issues in child mental health—parents' fears and lack of knowledge of what to do next. He outlined new initiatives to offer better education regarding signs and symptoms of illness to the public, and explained that multiple groups had signaled their commitment to creating more of a conversation around child mental illness. He reassured parents that they could reach out to experts for help. The first resource named, understandably, was a child's pediatrician.

While it is admirable—and understandable—for Obama to have been focused on access, the policy options that center on education and access to care (especially with pediatricians) miss important assumptions that too often remain unquestioned regarding child mental illness. The current model employed by concerned parents, schools, pediatricians, and policy makers is based on a concept of mental illness as a biological entity that hides undetected in children, much like other kinds of diseases such as diabetes. Policy makers assume that if we catch early signs of mental illness and begin treatment, we can stave off the worst effects. Further, if we begin to more aggressively screen children where they spend the most time—including schools and pediatricians' offices—we are more likely to encounter early cases. Parents, in this view, should be educated so that they are vigilant about changes in their children that could mean lurking mental illness. And their first-line resource—their children's pediatrician—should be poised to take action.

However, this model of mental illness is contingent on a number of historical factors that are questionable and thus the policy conclusions are problematic. As many scholars have demonstrated, mental illness definitions were created by a combination of investigators who were doing the best they could without objective markers of illness, backed up by professionals who wanted to promote their expertise and pharmaceutical companies with products to sell.[2] The idea that diagnosing and treating a child in order to prevent problems later in life has not turned out to be validated in practice.[3] And there is evidence that pharmaceutical companies have been working with some physicians to broaden some diagnostic categories beyond what even the American Psychiatric Association's already expansive *Diagnostic and Statistical Manual (DSM)* outlines.[4]

Not only is the supposed science behind mental illness diagnoses and treatments deeply problematic, but also the assumption that pediatricians should be the first-line resource for worried parents does not match with the

role that pediatricians have played in child health over the last century. Mental health was not part of pediatricians' practice for decades after the beginning of the specialty. When mental and behavioral concerns began to emerge as issues that could be addressed by primary care directed toward children, pediatricians had a much different perspective on the issues than the very small number of child psychiatrists who were directing conversations about mental illness.

In the last couple of decades, though, America's pediatricians have found themselves responsible for treating an ever-expanding population of children in emotional distress, especially through identifying symptoms of illness and prescribing medications. Families, insurance companies, drug manufacturers, and policymakers assume that pediatricians are the first-line providers for emotional and behavioral problems. Pediatricians are routinely scolded by child psychiatrists and epidemiologists for not doing more to diagnose and treat within their practices.[5] Some researchers have claimed that mental health issues affect up to 80 percent of all children sometime before they reach adulthood but that only a fraction of them receive treatment.[6] Instead of focusing on guiding children through normal developmental challenges, pediatricians have been expected to manage mental illness.

This article explores the changes in American approaches to child mental health since the 1960s through the lens of American pediatrics. This time period has witnessed the transformation from the pursuit of mental health to a broad quest to diagnose and treat mental illness. In the 1970s and 1980s, pediatricians in their practices and professional groups began to talk about something they called the "new morbidity"—the behavioral issues of kids that they speculated would take more time and effort as children continued to be physically healthier. But in the 1980s and 1990s, pediatricians conducted increasingly complex negotiations with child psychiatrists who were themselves moving from a focus on interpreting kids' problems through a psychoanalytic lens and toward a more concrete method of diagnosing kids with criteria of mental illness. This biological model was eagerly embraced by insurance companies, incorporated into shifts in health policy with managed care, and seized upon by desperate teachers and parents. With the widespread introduction of psychiatric medications for use in pediatric populations in the second decade of the twenty-first century, the emotional and behavioral challenges of developing children were transformed into mental illnesses. And policy goals shifted toward the logistical problems of educating pediatricians to diagnose and treat mental illness in primary-care settings.

CHILD MENTAL HEALTH AND THE NEW MORBIDITY

In 1967, George Washington University professor of pediatrics William Anderson gave his presidential address before the annual meeting of the American Academy of Pediatrics. Anderson, who regarded himself as a traditionalist who still made house calls, explained that the successes in the profession meant that new challenges were emerging. Pediatricians had worked hard to improve care related to infectious disease, but with improvements in public health, including nutrition, sanitation, and vaccines, those were no longer the major problems. Instead, the new challenge would center on the behaviors of young people.[7]

At the time when Anderson headed the professional pediatrics association, young people's behavior was indeed a national issue. Protests and riots roiled college campuses. Teenagers were revolting against their parents. While young political activists believed they were trying to save the world from the mistakes of the older generation, their elders perceived things much differently.[8] In the view of experts, young folks as a group were stealing, smoking, using drugs, and running away from home. Anderson warned pediatricians that these behaviors would lead to major health and legal problems. He urged his audience to look beyond the physical health of children in their practices. According to Anderson, pediatricians had a duty to address social unrest, to counsel families, prevent future rebellion, and instill moral values in their young patients.

Anderson did not say, nor did his professional colleagues of the time understand, that the youth rebellion meant mental illness. Nor did pediatricians as a group see themselves as primarily responsible for treating mental illness. Child psychiatry was the specialty in charge of conditions that at the time were identified as serious emotional disturbances.[9] While child psychiatrists opined that all parents could benefit from instruction about appropriate child-rearing practices, childhood mental illness was not seen to be widespread, nor was it particularly well defined. The field of child psychiatry was (and remains) tiny, and most children did not see child psychiatrists. Pediatricians saw themselves as in charge of managing normal development, treating typical diseases of childhood, and referring children with serious emotional or behavioral problems to child psychiatrists. Anderson's vision of the role of pediatricians was in helping to steer parents and children through the challenges inherent in normal development. Pediatricians' approach was about maintaining mental health, not treating mental illness.

As numerous historians have pointed out, American concern for the welfare of children has swelled at different times and in response to different circumstances.[10] In the decades after World War II, many were concerned

about the numbers of servicemen who had either been disqualified from the draft or discharged from the military because of psychiatric issues. Professionals in a variety of disciplines, as well as concerned citizens, focused on the need to help children grow into healthy adults who could effectively serve the nation. Psychiatrists, psychologists, and pediatricians all contributed to this effort in different ways. Psychiatrists treated individual children with serious emotional disturbances or neuroses in long-term psychoanalytically-based therapy, a form of intervention limited by available providers and the cost of prolonged care.[11] A small number of psychiatrists organized to create a subspecialty of child psychiatry, which emerged in 1952 as the American Academy of Child Psychiatry.[12] Psychologists, whose field began in academic institutions with laboratory experiments, started to perform intelligence testing on children in the 1920s and 1930s. This accelerated after World War II, when more psychologists moved into clinical areas, especially around children.[13]

Pediatricians had been primarily focused on children's physical health during the first decades of their specialty. As a group, they also took on the role of advocates for children in American society. Their primary specialty organization, the American Academy of Pediatrics (AAP), was founded in 1930 after the section on pediatrics within the American Medical Association (AMA) split off to become an independent entity because of conflict with the AMA on the 1922 Sheppard-Towner Act. Pediatricians thought that the public health benefit of Sheppard-Towner was important and they did not agree with the AMA's hostility to government support in child health.[14] Pediatricians saw their role as looking after the health of the whole child. In textbooks, pediatricians were offered advice from child psychiatrists about how to recognize and refer for common problems, including neuroses or troublesome habits (such as masturbation).[15] One of the most visible and outspoken pediatricians of the postwar era, Dr. Benjamin Spock, offered advice directly to families. Spock, who received some training in psychoanalytic theory with New York child psychiatrist David Levy, assured families that if they parented well they could prevent mental problems.[16]

But in the 1960s and 1970s, it began to seem increasingly inadequate to just provide advice to parents. A handful of pediatricians began to treat adolescents for a combination of physical and emotional problems with the observation that it was the pediatricians' job to treat the whole child. As historian Heather Monro Prescott has described, the advocates of this approach were dissatisfied with the role of psychiatrists regarding emotional issues and thought that they could do a better job incorporating mental and physical issues into a holistic view of the patient. This specific approach to adolescents

was confined to a relatively small number of hospitals and clinics, but the same kind of vision of the treatment of the whole child arose in multiple areas within pediatrics.[17]

In 1975, University of Rochester pediatrician Robert Haggerty coedited a volume on the importance of improving all aspects of child health. Haggerty and his coeditors talked about the relationship between a public-health approach and a medical perspective. Looking at public health meant trying to improve whole communities, not just handling health issues for individual children. Haggerty argued that pediatricians who only saw their individual patients in offices could not appreciate all the factors that affected children's health. And further, they would not be seeing many children at all, including those who really needed help, because of problems with access to care, as well as economic and social issues. The authors reflected that there were many factors involved in child health, from neighborhood safety to schools to conflicts with peers and authority figures. Haggerty's group articulated something it called the "new morbidity" in children's health care. In the old days, the group explained, the risk to children was death from contagious disease. But in the last quarter of the twentieth century, the biggest risk to children was from the consequences of social and behavioral problems.

As Haggerty and his collaborators outlined, "Learning difficulties and school problems, behavioral disturbances, allergies, speech difficulties, visual problems, and the problems of adolescents in coping and adjusting are today the most common concerns about children. In addition, family social problems and the management and handling of everyday life stresses are major concerns requiring attention." According to Haggerty, pediatricians who had the idea that they were going to be working with kids and families on sore throats or ear infections needed to rethink their field. As Haggerty explained, the new problems were just as important as the old ones. Even though these kinds of health problems would not kill—or at least not as directly as the old contagious diseases—they were causing social disruptions that interfered with the kids' abilities to manage their futures.[18] Haggerty's group exhorted pediatricians to become more involved in their communities and make sure that they saw the patients who needed help.

Haggerty wanted pediatricians to take up this new morbidity as a challenge. He said that child health specialists should address all of children's problems, whether they stemmed from purely physical ailments or stress over their environments or the consequences of their behavior. Haggerty and his coauthors recognized that their audience had not been trained to think this way, and encouraged the education of new practitioners to take a broad view of

the field. Within the scope of pediatrics imagined by the Rochester group, practitioners should see children in offices, go out to see families, visit schools, and advocate for change in the community. Haggerty and the work group that created this model of care did a pilot program with a small-scale intervention in a community in Rochester, New York. They acknowledged that this was only one example of how pediatrics might work, but they stressed that it should be applied throughout the nation.

Pediatricians' initial engagement on the new morbidity centered on understanding (and managing) issues children might have based on their environments and as a result of family and social problems. And pediatricians' continued engagement on child mental health into the 1980s was on the similar theme of understanding children's development and behavior and the kinds of things that might go wrong. The Society for Behavioral Pediatrics was founded in 1982 (funded by a grant from an agency led by Robert Haggerty), and the same year the AAP issued a policy statement that pediatricians needed to be more aware of psychosocial issues and to be able to treat common behavior disorders.[19]

The concepts of "behavioral" and "psychosocial" were vague and not well defined, even within the growing behavioral pediatrics literature. While Haggerty's Rochester group was concerned with a population focus and the need to address social issues in neighborhoods and cities, later behavioral pediatricians looked more at the social circumstances surrounding individual children. As an early textbook in the field explained, behavioral pediatrics involved helping normal kids deal with abnormal circumstances. Behavioral pediatricians partnered with psychologists to do behavioral interventions, such as rewards for positive actions and biofeedback. Behavioral pediatricians did not claim to be able to treat children with serious emotional disturbances—those children were still referred to child psychiatry. But behavioral pediatricians did make the argument that all practitioners in pediatrics needed to know something about development and behavior because these were common issues for all children.[20] Initially, the behavioral turn in pediatrics seemed to signal a broader focus on mental health, and a professional willingness to address social and behavioral issues and how they affected children. But changes in child psychiatry and in other areas helped to steer child mental health in a different direction.

DIAGNOSES, CONSULTATIONS, AND COLLABORATIONS

Behavioral pediatricians' evolving expertise in the ways in which normal children could experience problems raised questions about how pediatricians

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should interact with child psychiatrists. On the one hand, pediatricians wanted to know how to manage problems that might present to them. On the other hand, it was unclear how much there was of an overlap between what pediatricians might be confronted with and what should be the sole area of child psychiatry. In the 1980s and 1990s, pediatricians and child psychiatrists attempted to negotiate a working relationship, though they were never able to resolve questions around consultations, collaborations, or expertise. One major obstacle to establishing a stable relationship was that child psychiatry profoundly changed during this time period, particularly around the diagnosis of mental illness in children.

By the 1980s and accelerating into the 1990s, child psychiatry began to follow adult psychiatry into more of a biological model. The American Psychiatric Association's 1980 third edition of the *Diagnostic and Statistical Manual* (*DSM-III*) created for the first time a symptom-based method of making a diagnosis of a mental illness. The cadre of research-focused adult psychiatrists who constructed the criteria for mental illness removed any discussion of etiology from what would quickly become the bible of psychiatric diagnosis.[21] What that meant was that a person who complained of a depressed mood, sleep and appetite disturbances, and trouble getting motivated would be diagnosed with depression—whether those symptoms came entirely out of the blue, or were caused by problems in someone's marriage, stress at work, or even a history of having been abused or neglected as a young person.[22] The *DSM* criteria from the third edition forward had two major consequences to psychiatric theory and practice—they substantially increased the number of people who could be considered to have a mental illness (beyond the traditional populations of institutionalized patients and those undergoing psychoanalysis), and they opened up a growing market of pharmaceutical agents to treat these disorders.[23]

Child psychiatrists had been relatively willing to move toward a biological model with medication treatment for what is now called Attention Deficit/Hyperactivity Disorder (ADHD), though this was the only condition for decades in which many in the field agreed medication could be helpful.[24] But most childhood conditions were much more vague. Child psychiatrists were not well represented within the process to create *DSM-III*, and the section on child diagnoses was fairly small and somewhat controversial within the American Academy of Child Psychiatry. By the time that the next edition of the diagnostic manual was published in 1987, the *DSM-IIIR*, the APA was working with more child psychiatrists to engage the field on using criteria to diagnose children.[25] Researchers in the field increasingly looked to adult

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psychiatrists—who were using symptom rating scales and medication to manage patients—and started to import those tools into child psychiatry. Some began to insist that old psychoanalytic ideas about development needed to be thrown out so that children could be diagnosed and treated for mental illness. For example, Anna Freud had taught that adolescence was an inevitable time of turmoil and that mood swings and feelings of depression were normal in those circumstances. The new generation of *DSM*-influenced child psychiatrists argued that this was wrong—there was no reason that adolescence should not be a time of peaceful growth.[26] Although child psychiatrists talked then (and still discuss) prevention and use the phrase "mental health," what they increasingly started to mean was early and aggressive treatment of mental illness. In particular, mood and behavior problems that might have been seen as understandable parts of growing up began to be viewed as mental illness.

The implication of the new way of diagnosing mental illness in children using *DSM* criteria was that any child could be harboring symptoms. The old model of child psychiatry consultation, in which pediatricians learned enough to know when to refer their more severe patients to the specialist (child psychiatrist), was upended with the diagnostic criteria. Child psychiatrists encouraged pediatricians to begin to uncover symptoms in the children they saw in their practices. And they felt empowered to scold the primary-care providers for missing cases. In 1988 for example, a group of child mental health specialists—including epidemiologists—surveyed patients and parents within a group of medical practices. They were looking for people who, according to the experts, should have been diagnosed with some kind of psychiatric disorder. They found a much higher number when they interviewed patients and families with written lists of questions than pediatricians had in the course of their usual clinical care. The epidemiology team criticized pediatricians for failing to uncover and treat cases. And this critique—that there was important disease being missed by general physicians—became an insistent narrative that pediatricians were failing in their jobs.[27]

For pediatricians, it seemed that the new focus on getting primary-care physicians to screen for and treat mental illness in kids was following the same pattern that had occurred with stimulants for children with ADHD. Although child psychiatrists had been the ones to pioneer with stimulants and to stress the utility of these medications in hyperactive children, it was pediatricians who bore the brunt of the prescribing for patients and families by the 1980s.[28] When the leaders of the AAP met with the executive group in what had become the American Academy of Child and Adolescent Psychiatry

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(AACAP), the pediatricians complained that child psychiatrists continued to demonstrate their lack of respect for their primary-care colleagues.[29] On the other side, child psychiatrists complained that pediatricians were not making referrals to them but were sending their patients to psychologists or social workers, which was a sore point for psychiatrists in general.[30] Pediatricians countered by emphasizing the confusion about the different roles of child psychiatry, psychology, pediatrics, and behavioral pediatrics. The two organizations discussed collaborating on a document to help clarify these issues for patients and families, but it never materialized.[31]

A further source of conflict between child psychiatrists and pediatricians came from the latter specialty's work in advocacy. For decades, the AAP had regularly issued public statements about children's health, as well as safety issues involving children. In the 1980s, they continued with public statements about gun safety, attention-deficit disorder, child abuse, and family conflict. The leaders of the AACAP complained, though, because many of the AAP public statements made no mention of child psychiatrists, their role in treatment, or their expertise in psychosocial issues. And while AAP leaders periodically listened to complaints from the AACAP about public statements and lobbying efforts, the pediatricians' group continued to go forward in its own advocacy work without much of a mention of child psychiatry.[32]

And finally, the two organizations struggled over how to understand and manage the *DSM* criteria as they applied to children. Although the psychiatry researchers who constructed the *DSM* had intended to make mental illness look more biological (for example, by removing confusing psychoanalytic jargon), the diagnoses still seemed foreign to providers whose focus was usually on physical complaints, and who only sometimes had reason to ask about mental, emotional, or behavioral symptoms. The APA attempted to translate *DSM* into something useful for primary-care doctors—it constructed the *DSM-PC* in 1996.[33] But pediatricians were even more perplexed by the language of the *DSM*. They complained that the method of making diagnoses had no method for including a comprehensive approach toward children or any way to conceptualize prevention.[34] And when it came time to translate *DSM* symptoms to pediatricians, the AAP took over to construct a guide that embedded questions (that could be used to construct diagnoses) from common presenting complaints.[35] This guide did seem to be useful for pediatricians, though it did not stop child psychiatrists and epidemiologists from harassing pediatricians for not detecting enough cases and providing enough treatment.

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The pediatrics and child psychiatry groups continued to have ongoing negotiations about how best to approach child mental issues. But the decisive push toward making pediatricians employ a biological model for mental illness happened more because of changes outside the two professions. Although pediatricians continued to make efforts to promote health and to have a broad view on children's issues, insurance reimbursement shifts, increasing pressure on America's teachers, and the marketing of a biological model for mental illness to parents (by both child psychiatrists and pharmaceutical companies) made it very difficult for pediatricians to avoid the burden of diagnosis and treatment of mental illness in their patients.

THE SPREAD OF THE MEDICAL MODEL OF MENTAL ILLNESS

At the same time that pediatricians and child psychiatrists were imagining and reimagining their fields and the nature of child mental health and illness, policymakers, politicians, and an increasing proportion of the public began to address the growing problems in the cost and structure of health care in the United States. Even with the rise of insurance companies (or perhaps because of the possibility of reimbursement from insurance companies, especially Medicare) to help patients pay for treatment, costs of health care were increasing at alarming rates. In the 1980s, many argued that the solution to the problem was to manage care. Rather than let patients go to see as many specialists as they wanted—which could lead to an overuse of testing and specialty care—policy experts argued that the solution was to have patients see a primary-care provider, who would then refer them to specialty care as needed.[36]

Mental health occupied a strange place within the managed-care environment. Psychiatry is technically a specialty, though in the 1980s it was so far removed from primary care that it was hard to imagine that primary providers could make informed and appropriate referrals. And some insurance companies were worried that psychiatric costs would be prohibitively expensive and so they separated—carved out—mental health care into different management companies with different rules and reimbursement rates. So for people who had never encountered a psychiatrist or therapist before, the path to getting into treatment was complicated—and (perhaps intentionally) not inclined to help improve access. Insurance companies moved to aggressively manage what they saw as the fuzziness of mental health care and indicated that they were not interested in supporting endless therapy. Many of the carve-out mental health insurance providers instituted limits on therapy visits and psychiatrist appointments, only reimbursed for a short amount of time with psychiatrists, and

insisted on treatment plans—a shifting set of paperwork obligations to force mental health providers to make the process of mental health treatment into a set of definable objectives that could be met on a timetable.[37] And insurance companies eagerly embraced *DSM* diagnoses, especially the ways in which specific treatments followed from concrete diagnosis.

In the 1980s and 1990s, insurance companies—including government payers—set standards for practice and for reimbursement to reduce the billing variability around the country. Many insurance providers moved toward a model of standardized reimbursement for problems on the theory that matching complexity of problem to the quantity of reimbursement would encourage providers to be efficient with their practices.[38] This method of reimbursement did not necessarily take into account the time needed for management of problems, however. Pediatricians struggled to find ways to manage behavioral health issues. Even with a medical model, it was very hard to have enough time to detect, diagnose, and treat within the time frame for primary-care visits. Pediatricians complained that the time they spent trying to understand behavioral issues in children was not reimbursed and it was too hard for their patients to get access to services with separate mental health benefits.[39] Many pediatricians found that the most efficient way to handle parent and child reports of emotional issues was spend less time trying to guide mental health and rather to approach behavioral issues as a medical problem—and write a prescription.

At the same time that insurance reimbursement was pushing patients toward primary care, and pediatricians were struggling with the increased burden, America's teachers were also feeling stressed by increased expectations that they manage mental health issues in their classrooms. Schools had long been sites in which medical and psychological professionals enacted their expertise, especially around children who did not measure up to professionally defined standards of "normal."[40] But for decades, children who had profound struggles with intellectual or physical disability were contained in special schools or classrooms. After the passage of the Education for All Handicapped Children Act in 1975, teachers faced the increasing obligation of incorporating students with a variety of special needs into regular classrooms. Policymakers, politicians, and the public have often centered their anxieties around the future of the children in what happens to them at school.[41] But even with national worries and pressures on educators, funding for education regularly dropped during waves of state and national economic crises. So teachers found themselves managing larger, more diverse student bodies in overcrowded classrooms. Teachers in the 1980s began to push to have parents send their

children to pediatricians for medications for ADHD (which helped make children more quiet and compliant in classrooms).[42]

Over the 1990s, with the successive efforts to improve education, much of the focus has been on improving teacher effectiveness. And so teachers have had bigger classrooms, more diverse children—and been told that their professional success depends on the performance of children on standardized tests or other forms of assessment. Teachers have strong incentives to push back on families of children who are disruptive or time-intensive within classrooms, and the focus has become child mental health. Although reformers in the early part of the twentieth century had suggested that some children's problems should be managed by physicians as medical problems, the new medical model by the late twentieth and early twenty-first century was based on the idea that disruptive or difficult children had a biological disorder that could be treated with medications.[43] Frustrated teachers could send children home to their parents with the hope (and expectation) that they would be medicated prior to a return to school. And parents whose children were failing to progress in classroom settings often sought out treatment for their children, worried that their ability to succeed in life would be hampered by difficulties in school.

And so more and more groups—from child psychiatrists to insurance companies to teachers to parents—shifted toward seeing children's emotional and behavioral issues as a medical problem. It was not a given that parents would go along with this push toward medicalization of mental health issues. After all, parent activist groups were major figures in the Education for All Handicapped Children Act and led the movement toward including children with disabilities into mainstream American life.[44] But what a biological model offered for parents since the 1990s has been the opportunity to identify an external source of blame. The old mental health advice literature—from Dr. Spock to the child psychiatrist books on mental hygiene—assumed that parents (really mothers) were the ones at fault if something was going wrong with the children.[45] A *DSM* diagnosis offered a different path—one consistent with a consumer model in health care. Parents (mothers) were not to blame—it was all the result of a brain disease.

CHALLENGES TO THE NEW MORBIDITY

In 2001, the AAP issued yet another consideration of the concept of the new morbidity. But now it was clear that this general principle was no longer a call for the enhancement of pediatrics. Instead, it reflected a shift in the responsibilities of the primary-care doctors working with kids. The new statement

pointed out that pediatricians still had to attend to behavior issues, but also needed to be prepared to address school issues, mood and anxiety disorders, the rise in adolescent suicide, guns, school violence, and substance abuse. The AAP called for still more education—especially around interviewing and counseling, as well as prescribing of psychiatric medications—and changes in reimbursement structure to support pediatricians' efforts.[46] But what has become increasingly obvious in the last two decades has been the lack of clear answers to the increasingly thorny questions that have affected the perspective and practice of the nation's more than 110,000 pediatricians.[47]

One major source of support and education for pediatricians has come from the ongoing work of the subspecialty of developmental and behavioral pediatrics. Behavioral pediatrics textbooks in the 1980s and 1990s relied on child psychiatrists to author chapters on mental disorders that were a relatively small part of the information to pediatricians. As in the older standard practice, the assumption was that severely disturbed children and their families would be referred to child psychiatry and so the perspective of its practitioners would be helpful. In the last couple of decades, however, behavioral pediatrics texts have shifted toward more of an emphasis on what pediatricians can do. It is perhaps not surprising that in a recent behavioral pediatrics textbook, two members of the subspecialty provided the history of their small field—and largely left out the role of child psychiatry. They connected the work of developmental-behavioral pediatricians back to ancient work for people with disabilities. They also talked about the importance of psychology in the history of the field. When they did raise the issue of child psychiatry, they commented that there had been a brief moment of thought that behavioral pediatrics might belong to psychiatry. But then leaders of the field—including Robert Haggerty—decided that what pediatricians did was manage the vast majority of kids who were within the range of normal. Child psychiatrists dealt with kids with more severe problems.[48]

Behavioral pediatricians—of which there were 775 board certified in 2018—could not be a substitute for the more than 8,000 (and still inadequate number of) child psychiatrists in the United States. Further, the guidance coming from behavioral pediatrics steered general pediatricians in the direction of understanding behavior in a developmental framework. A 2006 textbook for pediatricians on behavior took readers through ages and stages, with very little attention to mental illness diagnoses or treatments.[49] And even when a 2018 text from the AAP on developmental and behavioral pediatrics discussed the potential for disorders, the emphasis was on understanding a child in context. In the chapter on anxiety and mood disorders, the authors

stressed that "the most important role of a primary pediatric health care professional is to develop a therapeutic alliance with the child or adolescent and the family, and to remain a safe, nonjudgmental, and concerned party. Pediatric primary-care clinicians should be prepared to offer psychoeducation and brief supportive counseling, including advice on sleep, exercise, nutrition, and coping strategies, along with initial medical management for children and adolescents presenting with milder symptoms."[50] While the behavioral pediatricians wanted their general readers to have an understanding of disorders, they by no means promoted a solely biological model of mental illness.

In the last decade, pediatricians have also been grappling with a diversity of ideas about how best to manage psychiatric medications in kids. Even as pediatricians attempted to engage with what seemed to be a straightforward mental illness, depression, in 2004 the Food and Drug Administration (FDA) issued a black-box warning about teenagers and antidepressants (Selective Serotonin Reuptake Inhibitors, or SSRIs). As Wales psychiatrist and historian David Healy explained, there are major possible side effects to SSRIs that the drug companies that marketed them in the 1990s hid from the public—severely increased agitation and new, intrusive thoughts of suicide.[51] These appeared even more dramatically in adolescents. The FDA's warning about serious potential harm to patients caused a great deal of dissent in psychiatry. Some said the warning was justified, while others said that it would increase stigma and cause more problems with depressed kids. But this put pediatricians in an awkward spot. What could they say to reassure concerned parents? Should they avoid antidepressants in kids? Should they take kids off the medications when they were already on them? The AAP responded by creating its own fact sheet for parents and families as they felt that information offered by the American Academy of Child and Adolescent Psychiatry was not adequate for their patients.

Pediatricians get one set of messages from their behavioral colleagues, as well as a conflicting raft of messages from child psychiatrists. And meanwhile in the last decade, much of the uncertainty and conflict about child mental health and illness has played out in messages directed to parents. In the increasingly market-oriented approach toward health care, parents have become avid consumers of both health-advice literature and pharmaceutical advertisements and "educational" offerings. Parents—especially mothers—have been the target for professional advice literature for more than a century as physicians and others have instructed them on a variety of issues from infant feeding to adolescent behavior.[52] But the concept of the consumer in health care over the last few decades has profoundly shifted the ways in which

parents approach mental health advice.[53] Thanks to the direct-to-consumer marketing of pharmaceuticals—not to mention the aggressive marketing toward physicians and use of thought leaders to promote diagnoses (as well as medication)—it is increasingly common for people to see all behavior problems in kids as some kind of "chemical imbalance."

Of course, because there really is no such thing as a chemical imbalance, there is a lot of strong opinion based on limited interpretations and assumptions about how to manage emotional and behavioral issues in kids. There has been a rancorous debate in the parenting literature, for example, about how to understand mood swings in children. Some, such as psychiatrist Demetri Papolos, argue that irritability, multiple mood swings in a day, difficulty switching tasks, and hostility toward parents are all signs of bipolar disorder.[54] Harvard psychiatrist Joseph Biederman has diagnosed children as young as two years old with bipolar disorder (based on interviews with their parents).[55] Both Papolos and Biederman argue that serious medications are needed for these mood swings—Papolos has been using ketamine, while Biederman has been prescribing Risperdal (while maintaining a close relationship with Janssen, the maker of Risperdal).[56] Child psychiatrist Stuart Kaplan, who wrote a book for parents entitled *Your Child Does Not Have Bipolar Disorder*, argues that these children with behavior problems actually have ADHD.[57] But even though there is a difference of opinion about the nature of the problem, the message that parents are getting is that if their children are not close to perfectly well behaved there is a problem that might require medication. And parents are bringing these perspectives—and expectations—in with them to their pediatricians' offices.

And with a consumer focus within the medical model, there is a significant risk for major disparities in how mental illness is diagnosed and handled in different segments of the population.[58] Affluent parents are able to mobilize resources and seek out the kinds of care to support a goal of identifying mood and behavioral problems as external to their children and not a byproduct of their parenting styles. For savvy parents who can follow advice such as that found in the book by Papolos, it is possible to shop for a mental health professional who shares their perspective. Children from lower-income communities and racial minorities, however, may have different reasons for their mood and behavior disturbances—and are certainly treated differently by the primary-care physicians or mental health professionals they encounter. Children on Medicaid, for example, are much more likely to be heavily medicated—and/or to have their behavior result in entanglements with the legal system.[59]

Although there has been suspicion that a consumer model of mental health care in children is problematic, there is little direction for how to manage it—especially since much of the mental health care for children in the United States is now provided by pediatricians. Many physicians are frustrated with direct-to-consumer marketing, and not a few have complained about the effects of the pharmaceutical industry on child mental health. But pediatricians have not been able to participate in much of this conversation, and are left to deal with parents' fears and often unrealistic expectations about how to explain and treat problems in their children. This has only been heightened with the increasingly alarming data coming from the Centers for Disease Control regarding the increasing rates of suicide, especially in children and adolescents.[60] Even though suicide has traditionally been seen as a complex, sociological phenomenon, it is increasingly framed in terms of individuals with mental disorders.[61] And though the rates of prescriptions for medications are rising along with the suicide rates (suggesting at the least a complicated relationship between treatment and suicide prevention), there is increased pressure on pediatricians to do more.[62]

CONCLUSION: LESSONS FOR HEALTH POLICY

The confusing, overlapping, and often inconsistent stances of the multiple professions involved in children's mental health illustrate an issue that Rosemary Stevens has pointed out in health policy, the challenges of Americans' preference for medical specialties. American physicians have codified an extensive system of specialization and subspecialization, and patients and policymakers assume that those with the most experience and knowledge will be the best to address a particular issue. But there are major problems with the fragmentation of care and competition among different specialty groups in the plethora of specialists, and most consumers do not have the knowledge base to sort it out.[63] In the case of pediatric mental health, the target of intervention—mental illness in children—was expansively (re)defined by child psychiatrists with a particularly narrow, biological model without clear validity and launched into a medical marketplace without guidance. At the same time, the very small number of developmental and behavioral pediatricians have been attempting to help busy pediatricians understand how to interpret children's behaviors. The result has been a lot of anxiety on the part of parents and teachers, as well as chaos among providers.

In many ways the modern open conversations about mental illness have been beneficial in reducing the stigma associated with diagnosis and treatment

for mental problems. Pediatricians are certainly much better educated about the signs and symptoms of mental illness than they were in the past, which is critical given the absurdly small number of child psychiatrists in the nation (in comparison to the apparent demand). At the same time, though, as Rick Mayes and Jennifer Erkulwater have pointed out with regard to ADHD, our system of heightened awareness, early treatment, and assumptions about disability that go along with mental illness can have profound effects on the children who are diagnosed—and on the policy decisions (and costs) down the line.[64]

From a policy perspective, it is understandable that the problems in child mental health seem to be largely logistical. If most care should be provided by pediatricians, the problem to be solved would be the best ways to educate these primary-care providers to give better-quality care. But as we can see from the history of the shift from mental health to mental illness, there is nothing inevitable about the truths espoused by different actors or the biological model of mental illness. We got there through a series of historical accidents and choices, some professional, some economic—rather than because that was the right model to use for children and families. In essence, mental illness became redefined as a primary-care problem and exported into primary-care settings by a specialty group (in collaboration with the pharmaceutical industry). Meanwhile alternative views such as those advocated by behavioral pediatricians are much less mainstream. As policy analysts have pointed out, our current system of health care in the United States is more weighted on the side of provision of medical services rather than exploration of health maintenance practices.[65] But instead of pushing pediatricians—though insurance reimbursement structures—to follow a biological model, what if we reassessed what it meant to offer understanding and consideration for developmental and behavioral needs?

In 2016, Massachusetts pediatrician Claudia Gold wrote a compelling book that called attention to the many problems of the biological model of mental illness, *The Silenced Child: From Labels, Medications, and Quick-Fix Solutions to Listening, Growth, and Lifelong Resilience.* Gold pointed out that time was critical for children—time to listen, to engage, to learn from them about what their behavior meant. Instead of looking to label—and then to fix—Gold emphasized that it was better for children, families, and society to listen to what children were saying with their behaviors. While Gold acknowledged the push of economics (both insurance and pharmaceutical industry driven considerations), her stories were powerful as was her insistence on the importance of listening and relationships.[66] Her perspective

suggests the value of a health policy directed toward understanding rather than fixing, building up instead of passing through, and most especially offering adequate time for health-care providers to engage with patients and families.

As this article has shown, what we think we know about childhood mental illness has been shaped by the social, cultural, and professional contexts of multiple medical and research specialties over the last half-century. We now have a popular biological model of mental illness for which there are medications, but it remains unproven that this model is accurate or appropriate for children. There are numerous problems with medications and concerns about the reliability and integrity of the research studies that purport to show improvement with medications.[67] These conditions are all a set-up for disaster when the consumer model of health care is applied. There is no way for families to become adequately educated about all the controversy and different options for child mental health and therefore no way for families—even those with resources—to make informed choices. And the fact that there is a wildly inconsistent medical marketplace for child mental illness means that there is high potential for significant health disparities based on parents' resources.[68]

Pediatricians have been advocates for populations of children for more than a century, and the American Academy of Pediatrics is continuing that effort. The AAP's vision statement for the future points out the importance of including mental health concerns along with physical health issues.[69] From a policy perspective, we can best support that by identifying ways to preserve health rather than just treat illness. The term "mental health disorder"—which is currently in use in mental health literature—reveals much about the shift in how we approach emotional and behavioral issues in children in the twenty-first century. If we are going to engage with the admirable goal of improving access of children to health-care providers, we also need to make sure that those providers are able to take the time they need to build up critical relationships with patients and apply developmental perspectives to understanding them. We need to expand training in behavioral and developmental perspectives, not just hand down more information about which medications to use. Access is important, but we need to make sure that ideas about efficiency and assumptions about biological illness are not prioritized over the mental health of the nation's children.

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NOTES

1. See White House press release, "Fact Sheet: President Obama Applauds Commitments to Raise Awareness and Increase Understanding of Mental Health at White House Conference," 3 June 2013, https://www.whitehouse.gov/the-press-office/2013/06/03/fact-sheet-president-obama-applauds-commitments-raise-awareness-and-incr. For some history of previous White House involvement in child health, see, for example, Ann Hulbert, *Raising America: Experts, Parents, and a Century of Advice About Children* (New York, 2003).

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3. It turns out that the question has not really been asked—it has just been assumed that early treatment leads to fewer problems later. E. Jane Costello and Barbara Maughan, "Optimal Outcomes of Child and Adolescent Mental Illness," *Journal of Child Psychology and Psychiatry* 56 (2015): 324–41.

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