To Refer and To Consult

Psychiatric Referrals of Adolescent Patients

WILLARD J. HENDRICKSON, M.D.*

THE question of psychiatric therapy for the emotional disorders of adolescent patients presents itself to the practicing pediatrician time and time again in many forms: whether and when to refer, and how to best make effective referrals. The evaluation by Hammar and Holterman,[2] appearing in the August issue of CLINICAL PEDIATRICS (page 462), of their results on referring adolescent patients for psychotherapy, points out our still meager knowledge and uncertain practices in this relatively new field. By implication, this raises the question of the adequacy of the training in treatment of adolescent problems currently being received by young psychiatrists as well as by young pediatricians.

Problems of Adolescence Traditionally Neglected

The temptation to ignore the unique and often troubling qualities of adolescents stems in part from the anxiety which they typically provoke in us as adults. As a result we tend to treat them either as large older children or as young adults, and, in a sense, they are both. The universality of this tendency is reflected by even such experienced specialists as Hammar and Holterman when they can say "most adolescents respond to the adult . . . who treats them as mature individuals." This is not quite true, though we can say with certainty that adolescents will *not* respond to adults who always treat them as infants.

The adolescent does not believe that he is a mature individual. He has trouble assessing his capacities, and needs our help in appraising and developing them. He knows also that the maturity of his judgments is markedly variable. He most appreciates being treated with roughly the confidence he deserves in each situation—no more, no less.

While we must share Dr. Hammar's concern over the inadequacy of psychiatric training for pediatricians, the picture is by no means entirely discouraging. Pediatricians have recently been at least as quick as the psychiatrists in overcoming the original inertia of us all, and in recognizing the need for special medical and psychiatric treatment facilities for adolescents. Specialized clinics for adolescents such as that in Seattle are now functioning successfully and are publishing papers such as this one in an attempt to appraise critically the results of their own attempts at psychotherapy in young patients.

This leads us to the problem of the nonpsychiatric physician who must turn to the psychiatrist as someone "more knowledgeable." In actual practice, how much more knowledgeable is the psychiatrist, however? Many have little or no interest in adolescent patients and avoid seeing them whenever possible. Most have had little formal training in this relatively new field. On the other hand, every large community has a few psy-

* Chief, Adolescent Service of the Department of Psychiatry, University of Michigan, Ann Arbor, Mich.

chiatrists who have had special training and who are interested in working with teenagers. The demand for their services is so great, however, that their schedules are usually so jammed with these challenging patients that they are unable to handle many who truly need their help. The success achieved in certain kinds of problems even by these psychiatrists trained and willing to see adolescent patients varies enormously from case to case and doctor to doctor. Thus, the physician who recognizes the need for psychiatric help for his adolescent patient is still in a dilemma.

Pediatricians and psychiatrists alike look toward further progress in the field of adolescent medicine. This report by Hammar and Holterman provides a step toward improving the situation by their systematic reviewing of the outcome of referrals for psychotherapy and by their judgments of "success." This study provides an across-the-board checkup on the physician's batting average. The authors found their own success rate to be disappointingly low, a result which we in the Adolescent Service at the University of Michigan also found in a yet to be published study of patients whom we referred for psychiatric care. The authors' analysis of their failures, however, has provided some excellent clues for those who make referrals.

"Too Little Time!"

One comment which seems particularly noteworthy is that "the physician rarely has the time, the opportunity, or is in a position to evaluate a patient's reaction to his referral, particularly those which are not successful." How often does the physician in practice take the time to phone the psychiatrist to make the referral in person, or later for a follow up inquiry? Similarly, how often do those of us who are psychiatrists find a few minutes to call the physician from whom we have received the referral? We can honestly say we "do not have the time," but perhaps we should wonder whether we can *afford* to not have the time. After investing hours in an evaluation, shouldn't we take a few more minutes to telephone our colleague, thereby trying to better ensure the sucess of our efforts for this patient, and also prompting greater success in later referrals?

"Consultation"

A few years ago Leo Bartemeier [1] in effect reminded us that we as psychiatrists would do well to recall the old fashioned meaning of the word "consultation." Webster's Dictionary defines the verb "to consult" as "to seek the advice of another, to converse, to compare views." We all know that the treatment of an adolescent can be challenging, puzzling, and frustrating, but the exchange of detailed clinical data, opinions and results between pediatricians and psychiatrists concerned with the care of these patients can be mutually supportive and educational to a remarkable degree.

As a rule, in our own Adolescent Service clinic of the University of Michigan Department of Psychiatry, the initial referral of each prospective patient involves at least one and often several phone conversations between a senior psychiatrist in the clinic and the referring doctor. The case is discussed in the light of observations by the referring physician and of the experience of the clinic. We discuss whether the patient's needs and the physician's purposes in making the referral are realistically served by an outpatient evaluation, or whether this particular patient may require treatment which could better be obtained at another facility. Again, the referring doctor is often consulted later by our department even during the psychiatric evaluation if the evaluation proves to be a long and puzzling one. This procedure seems time consuming, but can actually save time by eliminating studies which are of no value to the patient's case. Experience has taught us that the only way for mutually understandable information about referral criteria to be exchanged between psychiatrist and referring physician is through detailed discussions concerning the specific patients.

Some patients who are evaluated but not treated in this clinic may be referred to private psychiatrists or other facilities for treatment. With these, the advice to seek help is not merely given and explained. Our clinic

also assumes the responsibility, on a selective basis, to see to it that through parents or the family physician the advice is carried out. Talking to colleagues about our sometimes difficult always fascinating adolescent patients may take time, but is an enjoyable chore and mutually educational.

Advising Treatment—Whom to Convince

Many of the conclusions reached by Hammar and Holterman's analysis of results of psychiatric referral ring true, but a few may be somewhat misleading. Their reference, for example, to the need to "convince" the patient seems to imply:

1. That the adolescent patient must be persuaded to openly accept and demonstrate his need for treatment;
2. That the adolescent patient should be granted a choice about treatment.

The average adolescent does, as indicated, appreciate a frank interested straightforward approach. In early contacts he can be asked directly but tactfully about himself and his problems. Under these circumstances, he usually shows surprising initial ability to be candid about even the most difficult problems. At this point, there is mutual agreement between patient and doctor about the nature of the difficulties needing treatment. He can usually be told with simple explanations as to the reasons, but with no overt effort to convince him, just what is necessary in the way of treatment. He is by now secretly convinced, if indeed he was not convinced before seeing the doctor. In adolescents, as with all patients, the desire for help is unquestionably essential to treatment. The adolescent will not reveal this desire or motivation directly. He may express his opposition even though his behavior reveals relief that help is being offered.

Convincing should be saved for the parents. Many psychiatrists believe that the adolescent should take the responsibility for the decision to undertake psychiatric treatment, but actually it is his parents, with the doctor's help, who must make this decision. They must also continue to encourage him throughout treatment. Their lack of conviction about its advisability may discourage him or remove him from the needed help.

Psychiatric Treatment by Pediatrician—Advantages

Hammar and Holterman correctly observe that the pediatrician can offer much to the emotionally disturbed adolescent. In fact, with many youngsters the pediatrician has some advantages over the psychiatrist. The pediatrician is generally a family friend and well known to the adolescent whose anxiety about treatment is greater at this age than at any other. He fears becoming dependent, being different, losing control of himself, and he fears revealing his innermost secrets. These are normal conflicts of adolescence, especially are also prominent in all patients entering psychotherapy. The teenager often sees psychotherapy as very dangerous since it may accentuate conflicts which he already finds scarcely manageable.

The whole concept of treatment is necessarily vague and invites dependency. This, plus the adolescent's anxiety about having his innermost fears and secrets explored, makes seeing the psychiatrist an unpleasant prospect. Perhaps, most of all, he is afraid of treatment because he is usually wise enough to know secretly that he requires it, and is frightened by the strength of his own temptation to turn to the doctor. Feeling this way about help, it is often possible for the youngster to turn to a pediatrician or family physician with much less exaggerated anxiety, and less fear of the potential blow to self esteem and less of the other possible disadvantages of seeing a psychiatrist.

The pediatrician, being a less threatening figure, has a number of other practical advantages over the psychiatrist. He is closer to the patient, the family and the community situation, and is better able to gain direct factual information about the adolescent—a difficult clinical problem for the psychiatrist, since many of these youngsters and their parents are unreliable historians.

Because of his position as family counsellor, and the fact that he is physically and psychologically more accessible for consultation, the pediatrician can recognize developing problems early, and can help relieve conflict and reduce anxiety in the earliest stages when they are, hopefully, still reversible.

He knows the parents of his patients, and can interpret for them the youngster's treatment. He can better appreciate the threat to the parents when they recognize their child's need for professional help. Parents often not only interpret such a need as a reflection on the adequacy of their own parental abilities, but they tend to recapitulate some of their own adolescent conflicts under the stimulus of their son's or daughter's illness. Though the pediatrician may lack some of the technical psychiatric training needed to manage the extreme situations, he has the opportunity for early intervention when the problem is still not so frightening that it compels the parents to completely deny it.

"Too Little and Too Late"

Earlier case detection is an important area for future investigation if more disturbed teenagers are to begin treatment at an earlier and more easily reversible stage of their illness. Most sick youngsters are much more treatable at 14 than later in their teens. We now believe that adolescence is not only the period of special difficulties for psychologic treatment, but also of great opportunity for successful psychotherapy particularly if begun in the early teen years.

One of our greatest mental health problems is that of the "too little-too late" phenomenon. This is especially striking with adolescents, since the extreme ambivalence of their parents about treatment tends to lead to tragic delays in seeking help. Such delays are in part responsible for present facilities for child and adolescent psychiatry being swamped with chronic, severe cases requiring prolonged belated treatment. Ironically, these conditions make it more difficult to provide psychiatric help for those youngsters whose illnesses are still early and mild enough to have great promise of cure. As a matter of fact, some of the emotional problems of adolescents can be treated better by pediatricians and family doctors than by psychiatrists.

A close liaison between the psychiatrist and other physicians should aid in developing better methods for early diagnosis and for earlier therapeutic intervention. Then, those needing a psychiatrist would benefit more by timely early referrals. It is our feeling that regular give and take consultations between psychiatrist and referring physician should become routine when dealing with emotionally disturbed teenagers. All of us have much more to learn. And some of the world's best teachers of psychiatry are our own adolescent patients.

References

1. Bartemeier, L. H.: Amer. J. Psychiat. 110: 364, 1954.
2. Hammar, S. L. and Holterman, V. L.: Clin. Pediat. 4: 462, Aug. 1965.

A New Feature—CP Hand Book

In this issue Chapter 2 of *CP Handbook* appears as a perforated, loose-leaf punched insert (just before the editorial). Psychological Testing in the Office is presented succinctly and with illustrations. This handy, quick reference feature began with the November issue covering parenteral fluid and electrolyte therapy. Chapter 3 will deal with chemotherapy of leukemia and solid tumors.