Forward

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Child and youth mental health grew out of psychosocial and child guidance approaches that focused primarily on presumed social environmental influences on development and the expression of psychopathology. Only recently has the field evolved to begin to address the complex interaction between genetics and environment as that affects neurodevelopment in the creation of health and the development of disease. Traditionally, the field depended on theory, usually derived from observations and highly susceptible to attribution bias. These theories were often clustered around influential figures in the field—such as Freud; Mahler; Klein; Winnicott; Minuchin; etc., and were not troubled by the need to develop evidence to support or to refute their pronouncements.

Concurrently with the realization that children and youth actually had brains, and that these brains controlled their cognition, moods, behaviour, etc., arose the realization that neurodevelopment may be important as an area of study in child and youth mental health. At this same time, the happy convergence of new scientific methodologies: epidemiology, experimental science, statistics and probability theory served to create the evaluative frameworks by which hypotheses could be tested and theories supported or refuted. This intellectual revolution was reinforced by the practical realization that money spent on things that did not work or were harmful was not money well spent, and cost: benefit analysis entered the world of child and youth mental health as an added nail in the now rapidly closing coffin of the social theory and psychoanalytic (individual and family) perspectives that had held suzerainty for decades.

It is important to understand this historical background in child and youth mental health, because our perspectives on the family and its relationship to the mental health of young people have evolved along similar directors as the wider field. Early models of "mother blame" or "schizophrenia families" gave way to realizations that there were complex patterns of intrafamily interactions that did not necessarily explain the occurrence of mental disorders but may indeed have been a result of those disorders. Further unraveling of the complexities of the impact of genetic, of parental mental illness and of social determinants (such as poverty and single parenting), has lead to a more balanced view of families, and has initiated new domains of research, such as the impact of genes, parental mental illness and of social determinants (such as poverty and single parenting), on family functioning has lead to a more balanced view of families. This has initiated new domains of research, such as the impact of illness (burden of illness) on families and the role of families in recovery and relapse.

More recently, investigators have been refocusing their lenses and looking at family functioning and asking "what strengths does the family possess" and "how can the way family members interact be modified to increase the well being of the family and the way the family functions"?

A more comprehensive and nuanced clinical approach is also now coming to the forefront. This includes addressing the needs of the young person living with a mental disorder and working collaboratively with parents and other family members to determine how to best meet those needs. Because mental disorders frequently run in families it is increasingly being realized that interventions may need to target all those affected and not just the family unit itself. It is also increasingly realized that parents may have a role to play in the possible prevention and early identification of mental disorders in their children.

Clinical experience and research evidence is showing that when young people and their families are provided with effective early intervention, it has a positive impact. What this means is that when families know there's a family history of mental disorder, and when they see troubling behaviours or cognitive difficulties or emotional struggles, they should seek assessment and professional help as soon as possible.

In the current state of knowledge, it's not uncommon for primary care providers to be inadequately prepared to conduct the kind of child and youth mental health assessment required to tease out differences between mental health problems and a mental disorder. Thus it becomes easy to go to the default position which is 'don't worry, it's just a stage'.

This means that parents may have to take on the mantle of advocating to service providers that their child's problems could be the early manifestation of a mental disorder . . . This advocacy often results in parents 'resisting' innuendo or frank assertions that it might be their parenting or their own emotional problem that is creating the challenges for their child.

It's essential that primary care health providers take the time to educate parents on signs and symptoms of mental disorders and resist invoking the common default position that the problems are due to problematic parenting or environmental stress. Once educated, many responsible parents will bring their child for further assessment and treatment.

Furthermore, child psychiatrists, when consulting on or assessing a child where there is a family history of mental illness, must seriously consider that the problems they're seeing may be the

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early manifestations of a mental disorder and intervene accordingly.

Education about mental disorders is essential. This form of mental health literacy can offer parents and other family members valid information instead of blame and may be a fundamental component in the engagement of families in the often challenging treatment process.

Clinical experience and good research are jettisoning traditional models and replacing them with empirically supported evidence based interventions. We have much to learn and learning starts with humility and the willingness to challenge our perspectives and to listen to the wisdom of others. Child psychiatrists have much to learn from families. We need to listen better.

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