Iatrogenic psychological harm

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ABSTRACT

While prevention of iatrogenic harm is a sufficient priority to determine service structures and practice, the concept of harm is largely restricted to the physical. Psychological harm has received scant attention despite its importance, particularly for children and adolescents. A professional climate increasingly reliant on measurement and evidence and coloured by fear of litigation contributes to perpetuating the anomaly.The aim of this paper is to consider how and why iatrogenic psychological harm may happen, why it matters, how it may be manifest and how it may be prevented. Prevention of psychological harm should be as great a priority as that of physical harm.

INTRODUCTION

> I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous.[1]

"According to my ability and judgement"? How things have changed. According to guidelines and regulations perhaps? If external control supersedes personal judgement there can be a cost. Psychological safety depends on attention to individual detail, whereas practice is increasingly governed by the general, and by the measurable. Evidence obviously matters greatly, but for its interpretation and application, so do its broader context and limitations; psychological care is not readily amenable to objective assessment and is vulnerable in an evidence-governed culture.

Recognition of the importance of psychological well-being has informed paediatrics since its early days. However, current approaches may sometimes pull us away from achieving it. Inattention to iatrogenic psychological harm is a striking anomaly of a climate determined by considerations of safety in a risk-averse world. It can, however, be of greater and more sustained importance and less reversible than physical harm. It is a particularly important consideration in working with children, for whom crucial parental relationships may as yet be developing and when stress regulation systems are being programmed. Childhood brain development is shaped by experience; early experiences powerfully influence the preconceptions children take to subsequent ones, and their assumptions about themselves and others. They are ill-equipped to rationalise or challenge suboptimal psychological care, so may be more susceptible than adults to its potential consequences.

Psychological harm is a grey term, on a spectrum ranging from the slightly unsatisfactory to the frankly dangerous. Hard-pressed paediatricians inevitably fall short of the ideal sometimes, as every parent does, but recognising possible pitfalls helps. Standard setting and audit of psychological harm are fraught with difficulty. Attempts to achieve these can involve proxy measures which poorly represent the reality, yet disproportionately divert attention and resources.

Beyond anxiety and distress, iatrogenic psychological harm may broadly be understood as impairment, by omission or commission, of emotional well-being and healthy emotional development. This means protecting as a priority the parental relationships on which children, because of their immaturity, depend, and protecting self-esteem, identity and resilience to equip them for safe progress towards independence. The aim is to allow optimal emotional development despite illness or psychological, social or developmental disadvantage (box 1).

ROUTES TO PSYCHOLOGICAL HARM

Understanding the potential side effects of what we do and how we do it matters as much with psychological care as with administering drugs; the list can be equally long and the pitfalls open to the most caring and committed of paediatricians equally prominent.

Harm, minor or not, comes from misassumption, misjudgement and miscommunication. It comes from action and inaction, from what is said or not said and how, and from professional attitude and behaviour. It comes from assumption, inadvertent or otherwise, that medical training justifies overriding patients' views, and overinflated faith in investigations – a touch of arrogance perhaps. It comes from failure to listen, distraction by personal priorities and haste. It comes from failing to see through young peoples' eyes, talking over them and underestimating their capacity to absorb meaning from adult conversation, manner

Box 1 Psychological aims in paediatric practice

- Adequate parental attachment
- Good self-esteem
- Healthy identity
- Healthy relationships
- Healthy illness behaviour
- Effective stress regulation
- Safe coping strategies
- Sense of control and choice
- Sense of success
- Valued roles and responsibilities
- Coherent narrative
- Good mental health
- A safe transition to independence

Box 2 Why does iatrogenic psychological harm happen?

Individual practice
- Overlooking the possibility of psychological harm
- Disregard of normal emotional development; inadequate understanding of adolescence
- Devaluation of history and examination; over-reliance on investigations
- Failure to listen
- Failure to test out assumptions
- Failure to 'read' behaviour and relationships
- Failure to respect families' perceptions
- Disregard of gaps in knowledge or services
- Overlooking the message conveyed by professional language, behaviour and attitude
- Overlooking personal limitations
- Omitting to look beyond the immediate picture

Service structures
- Specialisation
  - Unsupported specialisation
  - Mind–body separation
- Inadequate professional relationships
  - Professional discontinuity
  - Inadequate time
  - Fatigue, stress
- Determination of practice by the general rather than the individual
  - Uncritical reliance on guidelines, protocols and evidence
  - Over-reliance on diagnostic categories and labels
  - Evidence-based rationing

and behaviour. It comes from disregard of normal emotional development, and from misjudgement which disturbs identity and self-esteem and precludes a coherent life story.

Harm comes from failing to recognise psychological need when it is there, and from supposing it to be there when it is not. It comes from suggesting that there is physical illness when there is none, and from suggesting that there is none when there is.

It comes from incautious handling of family relationships through inattention to their nature and importance, failure to protect or putting at risk those on which children depend, failure to address dysfunctional relationships, and neglecting to take responsibility for nurturing necessary new ones.

It comes from clumsy, stigmatising discussion of psychological factors through inadequate thought to their meaning, implied blame and disbelief. It comes from distancing families from supportive services which they may value. It comes from failing to protect from trauma through inadequate explanation, and from unregulated stress. It comes from overlooking the shortcomings of professional knowledge and systems (box 2).

There is, uncomfortably, common ground with routes to parental emotional abuse, qualitatively if not quantitatively[2] (table 1).

BUILDING FOUNDATIONS

Neonatology has responded robustly to recognition of the importance of early attachment; whenever measures to protect this are under-resourced or inadequately considered, resulting harm can have lifelong, perhaps even intergenerational implications. Potential consequences are more amenable to understanding than proof; such services may be vulnerable to financial

Table 1 Parallels between parental emotional abuse and psychological iatrogenic harm

Parental emotional abuse	Iatrogenic psychological harm
Inadequate parental attachment	Inadequate protection of parental attachment
Poor attunement to children's feelings	Poor attunement to children's feelings
► Poor personal foundations, drugs, alcohol	► Pre-established assumptions
► Fatigue, distractability, stress	► Fatigue, over-work, stress
► Inadequate availability to the child	► Lack of time to listen, discontinuity
Unregulated stress	Unregulated stress
► Fear	► Fear
► Chaos and unpredictability	► Ineffective explanation
► Pain inflicted by care-givers	► Uncontrolled pain; pain inflicted by care-givers
► Stressed parents…stressed child	► Stressed doctors…stressed child
Authoritarianism; excessive control	Over-reliance on professional status to assert control
Lack of mutual trust	Failure to establish trust
Inappropriate roles (eg, parental child)	'Befriending'
Inadequate boundaries	Unboundaried empowerment
Parents' needs overriding those of the child	Systems over-riding individual needs
Inappropriate expectations of the child	Talking over children; misjudging their understanding
Failure to promote self-esteem	Inadequate protection of self-esteem
► Criticism	► Implied criticism and blame
► Misattribution of behaviour	► Disbelief; psychological misattribution
► Lack of praise	► Insufficient acknowledgment of effort
► Failure to teach social skills	► Inadequate care to protect peer relationships
► Confused identity	► Insufficient explanation for a coherent narrative
Poor role model for coping strategies	Insufficient or stigmatising psychological provision
Personal boundaries	Privacy
► Inappropriate household norms	► Overlooking developmental and cultural needs
► Sexual abuse	► Inadequate explanation of intimate examination
Parental lack of insight into the effect of their behaviour	Overlooking the effects of professional assumptions, systems, behaviour

Box 3 Principles of attachment

- Attachment develops and is sustained through an interactive cycle which requires the baby to show its needs and the parent to respond
- Parents attune to the baby's overtures through tone, speed and pitch of voice, facial expression, touch and movement
  - -Providing a mirror in which the child's body signals and feelings are reflected
  - -Resolving breaks in attunement rapidly and reliably
  - -Teaching:
    - Foundations of verbal and non-verbal communication
    - The meaning of feelings and body signals
    - That others understand one's needs: relationships are valuable
    - That separation is safe: attention is readily regained
- Quality of attunement influences the programming of stress systems
- Quality of attunement is affected by stress, fatigue, anxiety, poor early parenting, mental health problems, drugs and alcohol and opportunity
- Foundations remain importance whatever follows

stringency if evidence becomes determining. Understanding attachment from first principles makes it easier to make the case (box 3). The quality of parental attunement to their baby influences the foundations of self-perception, preconceptions of relationships, and communication.[3] It teaches the value of achieving attention, appropriate means of doing so and confidence to relinquish it.[4] It continues the programming of stress systems which starts in utero, influencing physical and psychological health and behaviour over the life span.[5–11]

Illness distorts infants' opportunity and ability to show their needs and parents' to respond. In neonatal intensive care units, professionals, not parents, may be the front line of children's experience. There can be uncomfortable parallels with abusive homes – little routine, unpredictable noise, pain imposed by care-givers, multiple carers, lack of day–night differential, poorly attuned care, unregulated stress and no familiar comforter. While subsequent attention deficit hyperactivity disorder (ADHD) is generally attributed to antenatal risk factors or low birth weight, programming of stress systems in response to chronic stress and learnt hypervigilance could contribute[12–14]; similar mechanisms could underlie a suggested association between neonatal intensive care and subsequent problems with chronic pain.[15]

Even transient difficulty, unaddressed, can have continuing implications if learnt patterns become fixed. Suboptimal attachment originating with the baby, mother or both can establish a self-perpetuating cycle – a picture, for example, of a stressed, crying ('colicky') baby and a depressed, sleep-deprived, poorly-attuned mother.[4] Foundations remain important, although neural plasticity allows moulding by subsequent experience.

SAFEGUARDING SAFELY

Safeguarding becomes unsafe if it is selectively focused on physical injury. Emotional safety requires equally careful consideration of the distorted relationships which abuse represents: harm comes from inadequately analysing and presenting their

Box 4 Risk in safeguarding

M was assessed several times for bruising but on each occasion the parents' explanation was considered not to be inconsistent with the injury. At age 6 an injury was felt to be non-accidental and the child was removed to foster care. His behaviour indicated profound difficulty in relinquishing control and attention, difficulty in regulating temper and fear of rejection. He did not succeed in establishing an adoptive home.

implications (box 4). It comes, equally, from overlooking valuable attachments, failing to balance these against physical concerns, and underestimating the trauma of unplanned removal. It comes from disregarding in decision-making the diminishing likelihood with age of establishing permanence elsewhere.

There is scope for harm through forgetting that safeguarding also has risks – from overlooking, perhaps, that 'care' is far from risk-free, from disempowering already vulnerable parents, or from encouraging false accusation as a route to attention for those needy of it, for example.

Safe safeguarding requires all who undertake the work to be equipped to assess relationships as carefully as physical injury. It means recognising the importance of uncertain jigsaw pieces alongside evidence in constructing the whole picture – working beyond a purely evidential approach, and developing systems which allow this.

SUBSTITUTE PARENTING

Psychological risk comes from underestimating the overriding importance of adequate parental attachment, and the extent of children's vulnerability until this is achieved. Although not technically part of the corporate parent, in attitude and commitment paediatricians should be. Whenever statutory health assessments slide into tick-box exercises, harm can be done, if only by omission. Vulnerability coming from separation from family, from experiences in care and from moves compounds the consequences of troubled family relationships.

Harm comes through failure to recognise psychological need, disregard of responsibility to address it, and failure to realise the possibility of doing so – from assuming, perhaps, that behavioural difficulty is inevitable. It comes from over-rigid practice which disallows priority-led pragmatism, and from service structures which allow inadequate time and continuity for timely and effective responses to the crises typical of vulnerable attachment. Separation of child and adolescent mental health services (CAMHS) and paediatrics is a particular problem for this work.

PSYCHOLOGICAL HARM IN HOSPITAL

Unrestricted visiting, resident, involved parents and play therapists have greatly reduced the trauma of hospital admission, supported by charities such as Action for Sick Children.[16] However, physical well-being nevertheless sometimes has a psychological cost – often minor, but not necessarily so – which, if unrecognised, cannot be balanced against benefit in specific contexts.

Talking over patients, careless words and failure to visit on rounds may be immaterial to many, but for others sensitivity resulting from stress and isolation, chronic illness and prior experiences may afford these greater significance, picking away, perhaps, at already vulnerable self-esteem. Discomfort,

irritation or worse may come from inadequate time to explain and listen, from professional discontinuity, and from failure to pitch communication at the child's level.

Avoidable stress may come from inadequate regard for privacy and personal dignity, for example from overlooking age-related or cultural norms. It may come from allowing too little choice and control – or too much.

Self-esteem can be affected by inadequate protection of social relationships – disallowing visits from siblings and friends, or use of computers and mobile phones, for example. Distress may result from underestimating the emotional demand of friendships established in hospital – overlooking, perhaps, the need for information and support if others deteriorate. Liaison mental health services which can ease the way may be diagnosis-specific and under-resourced.[17]

MANAGING CHRONIC ILLNESS: KEEPING AN EYE ON THE FUTURE

Chronic illness allows particular scope for psychological harm because illness entangles with emotional development. Inadequate support in reconciling these can compromise self-esteem, identity, family attachments, peer relationships and resilience. The aim is healthy behaviour, identity and function, with illness an incidental, not a defining characteristic. This means thinking ahead, recognising that present experience is built upon, not overridden by what follows.

Inadequate support of parents contributes to risk. Long-term extrapolation of parenting appropriate to short-term illness presents problems. Over-dependency, distorted discipline and different rules for ill children affect development, behaviour and family relationships; patterns readily become fixed.

Self-esteem is vulnerable if explanation is insufficient for children to understand the condition and achieve a sense of control, or if peer relationships, opportunities for success and 'normality' and healthy coping strategies are inadequately encouraged.

Harm can come from overlooking the complexity of recovery when peers and expectations change rapidly and developmental stages are missed, and when entire families have adjusted around illness; those who adjust to illness face the equally difficult task of adjusting back again.

ADOLESCENCE

The ambiguities of adolescence may be less immediately recognisable in a professional context than a parental one. Caring for adolescents involves recognising the normal – and the 'normal' distortions brought by illness or disability. It means being aware of the sometimes irreconcilably conflicting roles into which professionals may unwittingly be cast.

Adolescence is about ambiguity and ambivalence. It is about testing the water in independent identity and function. Adolescent relationships with parents can be as confusing to witness as to experience; knowing the normal matters. Parents learn to pass and return the baton in adolescents' fluctuating, sometimes simultaneous quest for dependency and independence. The same may be needed of paediatricians. They may find themselves part-physician, part-friend, part, almost, in loco parentis – ambiguous roles in an ambiguous process.

Choice, responsibility and control over destiny are the aim. They are, however, the aim, not the achieved destination. Responsibility to set limits is as important as to allow independence: 'empowerment' without boundaries is as unsafe in a professional context as in a parental one. Adolescent testing may be inappropriately reinforced if unrecognised as such. It comes in many guises, some more obvious than others, its consequences shaped by others' feedback. Misplaced approbation and flattery into 'befriending' can distort developing identity and displace the protective parental relationships which underpin safe progress to independence.

Knowing the 'normal abnormal' matters. The timing and nature of adolescent separation may shift out of line with physical maturity. Past neglect can produce adolescent over-dependency – or the converse: coping strategies, while 'different', may be adaptive and need protection. For those recovering from abuse, separation during turbulent adolescence may be the necessary route to long-term protection of crucial relationships with foster or adoptive parents. Overlooking this can make what could be a temporary phase a permanent one.

Chronically unwell young people who are inadequately supported in reconciling ill-health with 'normality' may resolve the dilemma through 'ill' – or 'mentally ill' – identity, reinforced, perhaps, by an 'ill' peer group. Illness readily becomes defining or even competitive, hindering recovery. Others deny illness and refuse treatment; denial is obvious if the illness is understood, not necessarily so if not. Inappropriately concurring with denial in the name of 'empowerment' may, paradoxically, fuel confusion and blame.

HANDLING THE PSYCHOLOGICAL

All paediatricians exploring psychological territory should be alive to risks. Treating the correct psychological problem matters as much as treating the correct physical one. Harm, of varying degrees, comes from qualitative or quantitative misjudgement, and from imprecision in meaning. It comes from clumsy presentation of psychological issues – apologetic, stigmatising or unexplained – which distances families from potentially valuable services. It comes from imposing treatment which feels inappropriate, in a manner uncontemplated with physical intervention.

Mind–body separation allows psychological factors to seem unusual, or more significant than is warranted. 'Psychological', undefined, acquires a vagueness approximating to 'unreal', with toxic undercurrents of blame. Psychological terminology may unnecessarily pathologise, or imply judgement – 'functional overlay', for example, lingering still in paediatric if not psychiatric circles, hinting at deliberate intent.

Psychological attribution needs supportive evidence, as physical attribution does. Imposing hypotheses which require rewriting of young peoples' understanding of themselves and relationships is risky. Incomprehensible formulations hazardously confuse developing identity, and leave them impotent to recover. CAMHS professionals rarely present on first encounter formulations with far-reaching implications – that symptoms are volitional or induced, for example. Similar circumspection is warranted for paediatricians, mindful of the harm if incorrect.

MINDING GAPS

Knowledge gaps are fraught with risk – particularly, disquietingly, unrecognised gaps. Professional approaches can encourage us to overlook when we do not know, so imposing assumption.[18] Gaps readily become obscured in an illusion of certainty generated by, for example, diagnostic labels and care pathways; many are papered over with psychological attribution by default when illness is not understood – an ironic product of a scientific era (box 5). Harm may arise through failing

Box 5 Risk in knowledge gaps

- J became progressively unwell aged 16, with dizziness on standing, polydypsia, palpitations, chest pains, insomnia, fatigue, weakness, nausea and weight loss. One doctor screwed up his lengthy list of symptoms and threw it in the bin saying it was 'chronic fatigue'. Another asked if it was 'girl problems'. At age 18 tilt table testing demonstrated postural orthostatic tachycardia syndrome (POTS), resulting in a programme of treatment involving medication and physiotherapy.
- He commented: "I know for sure that with time and effort the physical symptoms of my condition, POTS, will subside. I am equally convinced however, that avoidable psychological issues will stay with me for the rest of my life. Most of these have resulted from my experiences with often patronising, unsympathetic and cruel medical professionals. The constant dismissal of my symptoms, attributing them not to a physical cause, but to depression, despite my protestations, left me doubting myself to the point where I 'accepted' that I wasn't ill. Even months after a positive and incontrovertible diagnosis, I still often think that I am not really unwell, but that it is 'all in my head'. I don't think I will ever regain the self-confidence, or trust in the health service." His mother commented that she felt herself to be blamed, and described relief when he reached 18 "because they couldn't take him away".

to notice young people's personality and attitude, and through overlooking the dangers of misjudgement. It comes from wrongly assuming that there is secondary gain – for example that attention from illness is 'needed' – without checking the plausibility of such a suggestion or considering whether or not there are risk factors [particularly vulnerable attachment] to support it.[4] It comes from underestimating the trauma of misplaced accusation – if, for example, poorly understood illness prompts suggestion of abuse – experienced, for example, by many of those labelled with 'severe ME'.[19]

Disregard of mechanism in so-called 'functional' illness generates a quagmire of misattribution, confusing and distorting developing identity and generating blame. Poorly understood illness can be conceptualised in different ways, but should make sense to young people. Harm comes from interpretation which, even if plausible, contradicts a young person's established narrative – the safest starting point if it allows appropriate care.

DIAGNOSTIC LABELS – HANDLE WITH CARE

Labels are not risk-free. When their origins, implications and limitations are forgotten harm, psychological or physical, can follow. In closing minds labels may close ears, encourage uncritical assumption and undermine trust.

'Diagnoses' readily become seen as circumscribed, concrete realties – sometimes legitimately, but not always. When they acquire status beyond their merits yet services are built around them in inflexible, predetermined care pathways, subcategories become lost to view, further submerged by statistical evidence if interpretation and application of research lose track of individual clinical detail. Those mislabelled, or unrepresentative subgroups, can be trapped in helpless limbo. Labels, rather than individual need, may determine treatment. For example, the timescales of rigid adherence to National Institute for Health and Clinical Excellence guidelines for ADHD may not always suit the priority of achieving a stable home for children in care whose symptoms are associated with unsatisfactory attachment. Pragmatism based on individual need may sometimes be the surer route to psychological safety.

Box 6 Risks in labels

F was adopted at age 5 because of severe emotional abuse. He had no speech, avoided eye contact, and had markedly delayed symbolic play and difficulty in regulating stress. He was hyperactive with very poor concentration. He was placed in an autism unit. His parents noticed that he was markedly hypervigilant to those around him; he would speak if he thought he was not observed and when playing with a child with normal speech. The assumptions and experiences relating to a diagnosis of autism appeared to contribute to holding him into an 'autistic' pattern of interaction; he interacted more effectively in sessions at a mainstream school.

Causation does not determine routes to recovery: psychological precipitants, like infective ones, may be long past, and resolved, and imposing psychotherapy may be as inappropriate as imposing antimicrobial treatment.

Labels sometimes unhelpfully locate the problem with the child, deflecting attention from the parent–child relationship which may be the key to recovery – a consideration, for example, in naming, rather than describing 'reactive attachment disorder' or 'ADHD' in the context of abuse.

Children may grow into diagnosis-related assumptions, the label becoming integral to their identity, shaping others' expectations and their own; children who, through early troubled care, are hypervigilant or lack self-esteem may be particularly prone to doing so (box 6).

Labels are not readily shed; their implications change with maturation. Labels acceptable for young children may be millstones at adolescence.

We should perhaps resist labelling simply because we can, rather considering advantages and disadvantages, immediate and future. For example, for some who could be labelled as having 'Asperger's syndrome', self-esteem may ultimately be better protected by emphasising their particular talent rather than defining them by abnormality.

HARM THROUGH SYSTEMS

Guidelines, targets and regulations designed to achieve physical safety may, in moulding practice more to the general than the individual, have a psychological price. Inflexibility, control and sameness alleviate anxiety but, as in obsessive compulsive disorder, may give a mere illusion of safety. Imposed systems discourage the thought and initiative needed for the consideration of individual detail on which psychological safety depends.

History and examination, the principle routes to individuality, have been devalued by 'objective' investigations and squeezed by pressure of time and discontinuity. With them go trust: we expect patients to trust us while hesitating to trust each other; we may somehow trust scientists' objectivity more than patients' testimony.

Regulation encourages quantifying. However, psychological harm is not readily quantified. An evidential approach masks the subtlety of individual variation and submerges subgroups. Psychological care is compromised if evidence determines

Box 7 Potential manifestations of iatrogenic psychological harm

Individual function
- Depression, anxiety
- Self-blame
- Poor self-esteem
- Lack of sense of control; helplessness
- Ill identity
- Fear of recovery
- Confused narrative

Relationships
- Over-dependency
- Excessive separation
- Damage to parent–child relationships; blame of parents; parental blame of the child
- Difficulty in establishing and maintaining peer relationships
- Dysfunctional peer relationships
- Parental anxiety

Illness behaviour
- Denial
- Non-compliance
- Exaggeration of symptoms
- 'Competitive' illness
- Attention-seeking through illness

Regulation and adjustment
- Post-traumatic stress disorder
- Attention deficit hyperactivity disorder
- Sleep problems
- Dysfunctional coping strategies (eg, substance abuse, self-harm)
- Control issues (eg, eating disorder, obsessional compulsive disorder)

Distancing from psychological support
- Perceived stigma
- Fear of misattribution
- Fear of loss of control

Professional experience
- Mutual mistrust between families and paediatricians
- Perceived defensiveness
- Delayed recovery

rather than serves practice, and vulnerable if it becomes a tool for rationing.

Specialisation has a cost. The greater the specialisation the greater the 'elephant in the dark' problem[20] – and the greater the discrepancy between what doctor and patient see. We do not expect to understand others' professional territory – a particular problem of mind–body separation. We assume more, while seeing less – a recipe for psychological harm.

MANIFESTATIONS OF IATROGENIC PSYCHOLOGICAL HARM

Manifestations of psychological iatrogenic harm are rarely unequivocally or specifically attributable, and then only by critically considering the wider picture. Iatrogenic harm may be one factor among many, on a spectrum merging with merely suboptimal care.

Harm is manifest, broadly, through difficulty in functioning effectively individually or through relationships, and in adjustment and regulation. There may be anxiety, distress and frank trauma (box 7).

Suboptimal psychological care may generate patterns whose origins are lost in time by becoming self-perpetuating, built in, for example, to 'anxious' relationships. Consequences may be misattributed to the illness or misread as supporting the incorrect hypothesis which generated them.

PREVENTING IATROGENIC PSYCHOLOGICAL HARM

> More than anything, self-complacency blocks the workmanship.[21]

Prevention of iatrogenic psychological harm needs to be pursued as rigorously as that of physical harm, despite the greater difficulty of certain recognition. To do so requires flexibility, pragmatism and trust rather more than regulation and external control. It means working with the unquantifiable, multifactorial and, often, indefinable, in a way which may seem anachronistic, valuing judgement, wisdom, intuition, and experience as much as evidence and regulation. It means relaxing control to emphasise principles more than absolutes.

It means applying evidence wisely, ensuring that it guides rather than determines practice, and working comfortably without evidence where there is none. It means acknowledging the importance of the conceptual as well as the evidential, recognising that wisdom applied without evidence may sometimes be safer than the converse.

Psychologically sensitive care means restoring the individual to the core of practice, ensuring that the patient, not the diagnosis, is the starting point. Seeing patients' individuality requires individuality in approach – listening with a genuine desire to hear, and valuing the detail of history and examination as though there were no investigations to be had. It requires self-reflection and humility as much as empathy, and remembering that fatigue, stress and haste are as bad for professional relationships as personal ones.

Psychological safety requires certain recognition of how much we do not know, realising how narrow the professional perspective is compared with that of the family, remembering the distortion of the snapshot view, and determinedly seeing through young people's eyes and those of their parents. It requires circumspection about how professional systems disguise and fill gaps. It requires recognition that we make assumptions, and why – sometimes correctly, often not – and remembering to test them out, not merely impose them. It means resisting using professional status to override patients' testimony, and recognising the importance of starting from their understanding. It means ensuring that those who fall in recognised or unrecognised knowledge gaps are as safe, psychologically and physically, as those whose conditions are understood.

It means adjusting and readjusting the focus – looking from the fine detail to the context of the wider picture and back again, checking each against the other. It means remembering how we can be blinkered by specialisation, and how we more readily see what we expect to see than what we do not understand. It means applying as much objectivity to the system itself as to its content. It means remembering the uncomfortable lesson of history, that our practice will be found wanting in time, and that children carry into their future the implications of our care.

To achieve psychological safety, training and service organisations need to ensure that mind and body are fully integral, both in individual practice and through seamless integration of paediatrics and CAMHS.

Training needs to equip paediatricians to consider how emotional development is achieved, how illness and professional

practice influence it, and how it should influence practice, to recognise how and when psychological harm is likely, and to understand how it may be manifest. It requires reading of the quality of parental attachment to be as much second nature as judging whether children are ill – a subconscious awareness as much as a conscious one – and understanding why it matters. It requires recognition that professional words and behaviour are potentially as toxic as therapeutic.

Preventing psychological harm means protecting the art and humanity of medicine as much as the science, and valuing those motivated by these. We need more science – but sometimes less.

In particular, it means remembering that psychological harm is a possibility, and happens.

POSTSCRIPT – A TOUCH OF IATROGENIC PSYCHOLOGICAL SELF-HARM?

How many private conversations bemoan the loss of a sense of being valued professionally, and of freedom, control over practice, trust and choice? Iatrogenic harm to the profession? Inattentive safeguarding? Pendula swing but may need to be nudged to do so.

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Iatrogenic psychological harm

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Notes