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APERCEVOIR: THE PEOPLE OF CHILD AND ADOLESCENT PSYCHIATRY

Dr. Peter Szatmari

Lind Grant-Oyeye

Until Oct 1st, 2021, Dr. Szatmari was Chief of the Child and Youth Mental Health Collaborative between Centre for Addiction and Mental Health, the Hospital for Sick Children, and the University of Toronto. He started his career working on the Ontario Child Health Study, the first epidemiological study of mental disorders in children and adolescents in North America. He has also worked in the areas of ADHD, disruptive behavior disorders, depressive disorders, anxiety, and impairment due to mental disorders. He is well known for his work in autism spectrum disorders and has made contributions to that field in diagnosis and classification, in genetics and in outcome studies. He holds Senior Scientist positions at both CAMH and the Hospital for Sick Children, more recently, as Director of the Cundill Centre for Child and Youth Depression, he has focused on improving mental health systems for youth and on the treatment of depression. He has over 400 publications in peer-reviewed journals and was recently elected as a Fellow of the Royal Society of Canada.

Dr. Lind Grant-Oyeye (LGO): Thank you very much for agreeing to this interview.
Dr. Peter Szatmari (PS): Not a problem. I am delighted to chat with you.

LGO: You were interviewed by JCACAP a few years ago, where you discussed various topics such as your family background.

PS: Yes, my unconventional family background. But maybe not that unusual for a generation that immigrated to Canada after the Second World War.

LGO: Fascinating, I would say, with the mention of your father being a spy for Britain during War and other aspects of your heritage.

PS: Yes, that was certainly interesting. Not quite Le Care, but close.

LGO: The interview provided some insight into your work life and personal background. What can you tell us about your other interests? For example, what do you do for leisure?

PS: Well, I have three wonderful grown-up children. I have one delightful, charming grandson. I love to spend time with them. I love to go walking in the woods. We have a cottage, and we go regularly, every weekend. I go for a hike every weekend and listen to the BBC.

LGO: Can you tell us what about the BBC, you like specifically?

PS: I just love the BBC. I do not know what it is, but I listen to BBC 3, all the musical programs and the English accents and whatever. Basically, you know, in many ways, I am an anglophile. There is something about England between the wars that fascinates me. When I listen to the BBC, I imagine I am in London in the 1930's.

LGO: You mentioned listening to music on the radio. What genre of music do you enjoy?

PS: I listen to jazz a fair bit and Classical music. I rediscovered the pleasures of vinyl at Christmas with a lovely Christmas present, a gramophone. Remember those? I dug out my old vinyl records, which still sound pretty good. Listening to my old records has given me a lot of pleasure as well as a re-boot of nostalgia.

LGO: Vinyl records seem to have become popular in the last few years, especially with youth. Speaking of British culture, Tea, or Coffee?

PS: It is interesting, that my wife is totally tea, but I am totally coffee.

LGO: Can you tell us more about your relationship with the United Kingdom, for example, any previous visits?

PS: A professor of child psychiatry, David Taylor, from Oxford, came to McMaster when I was a resident, and I did my six months of child psychiatry training with him. I was enthralled with him and enjoyed being with David so much that I decided to do the last year of my training in the United Kingdom. It was an amazing experience. Sadly, Prof Taylor died last March which was very sad. Michael Rutter (another giant in our field and a colleague of David's also died last year. We lost two major figures in our field within months of each other.

LGO: I am sorry to hear about your loss.

PS: It is the end of an era. Thank you.

LGO: Speaking of changes, I gather you are stepping down or retiring from your current position. What is the situation?

PS: Retiring is not in my vocabulary yet. I am stepping away from my current leadership positions and focusing on a different kind of activity for this next stage of my career. For the last nine years, I was the Chief of the Child and Youth Mental Health Collaborative. This was a unique opportunity in Toronto, to be the Chief of Psychiatry at SickKids, the Chief of Child and Youth Psychiatry at the Centre for Addiction and Mental Health and Head of the Division of Child and Youth Mental Health at the University of Toronto. It was a high intensity job, with lots of commitments, an opportunity to make a difference. And as of October 1, I stepped away from that to focus on the different research activities that I'm engaged in, as well as to be the Director of the Cundill Center for Child and Youth depression at CAMH. I am very focused on using evidence to try and change the mental health system for children and youth.

LGO: Regarding evidence-based medicine and research, it is noteworthy that you have undertaken extensive work in the area of autism spectrum disorder. What recent changes have you noticed in the field?

PS: Well, if you will allow me to go back to 1980 when I was working at –Chedoke Child and Family Centre. There was not a single child at that facility that had a diagnosis of autism in 1980. It was considered a rare disorder. Not a single child at an academic, child psychiatry developmental pediatrics center. At that time, we were just starting to learn about diagnostic criteria (I know it's hard to believe). DSM III had just been published. And the criteria for autism were very narrow and restrictive.

And then I was referred a youth whom I could not figure out. In the end, I determined that he had autism, but it was a very different presentation from what was described in DSM III. That got me interested in the more subtle forms of autism and the overlap with traditional mental health disorders like ADHD and anxiety.

Overtime, we have seen an unbelievable explosion in research into what autism spectrum disorder looks like, what causes it, how to manage it, and what is the range of important comorbidities. If I look back on my research career with autism, I see that I have really been preoccupied with one question, and one question only, and that is to describe the heterogeneity and the diversity within autism; that is, heterogeneity within the person with autism at a particular point in time and over time, and heterogeneity between individuals with autism. So, intra-person heterogeneity and between person heterogeneity and what accounts for that heterogeneity, and how do you treat it, what is modifiable?

Although progress is not a word used often, I think we certainly have made progress in many areas including understanding etiology, but in particular, knowing how to treat and manage autism. I think probably a key change has been the concept of 'neurodiversity'; to not necessarily think of autism as a disorder, unless like other mental health conditions, there's distress and impairment. If there is distress and impairment, then you can think of it as a disorder, but one should not automatically assume that autism is a disorder that needs treatment.

I think another important change is that folks are now taking a strengths-based approach to treatment planning. The history of autism has been solely focused on treating deficits and delays. I think a strengths-based approach to autism, thinking of the strengths and talents that people have, has been a major and very welcome change.

LGO: You also discussed your training experience in the previous interview. Are there any changes you foresee in the future?

PS: When I was at McMaster, we were the only problem-based medical school in the world. I see more and more medical schools adopting the problem-based approach, which I think is the right way to go. I would love to see problem-based learning extended to post-graduate education as well. There are some developments in this area but not so much in Canada. We must treat child psychiatry residents as adult learners and not the passive recipients of

information. The challenge will be how do we balance the welcome expansion in medical knowledge, with the limited time there is available and not burden residents so that they burn out in their learning endeavors?

Another thing I want to say is, we still have not incorporated public health and the social determinants of health sufficiently into the medical school and post-graduate curriculum. Public health (which includes mental health) is really the foundation to making significant changes to the health of the population. I think the pandemic has shown that we ignore public health and the social determinants of health at our peril.

LGO: On reflection**,** what other career pathways would you have considered other than medicine?

PS: Well, as you know from the previous interview, there was no alternative to psychiatry. So, if I had not gone into psychiatry, I would have gone into psychology. During my undergraduate degree, I did a lot of philosophy courses. Maybe I would have gone into philosophy, but my secret ambition would have been to be a writer.

LGO: Do you mean to non-academic writing?

PS: I have written two books, one on autism and one with my friend and colleague, Pier Bryden, on general child and youth mental health. In a sense, these books are structured as stories. In these books, we tell stories, stories about kids, kids with autism, kids with anxiety, depression, ADHD and so on. We tell stories and then use the empirical evidence to illustrate to parents, how to cope with these mental health conditions.

I think story telling is an important part of child and adolescent psychiatry. One of the reasons I love our field is because basically the clinical work is storytelling. We listen to stories. We listen to children's biographies. We listen to oral memoirs, and we translate it back to families and hopefully, they can now make sense of what is happening to their kids. Storytelling is an important, but neglected, part of our profession. I think it needs to be done properly, of course, because it is nonfiction. I call it evidence-based stories, but I don't know if that's quite the right term.

LGO: That is a great perspective, understanding child and adolescent psychiatry as bringing meaning to a narrative. Given the wealth of experience and knowledge you have acquired, I wouldn't want to call it regret, but is there something you wished you had done differently in your career?

PS: You can use the word regret. I have many regrets over my career. Let me give you one example. As I mentioned I started my career in Hamilton at the Chedoke Child and Family Center. That hospital was originally a tuberculosis Sanitarium, for both young people and adults with tuberculosis. I recollect that there was a cabinet full of the most amazing Inuit sculptures in the lobby of the hospital. I always wondered where that art came from. Remarkable Inuit sculptures in a hospital in southern Ontario? How did that come to pass? I also saw photographs of both Inuit children and adults who were patients at Chedoke, because they had tuberculosis. What that means is that Inuit children who had tuberculosis were taken out of their local communities, flown hundreds and 1000s of miles south to an industrial city, Hamilton, and placed in hospital. The Inuit adults spent time making these amazing sculptures and presumably gave them to the hospital.

To me, that is an example of the 'scoop' phenomena that happened later with Indigenous and First Nations children. I never truly appreciated the impact of our health system on Indigenous children, but it was there, in front of me in the foyer of a hospital. I should have thought more deeply about what those beautiful sculptures meant. What did those photographs of Inuit children and adults mean? How were those sculptures made? Who were those children? How did they get there? How did they feel at nighttime, as the lights went out, and they were put to sleep without their parents, without their local community? They tried to build a culture in the hospital that reminded them of their Inuit community. That was an example of medical colonization that I never thought enough about, and I regret that.

LGO: From your statement, I hear you advocate for deeper reflections in practice.

PS: I think reflection about our field is essential. We cannot repeat the mistakes of the past, which are many in child psychiatry. We must think not just about the patient in front of you, but the entire population of kids with mental health challenges who are not in some form of treatment. We need to think about, again, about the social determinants of health and I really do welcome the focus on equity, diversity, and inclusion in the last couple of years. We have a lot to do to right those historical wrongs.

LGO: Now, to the desert Island question, who and what would to a dessert island? You are allowed three.

PS: My desert island? Well for sure my wife

LGO: If you wish.

PS: I would not go anywhere without her, then I would take my camping equipment. I would make sure that I had my coffee maker and a Therma rest for my nice warm sleeping bag. Then I would take my iPhone, so I could listen to BBC 3. I would also take a book (an English novel from between the wars?). Okay, that's more than three!

At my age, I think I am allowed more.

LGO: For your service, you have certainly earned more.

LGO: What would you like your legacy to be, years from now?

PS: It is nice of you to think I might have a legacy. Well, any legacy I might have is not an idea, nor a set of research finding because ideas and research findings have a very short half-life. If there is any legacy it will be the wonderful people that I might have influenced, even in a small way, over the course of their personal or professional career. I have been so lucky to work with many wonderful people both young and old. I have had amazing mentors in my life. Some of the most incredible people in health care in Canada and internationally. I have tried to be a support and a mentor to many people, as well, in turn. If anything, I hope that will be my legacy; to help people to see clinical care, teaching and research as instruments of social justice for kids.

LGO: Thank you once again for the interview. Do you have any nuggets of wisdom for the upcoming generation of child and adolescent psychiatrists?

PS: My advice is, do not accept the current wisdom. Always ask questions. Always probe and inquire, take the time to do so. Do not get crushed by the demand of clinical services. There is such a temptation to just put your nose to the grindstone and work through a case load. We need to encourage trainees at every clinical encounter, to ask, what is the one thing about this child that I don't know? What is the one question I need to ask and answer to improve this kid's quality of life? For every clinical encounter, there's a question there that needs to be addressed. We need to be able to take the time to think about what that question is, articulate it properly, and go and find the evidence for that question (if it exists) and then apply the evidence to that patient to make sure that we are practicing in a critical and reflective way.

LGO: Thank you once again. JCACAP wishes you all the best.