

Paediatrics in child and adolescent psychiatric training

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The experience of a paediatric placement is described. Difficulties encountered mirror those experienced in liaison child psychiatry and the basis for this is discussed. Early collaboration during specialist training of paediatricians and child psychiatrists can enhance the working relationships between the disciplines and the clinical skills of both.

In the past many child psychiatrists would have come to child psychiatry through paediatrics, but more recently there has been a trend towards early specialisation so that previous experience in paediatrics is less common.

The Joint Committee on Higher Psychiatric Training (JCHPT) recommends "It is desirable that trainees with no experience in paediatrics are able to obtain this during their higher training". The benefits of paediatric experience towards training in child psychiatry have been discussed (Duke, 1994; Hill *et al.*, 1992).

My interest in undertaking paediatric training arose from a placement in liaison child psychiatry. I was aware of my limited experience in paediatrics and puzzled by problems encountered in collaborating with paediatricians, in particular around the consultative process. At times we appeared to speak different languages. Thus in my third year of higher training in child and adolescent psychiatry, I undertook formal training in Paediatrics in the Paediatric Department of University College Hospital Galway, Ireland. This is a regional unit serving Co. Galway, and is a tertiary referral centre for Counties Mayo and Roscommon. It has a catchment area population of 343 000 with 3200 admissions per year.

Description of placement

The paediatric placement was two days per week for five months. In consultation with the paediatricians and Clinical Director in Child Psychiatry, Monday and Thursday were organised as this offered a wide range of paediatric experience relevant to child psychiatry and which incorporated formal teaching sessions.

The placement included one speciality clinic per week, which provided out-patient care for children with asthma, diabetes and cystic fibrosis. There was one clinic for children with physical and mental disabilities on alternate weeks, and one general paediatric out-patient clinic per week. During out-patients I became a member of the paediatric team providing paediatric care for these children. Alongside my paediatric colleagues I would select a patient's chart in rotation, see the child and their parents and assess physical well-being and manage treatment. Each case was supervised by a consultant paediatrician. In the general out-patients a wide variety of problems were encountered including recurrent urinary tract infections, muscular dystrophy, enuresis and ecopresis. During the speciality clinics the focus was on monitoring the child's condition and treatment, preventing complications and promoting a normal childhood lifestyle.

The physical and mental disability clinic involved ongoing developmental assessment of children, support for their parents and contact with community physical and mental disability multidisciplinary teams. A considerable variety of conditions were encountered, for example cerebral palsy and more unusual conditions such as Angelman's syndrome. I attended in-patient ward rounds and teaching sessions which included case conferences, journal clubs and tutorials. This provided instruction and supervision of the physical and developmental examination of children, discussion of illness and ongoing management of problems as diverse as febrile convulsions and non-organic failure to thrive. The overall placement was supervised by the Clinical Director in Child Psychiatry.

The presence of a child psychiatrist on ward rounds facilitated referral to child and adolescent mental health service for some children and their parents. For others, due to parental resistance to referral, it was difficult to make the link between paediatrics and child psychiatry and referral could not be negotiated.

In the out-patient clinics it was pleasantly surprising how resilient many children and their

parents were in the face of chronic, sometimes life-threatening illnesses, and how committed they were to often complex and rigorous treatment regimes. The child and family oriented approach to problems adopted by paediatricians was impressive, and it was intriguing to encounter with such frequency problems similar to those seen in child psychiatry, for example enuresis, encopresis, social problems and behavioural problems. However, the time constraints of the clinic, which required a focus on a narrow range of issues with each child and their parents, allowed little time for exploring the psychosocial aspects of problems.

To enhance the experience base, I elected to take the Diploma in Child Health (DCH) examination, University College Dublin, with my trainee paediatric colleagues. This examination has a broad theoretical and practical base covering child psychiatry, public health medicine, epidemiology, normal child development, paediatric medicine and surgery and infectious diseases, and is a general professional qualification. This formal grounding in child development, developmental assessments and paediatric medicine has been an invaluable adjunct to my training and has added another dimension to my skills as a child psychiatrist. The experience has significantly influenced work with pre-school children and highlighted the importance of developmental assessment as part of a comprehensive psychiatric evaluation. Greater attention is paid to the evaluation of hearing, speech and language, social and emotional development, vision and fine motor skills, and gross motor skills. Paediatric training has provided a structured approach to developmental assessments and a comprehensive framework for assessing and managing developmental delays and disorders.

The placement has highlighted my awareness of the value of taking a developmental approach to children and their parents and explaining problems and behaviour to them in a manner that takes into account the developmental level of the child.

The personal experience of moving to a paediatric unit from a base in child psychiatry was akin to being separated from a parent. There was initial 'protest' with disorientation of role and doubts about the project, followed by 'despair', due to a sense of deskilling and attempts to adapt to and integrate a different model of working while trying to hold onto one's personal identity. It was sobering to realise how my clinical skills and knowledge of medicine had decayed over time. Despair was confounded by the need to integrate rapidly the 'surgical sieve' model of symptom identification and differential diagnosis in preparation for the DCH exam which loomed on the horizon. 'Denial' was a

useful temporary defence to the emotional response during this time and it was certainly comforting to return to the 'secure base' of the child guidance clinic three days a week.

Comment

This 'separation' experience brings into focus the potential there is for confusion and misunderstanding when child psychiatrists and paediatricians attempt to collaborate. There is a conflict of models, the psychological understanding of children's behaviour requires a perspective on time, an appreciation that there is no quick answer and a tolerance for ambiguity that are foreign to the 'action orientation' of most paediatricians (Anders *et al*, 1982).

Successful collaboration requires a recognition and understanding of the different models and the finding of some common language. I would suggest joint training of paediatricians and child psychiatrists as one way of addressing this gap. The issue of joint training is pertinent to child psychiatry in Ireland. Several recent consultant appointments in child psychiatry have included a commitment to a paediatric hospital, or paediatric wards in general hospitals, with the intention of developing child psychiatry liaison services.

The paediatric literature in the US, Australia and the UK suggest that paediatricians are seeing less organic disease and more problems described as the 'new morbidity' (Haggerty, 1974; Oberklaid, 1988). This new morbidity includes learning and school problems, behaviour/hyperactivity problems, enuresis and encopresis, headache and abdominal pain, adolescent problems, developmental disorders, child at risk and parent/family counselling. It is estimated that 28% of children aged 7–12 years referred to general paediatric clinics have some form of psychiatric disturbance (Garraalda & Bailey, 1989).

A recent British Paediatric Association survey of newly appointed consultants bemoans the lack of training in the less disease-orientated areas of paediatrics such as child psychiatry, and identified this as an area that many consultant paediatricians felt their training ill prepared them to cope with (Lenton *et al*, 1994). Thus joint training of paediatricians and child psychiatrists would be of value to both professions and in particular to those involved in paediatric liaison child psychiatry.

I propose joint training to take place at registrar/senior registrar level as part of specialist registrar training. At this stage career choices have been made, individuals are highly motivated, creative and innovative and aware of issues such as service provision and development. Most higher training schemes have provi-

sion for training in related specialities, so it is generally possible to facilitate the interested trainee.

I would suggest block placements in child psychiatry or paediatrics for several months, and involvement of trainees in teaching sessions and promotion of joint child psychiatry/paediatrics research projects to facilitate the collaborative process.

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