Current topic**Training of paediatricians for psychosocial aspects of their work**

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It is clear that an enormous amount of child psychiatry is done in settings other than child guidance clinics and departments of child psychiatry, and is done by people whose basic training is not psychiatric. It is often said that up to 50% of adult general practitioners (GP) consultations are for psychosocial problems, most of which will be handled by the primary care team. The percentage of GP consultations for children for psychosocial reasons is lower, but still substantial,¹ and most of these children will not be referred to a child psychiatrist. In the United States, a study of 166 398 visits to primary care paediatric facilities found psychosomatic diagnoses in 8 to 10% of attendances, while social, behavioural, or educational problems accounted for 5 to 15% of visits.²

Most paediatricians recognise that around one third of their outpatient referrals will be for predominantly emotional or behavioural problems, and that these too will be a major consideration on their wards. The management of child abuse and other disorders of parent/child interaction will also constitute an appreciable part of their work. It is, of course, increasingly well recognised that any chronic illness carries with it psychosocial implications.

Recent research into the work of district handicap teams has found that around 50% of children with chronic handicaps of all types have additional behaviour problems or psychiatric disturbance requiring treatment. Other epidemiological studies of normal populations show the extent of the problem; a study of three year olds in Waltham Forest³ found that a substantial number of children had behaviour problems and two thirds of these still showed problems five years later, while Jenkins *et al*⁴ also found behaviour problems among preschool children in inner London to be at least as common as physical health problems at most ages. In the Isle of Wight study, Rutter and colleagues found high rates

of psychiatric disorder; additionally, those children with a physical disorder, such as asthma, had twice the rate of psychiatric disorder as the general population of 11 year olds. Rates among children of this age with epilepsy or neurological disorder were four times those of the general population.⁵ For some time school doctors have been concerned with the number of children referred to them for predominantly behavioural and emotional problems, and again this is borne out by epidemiological studies such as that by Bax and Whitmore.⁶

Clearly, the child psychiatry services can only meet the needs of a small proportion of these children, and we must acknowledge that most of these children will be seen and, we hope, helped by non-psychiatrists in a variety of settings. These will range from community settings of child health clinics, day nurseries, GP surgeries, and schools to the children's wards and outpatient departments of hospitals.

Skills

It follows that some of the skills of the child psychiatrist should be taught to those, such as paediatricians, who spend considerable time dealing with the psychosocial needs of children and their families.

The first skill to learn is that of taking an adequate history to include psychosocial factors. This is not always easy where there are time constraints, as in outpatient clinics, but where relevant, time must be made. The history taking should be as systematic as it would be for an obviously organic complaint, such as haematuria. Paediatricians may find difficulty in probing for evidence of psychological disturbance when a child presents with a physical complaint, and may be helped by learning techniques for eliciting this information without being intrusive. Inquiring about the reasons which prompted referral at this

particular time, and who is chiefly concerned about the child's symptoms may produce illuminating responses. It will often be appropriate to interview the parents without the child, and vice versa. The ability to talk to children of different ages, with or without their parents, without feeling uneasy has to be learnt, as has the ability to confront parents with suspicions of child abuse.

Where it is evident that psychosocial rather than organic problems are predominant, the paediatrician is responsible for first line management and should be confident in this role, knowing when to involve appropriately other members of the team such as the social worker or psychologist. Management skills should usefully include simple behavioural techniques which have for a long time been used in the management of enuresis, but more recently have been shown to be effective in other situations such as sleep disturbance in young children.

Counselling skills are clearly important: the paediatrician will often be the first to have to break bad news to the family after the birth of a handicapped child, or the diagnosis of leukaemia. The way in which this situation is handled is known to have long term implications for the family and child. Counselling and the recognition of a family's capacity for coping with chronic stress is a part of the continuing management of any child with chronic illness or handicap and should not necessarily be delegated to a social worker.

A knowledge of family dynamics and ability to recognise deviations which may be harmful is clearly relevant.⁷ For example, a paediatrician should be able to recognise confidently a situation in which the mother and daughter are over close, to the exclusion of the father. Perhaps only a minority of paediatricians will want to acquire family therapy skills themselves, but the recognition of which families might be helped by these skills should be a part of every paediatrician's expertise.

Good paediatric management has always included referring a child for specialist help where appropriate. It is usually clear when a paediatric neurologist should be consulted over a child's deteriorating neurological signs, but not perhaps as easy to decide when to refer to a child psychiatrist. The decision is certainly easier where a psychiatrist is part of the paediatric team. Some guidelines on the 'who, when, and how' to refer to the child psychiatrist were recently given in *Archives*⁸ and need to be considered in view of the high failure rate in attendance for psychiatric consultations. As pointed out in that article, this may reflect the uncertainty of the referrer as much as the unwillingness of the family to accept that there are specialist skills on offer.

Training

Attitudes towards psychosocial aspects of paediatric care are first formed in the preclinical years. As a first requirement for training in this area of work, undergraduates should be exposed to paediatric clinical care in which the quality of psychosocial management is high. Concern for parental anxieties should be obvious in both inpatient and outpatient work. A discussion of the clinical signs of Down's syndrome should, for example, always be accompanied by consideration of the particular pattern of psychological development, schooling needs, and ways in which parents can be helped to cope. Those marking paediatric questions in qualifying medical examinations should give credit for attention to these aspects of care.

Sensitivity to psychosocial issues often seems to be lost at paediatric house officer level. This may be because the pace of work and degree of anxiety experienced are so great that young doctors feel they have to concentrate on what they regard as the essentials of practice. It should be the responsibility of consultants to ensure that high quality psychosocial care is seen to be an essential component of practice. The consultant can do this by always showing interest in parental background, attitudes, and coping styles. Where psychological and social factors may be important in the aetiology of a condition (for example, encopresis, asthma, or atypical pain) the consultant should show similar concern to determine the mechanisms involved as if the causation were physical.

As in other areas of paediatrics, training of junior staff should consist primarily in the acquisition of those clinical skills necessary for satisfactory assessment and management. Junior staff should have the opportunity of observing the consultant interviewing parents and children, separately and together. Interviewing methods should be discussed as well as the ways family members respond and behave. If at all possible, junior staff should also have their interviewing techniques directly observed, or at least discussed at second hand. A consultant who asks 'How *exactly* did you put it when you asked the mother how she dealt with the soiling?' is appraising a diagnostic skill to the same degree as if he were asking how *exactly* a lumbar puncture was conducted, or an intravenous line inserted.

The management of conditions without organic cause or with a considerable psychosocial contribution should also be frequently discussed in relation to both inpatients and outpatients. Junior staff are likely to be allocated new outpatients of this type. It is often tempting to see the medical task as beginning and ending with the exclusion of serious

organic disease. Supervision of the work of junior staff is necessary to ensure that parents do not go away with a confused impression that they have a disabled child who has 'nothing wrong with him'. The impression is sometimes given that while paediatric management of organic problems is a matter in which technical competence requiring careful training is necessary, the management of non-organic problems is a question of personal style in which the trainee has to find his or her own way.

The paediatrician in training will also need education in working with members of other disciplines dealing with the psychosocial aspects of the care of children and families. These include social workers, psychologists, psychiatrists, teachers in ordinary and special schools, GPs, and health visitors. Skills involved in multidisciplinary work can be acquired by attendance at case conferences and interdisciplinary courses. Cases of child abuse provide particularly valuable experience in this respect. The checking of letters written by junior staff to colleagues in other disciplines can also serve an educational purpose. All paediatric staff should, of course, spend some time visiting facilities in the community such as special schools and children's homes, preferably to discuss with staff the care of children with whom they are medically concerned. It is highly desirable for junior paediatric staff to spend part of their training attached to child psychiatry departments.

Organisation of paediatric care

The future system of delivery of secondary paediatric care is likely to involve closely integrated hospital and community paediatric as well as child psychiatric services, all of which will be consultant led. The main facilities of the hospital consultant service will continue to be the inpatient and outpatient units. Community services will centre on a district handicap unit from which a number of other disciplines (speech therapy, physiotherapy, clinical psychology, etc) will operate. The child and family psychiatric service will also be at least partly based in the district general hospital. The delivery of high quality psychosocial care for children presenting to the paediatrician with physical illness or with physical symptoms of wholly or partly non-organic origin will call for close planning and coordination between these various services. There is likely to be a more effective voice for children if these disciplines combine to form a paediatric division within the 'Cogwheel system'.

It is important that in each of the components of paediatric secondary care (inpatient unit, outpatient department, district handicap unit, and child psychiatric unit) opportunity exists for sharing informa-

tion and skills, and for ensuring that methods of assessment and management appropriate to a child's needs are available. The regular psychosocial ward meeting,⁹ the ready availability of social work help in outpatients, the presence of a psychiatrist as a member of the staff of a district handicap unit, and attachments of paediatricians in training to child psychiatric units are four mechanisms for ensuring this occurs. Large meetings are expensive and sometimes uneconomical. At an inpatient meeting, for example, it may well be sufficient for there to be just one representative of the community paediatric and child psychiatric services. This representative should, however, be well informed about the other skills available in the unit he or she represents.

Research

There is now enough established knowledge on methods of assessment, behavioural management, and counselling techniques to ensure that sensitive and, at least sometimes, effective assessment and management of psychosocial aspects of paediatric care can be achieved. But there remain considerable gaps in knowledge. There is a lack of an adequate nosology enabling classification of physical symptoms of non-organic origin. The psychophysiological basis of these symptoms has not been adequately investigated. There has been little proper establishment of standardised assessment techniques useful in this aspect of paediatric care. Although a number of management techniques derived from psychodynamic, family, and behavioural theory do seem to have at least limited effectiveness^{10 11} others have been little subject to scientifically satisfactory evaluation. A considerable research effort therefore needs to be mounted to investigate conditions which, as stated previously, take up perhaps a third of a paediatrician's time. This is a subject which lends itself to small scale investigation as well as to more intensive studies, and some junior staff should be encouraged to undertake projects in the field. The research techniques involved are no less demanding scientifically than investigations into organic aspects of care. The exercise would be of considerable value to those undertaking them, and might perhaps lead to considerable advances in knowledge.

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Comment

Children's doctors and children's teachers share a common cause

The relationship between paediatricians and teachers might be described as cordial but not close, but there are those who think it should be closer. (A similar gap exists between their salaries with a secondary school head of department earning about half of a NHS consultant on the top incremental points). Doctors who are wearied by the three health service reorganisations in the past decade might consider themselves fortunate after reading a book¹ by Dr Harry Judge of the Department of Educational Studies at the University of Oxford. In a partly autobiographical tale he describes the upheavals secondary education has faced since the end of the war; teachers have had to deal with secular changes, such as the variation in pupil numbers with the postwar bulge, on a much greater scale than paediatricians. Teachers are fair game for the armchair critic who always knows how (and what) they should teach, a belief perhaps shared by education ministers whose decisions have sometimes owed more to political whim rather than sober planning and strategy. How would doctors tolerate such interference?

Education, health, and a secure family life are the most important influences that a civilised society can offer children. (One might argue that such a society would be better judged by the quality of education offered to its less able members rather than to their more intelligent peers). A recent article² in *The Times* suggested that society was not meeting these responsibilities—particularly because of changes (and some would say deterioration) in the pattern of family life and personal relationships. It concluded that 'over the last 10 years the position for all children has got worse. Children simply count for less in British Society than they did'. Paediatricians have traditionally allied with parents to press for the best in health services for children; it is hoped that consultant paediatricians, especially those working in community child health, will develop similar links with teachers in the sphere of educational medicine. And is it not now time that the professional associations of paediatricians and teachers joined forces to campaign for the best in health and education for our children?

¹ Judge H. *A generation of schooling*. Oxford: Oxford University Press, 1984.

² Moorhead C. Our children under siege. *The Times*. 1984 December 18.