Child psychiatry and the undergraduate

A recent survey of undergraduate teaching in child and adolescent psychiatry raised several points, among them the question of what paediatricians might expect from undergraduate training in this branch of children's medicine.¹ It is generally accepted that the overall prevalence of childhood psychiatric disorder lies between 7% to 14% with the higher rates obtaining in areas of greater social disadvantage.² Children with such disadvantaged backgrounds are common in paediatric clinics so it is perhaps not surprising that Fitzgerald found that 44% of 7–11 year olds attending paediatric surgical outpatients and 25% attending paediatric medical outpatients showed 'considerable behavioural deviance'.³ Garralda and Bailey identified 23% of 7–12 year olds attending general practice as having psychiatric disorders.⁴ In a subsample of this group psychiatric disorder seemed a relevant factor contributing to somatic consultations.

These figures suggest that it would be reasonable for paediatric trainees to expect a thorough grounding in child and adolescent psychiatry to deal with their immediate paediatric workload or to equip them for a future general practice workload, and in fact some senior house officers in paediatrics are undertaking vocational training for general practice. Postgraduate experience in child and adolescent psychiatry is recognised as being an important component in training in adult psychiatry,⁵ but it is difficult for trainees in paediatrics to obtain such training as virtually all senior house officer and registrar posts in child and adolescent psychiatry are now integrated into rotational training schemes in psychiatry. Adequate undergraduate training is thus essential.

On average, only 20 hours of teaching time is available for teaching of child and adolescent psychiatry.¹ Of 28 medical schools surveyed 10 had very little or no teaching of child and adolescent psychiatry when the students were with the paediatric firm. None of these schools had teaching aims for child and adolescent psychiatry that would be relevant to paediatrics. Of the other 18 schools (where some child and adolescent psychiatry was taught within paediatrics) only six made any reference to joint teaching with paediatricians and only eight cited teaching aims relevant to paediatrics—for example, understanding the impact of illness on a child, provision of treatment skills for future paediatricians, and breaking bad news to parents. It

seems unlikely that undergraduates will receive paediatrically orientated psychiatry teaching unless this occurs within the paediatric firm and even then not all schools will provide such teaching. Is this something to be concerned about? What aspects of such teaching would be relevant to future paediatricians? We suggest the following:

- (i) Specific training in how to interview children and whole families.
- (ii) Recognition and diagnosis of specific childhood psychiatric disorders.
- (iii) Recognition of specific aetiological factors that may be influencing the presentation, course, or compliance with treatment of paediatric disease such as childhood psychiatric disorder; family influences (marital discord, inconsistent discipline); social influences (school and neighbourhood); individual characteristics of the child (temperament, intelligence, social and emotional development); psychiatric disorder in parents.
- (iv) Understanding of the interplay between psychosocial factors and physical factors in paediatric disease.
- (v) Knowledge of the pattern of services available for children with psychiatric disorder.
- (vi) Provision of management skills for dealing with common behaviour problems (tantrums, eating and sleeping problems, elimination problems) either directly or indirectly via treatment recommendations to referring general practitioners.

There are other advantages accruing from a close relation between the teaching of paediatrics and child and adolescent psychiatry. Joint teaching exposes each specialty to the other and encourages good liaison if clinical as well as theoretical teaching is carried out together. In this way such undergraduate teaching can become a component of the postgraduate training of paediatricians in child psychiatry as well as the postgraduate training of child psychiatrists in paediatrics. At Queen Mary's Hospital for Children, Carshalton, where St George's students are routinely taught in this way, there are frequent comments in the students' feedback about the value of seeing such a close

working/teaching relation. There is a dearth of research evidence concerning the psychological problems that actually present to routine paediatric clinics and wards—a closer relationship between the two specialties would help rectify this lack of knowledge.

In summary, childhood psychiatric disorder is common but the teaching of child and adolescent psychiatry is patchy and its relevance to paediatrics not always recognised in the design of teaching programmes. Its value is more likely to be recognised where it is taught within the paediatric firm. Close liaison between paediatricians and child and adolescent psychiatrists about teaching aims, curriculum planning, and time allocation would be of benefit to both specialties. Child and adolescent psychiatry is a rather fragile specialty, which traditionally has had much of its clinical base placed away from acute medicine in the community. It needs the support and involvement of paediatricians if it is to deliver the training that paediatricians would expect for their junior staff.

References

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