*Trainees' Attitudes in Child Psychiatry**

By M. E. Garralda

Interest in the training of psychiatrists is not a new development in Great Britain (Lewis, 1964). Child psychiatry training has a more recent history (Warren, 1974). The RMPA in 1967 approved documents outlining principles and requirements for the training of child psychiatrists. The most recent guidelines were issued by the Joint Committee for Higher Psychiatric Training (JCHPT) in 1975. They advanced the principle that a variety of experience was a requirement of any training programme, and they detailed the types of clinical experience, supervision facilities and formal teaching occasions that should be available.

The RMPA recommended that specialization in child psychiatry should take place at the registrar and senior registrar levels. At present, there are in Great Britain provisions for about 100 senior registrars to pursue such training (communication by the JCHPT, 1979). The study reported here aimed at investigating trainees' attitudes towards the guidelines issued by the JCHPT, and the degree of satisfaction with the way these were being implemented.

Thirty senior registrars were selected to proportionately represent geographical areas where a training in child psychiatry was available. In January 1979, they were sent questionnaires covering background factors, such as length of medical and psychiatric experience, and requesting them to indicate, on a three-point scale, the importance they attached to different aspects of their training as issued in the JCHPT guidelines. They were also requested to report, again on a three-point scale, how adequate they thought their programmes were at providing those experiences.

The questionnaires were filled in and returned by 23 trainees (76 per cent), and the results reported below refer to the attitudes expressed by these respondents.

Most had been working in child psychiatry for over two years. Previous experience of over two years in general psychiatry was almost universal, and just over half had worked for at least six months in paediatrics. Most training programmes included hospital in-patient and out-patient work, consultation with other agencies, and opportunities for working in forensic and mental handicap settings.

Importance of training factors

The majority agreed with the importance of acquiring experience in the different aspects of training listed in the questionnaire. Over 80 per cent thought that it was important to gain variety of experience, and more specifically with neurotic and conduct disorders, conditions associated with physical illness, and developmental disorders. Learning disorders, psychoses and delinquency were slightly less popular (between 60 and 80 per cent), and only 39 per cent thought that experience with mental handicap was important.

Whereas this is in keeping with current psychiatric thinking and practice, the low interest expressed towards mental handicap calls for comment. The Court report (DHSS 1976) has made recommendations for increased involvement of child psychiatrists in this field; yet the results from the questionnaire suggest that future child psychiatrists themselves are not going to be enthusiastic supporters of the recommendations.

The importance attached to gaining experience with different treatment modalities ranged from family and psychodynamic therapies, with a positive response of over 80 per cent, in-patient treatment, behaviour therapy and consultation with other agencies (60 per cent to 80 per cent), down to counselling to parents, drug therapy and group treatment (less than 45 per cent).

Over and above this general eclecticism, the pre-eminence of dynamic and specially family therapy is interesting. Family therapy is a relative newcomer to the field of child psychiatry. Whether its popularity is related to its novelty, with the promise of efficacy that this implies, or whether it derives from a special, if surprisingly belatedly recognized, affinity with child psychiatry and its traditional emphasis on family function, is still difficult to judge. Whatever the reason, the attitudes expressed here would make it an area of priority in training.

Alongside of the interest shown in family therapy, the poor showing of drug therapy is noteworthy. Even if it is true that drugs have not been shown to have a particularly crucial part to play in child psychiatry, this is the one field of therapy in which medical practitioners, as opposed to non-medical colleagues also dealing with disturbed children, have a specific role. The low priority for the use of drugs is a matter worth investigating, as it could be argued that low interest might result in little use in cases where medication can in fact be a potent therapeutic ingredient. Perhaps more importantly, this may result in little research, with loss of possible effective means of relieving distress in children.

As would be expected, the importance attached to supervision with various treatment modalities closely paralleled the findings for clinical experience; and case conferences were the most popular teaching occasion, in preference to seminars and particularly to journal clubs.

Adequacy of training experience

Opinions on how adequate programmes were in providing training followed a similar pattern to those described

* This study was independently carried out by the author, and was in no way sponsored by official training bodies.

https://doi.org/10.1192/S0140078900012955 Published online by Cambridge University Press

for importance of experiences, although, not surprisingly, percentages expressing satisfaction were overall 10-20 points lower. The largest discrepancies between importance attached and judged adequacy were in two areas: firstly in the field of disorders associated with physical illness and developmental disorders; secondly in the area of learning disorders and behaviour therapy. It is interesting that these are two areas in which other professionals are most likely to be involved. The former two groups are often referred to paediatricians, and the latter have increasingly been regarded as falling within the expertise of psychologists. Nevertheless, because of the association of these disorders with psychiatric problems, the psychiatrist's contribution is important, and the acquisition of experience during training is necessary. It is an open question whether the present perceived inadequacy is due to low emphasis in training programmes, or whether it is connected to faulty interdisciplinary adjustment.

The study reported here was limited to a sample of trainees, and in order to improve on its validity a more comprehensive survey is now in progress. From the present study, it can be concluded that respondents are on the whole in agreement with current training guidelines, but for the benefit of training in child psychiatry areas have been identified which deserve further investigation.

ACKNOWLEDGEMENTS

Thanks are due to senior registrars for their patience and co-operation in completing the questionnaire.

REFERENCES

DEPARTMENT of HEALTH AND SOCIAL SECURITY (1976) *Fit for the Future—the Court Report*. Cmnd 6684, 2 volumes. London: HMSO.

LEWIS, A. J. (1964) Psychiatric education: background and history. In *Psychiatric Education* (eds D. L. Davies, M. Shepherd). London: Pitman Medical.

ROYAL MEDICO-PSYCHOLOGICAL ASSOCIATION, (1967). The training of child psychiatrists: a memorandum prepared by a subcommittee of the Child Psychiatry Section. *British Journal of Psychiatry*, **114**, 115-7.

THE JOINT COMMITTEE ON HIGHER PSYCHIATRIC TRAINING, (1975), First Report London: Royal College of Psychiatrists.

WARREN, W. (1974). Child Psychiatry and the Maudsley Hospital: An Historical Survey. Third Kenneth Cameron Memorial Lecture. London: The Maudsley Hospital.

M. E. GARRALDA
Senior Registrar

Maudsley Hospital,
Denmark Hill,
London SE5.

Correspondence

The Limits on Freedom

DEAR SIR,

Compulsory treatment is an emotional issue for the Press and members of the public, hazy about the law's safeguards and the real situations psychiatrists may face. Two recent cases make me think some of our members may be equally confused about the valid limits of permissiveness. A little open discussion of these limits may be useful, to see what others think.

A young student at the start of his career had three admissions in quick succession to different hospitals because of attacks of a psychotic illness with bizarre withdrawal, sudden violence, paranoid delusions and hallucinations. The second and third admissions were compulsory under Section 25. On the third he proved very difficult to control but eventually settled with regular injections of an intramuscular depot phenothiazine. He was discharged, attended out-patients regularly, and was able to resume his education while living at home. He had completed three terms, when his parents moved with him to another part of the country. Unfortunately his treatment faltered, and his symptoms began to return. He became paranoid, frightened his parents with aggressive outbursts, and wrote a letter threatening death to a former neighbour who had become involved in his delusions. He was seen by a local psychiatrist, who had information also from the patient's previous admissions, but decided he could do nothing because the patient himself said he did not want any further treatment. This left the problem with the parents, whose family life was already being ruined, and the father in fear of physical injury. It also jeopardized the student's future since he was unlikely to be able to continue his studies properly while so liable to paranoid disturbance.

The second case was that of a research scientist of 40, who for the previous five years had been unable to work; his marriage had disintegrated, and he was drifting in and out of hospital as an informal patient. Whenever he came in he was so suspicious and uncommunicative that he would not agree to let the doctor contact his previous medical attendant, or any previous employer or teacher. In consequence, information needed for establishing a certain diagnosis had not been sought, and prognosis depended on the evidence of a static or slowly deteriorating state over five years. However, he had sometimes been persuaded to take phenothiazines, and had thus improved and discharged himself or been discharged; but he would not continue treatment once he was out, and often failed his out-patient appointments, and his condition deteriorated again.

The outlook for the future functioning of both these patients appears black: yet there is evidence in both that