



education & training

Psychiatric Bulletin (2004), 28, 378–381

D. MARY EMINSON AND IAN M. GOODYER

Time for change to a developmental perspective in the education and training of psychiatrists

The practice of psychiatry in the UK has for most of its existence been focused on the needs of adults, and it has been with this age group in mind that educational programmes and training needs have been formulated. It is not surprising, then, that the content and shape of psychiatric training programmes have followed this clinically-driven pattern. Trainees entering psychiatry begin their clinical careers working with adults or older people and are expected to obtain a grasp of the fundamental clinical tools of the trade working with these populations. Experience with younger people's mental health is explicitly excluded in the first year of training, emphasising the primacy of adulthood in the approach to learning clinical mental health skills.

This approach to education and training in the subject has been in place since formal training programmes were established, emerging unscathed from the last major reform of training, 'Calmanisation'. Currently, a further set of changes in postgraduate medical education is taking place. Two-year foundation programmes are being introduced, combining pre-registration house officer and first-year senior house officer training. These arise in the context of new political imperatives – a drive to abbreviate specialist training, closer identification of core competencies for all specialists, and greater regulation and revalidation of medical competence. This provides an opportunity to examine whether the structure and philosophy of education and training in psychiatry needs review, a chance to ask if it remains 'fit for purpose'. Although this paper addresses these questions from a child and adolescent perspective, we believe that the changes proposed are relevant to all psychiatrists. First, we consider current arrangements.

Current training in child and adolescent psychiatry: fit for purpose?

The major dissatisfaction among child and adolescent psychiatry trainees and trainers is the overcrowded higher training curriculum. There is widespread concern about insufficient time to allow for specialisation within the subject, and universal acknowledgement of a need to expand postgraduate experience. These concerns reflect

growth of the child psychiatry knowledge base in the past 10 years. 'Special interest' sessions in higher training have already been abandoned because core training time is insufficient. A second concern is the adequacy of basic training as a platform on which higher training can build. In a recent Faculty survey, 85% of child psychiatry specialist registrars wanted their training period extended. Extraordinarily, these specialist registrars saw their training as beginning only when they entered the higher training grade – suggesting that assumptions about basic specialist training have been misplaced. The notion that the first 30 months provide an effective foundation on which later training builds appears to be fundamentally flawed for some – perhaps many – trainees. The mechanism by which higher training committees can influence basic training within the College appears to be weak. Although at a deanery (and sometimes trust) level there might be child psychiatry tutors for basic training, these are often posts with no clear role and few powers. These tutors hold no responsibility for vertical integration of basic with higher training, in either a clinical or an academic framework. Nor do they have responsibility for the child and adolescent experience of basic training as a whole. The posts have no central equivalent on the College's basic training sub-committee, which is not designed to represent different Faculties; if any member of the committee is a child psychiatrist, this is serendipitous and rarely occurs. This structure is ill designed to modify the overwhelmingly adult focus of training. A final drawback of the current structure is that it severely discourages potential recruits from paediatrics – a natural constituency from which to recruit 'second choicers' to child psychiatry. These doctors are deterred by what they see (incorrectly but understandably) as largely irrelevant basic training. Given the recruitment crisis in psychiatry as a whole, they constitute a significant loss.

These extensive concerns are almost inevitable consequences of the way child and adolescent mental health is currently represented within the training structure, which assumes the basic model of psychopathology is that of a mature adult, instead of the study of basic science incorporating the essential perspectives of human development. Child and adolescent development and



related psychopathologies are placed at later stages of the curriculum – as if a child were a special kind of adult. This upside-down approach to education and failure of concept integration might have mattered less when the knowledge base of the subject was more limited, as was the case when the current training structure and curriculum for the MRCPsych examination were developed. There was more flexibility to study child development later in training, perhaps, and a much greater tendency for trainees to begin psychiatry after experience in paediatrics or general practice. Hence arguments have been made by child psychiatrists to extend higher training. We contend that the current assumptions and practices are unsustainable in the context of the post-graduate training trends outlined earlier, especially given psychiatry's current recruitment difficulties. We argue that remedies must be sought by addressing the training period as a whole.

Are these problems found elsewhere?

Are other countries experiencing similar pressures and tensions as 'sub-specialties' develop? In Europe this dilemma is avoided in some countries by the status of child psychiatry as a separate specialty, in which training begins and ends with children and adolescents, and includes paediatric skills and experience with adult psychiatry in the middle of the training period. Such an approach allows 5–6 years to develop a substantial knowledge base and commensurate skills with children, adolescents and their families, thus avoiding many of the current problems of child and adolescent psychiatry trainees in the UK. British child psychiatrists could solve the 'overcrowded curriculum' problem in a similar manner, by creating unified child psychiatry training, within the College, separate and parallel to that in adult mental health. However, we believe that this would not be a good solution overall, either for patients or for psychiatry.

What we are clear about (and where we differ from our European colleagues) is that both research findings and the agendas of service modernisation are strongly in favour of psychiatry remaining a single, integrated specialty. Child and adolescent psychiatry is a clearly delineated area of expertise with its own CCST, developed in higher training from the platform of a common basic curriculum. However, we argue that this integration should be achieved by establishing an overarching 'life span' perspective to psychiatry as a whole. Embracing this approach would enable all psychiatrists to grasp the fundamentals of human development as they pertain to psychiatry – with skills at working across generations and basic competence with all age groups.

The life-span approach

Developmental psychiatry can be defined as 'the recognition, assessment, treatment and management of mental states and behaviours across the life span'. It is the study not merely of the childhood years, but also of the continuities and discontinuities in human structure

and function over the life cycle. It is based on knowledge of development and of gene-environment interactions in the aetiology of mental illness and disorder, and an examination of the effects across generations (Rutter, 2002). This life-span learning approach in psychiatry relates to the developmental frameworks employed in physical medicine and could be applied in medical school, in the foundation period, in basic training, higher training and subsequently as part of continuing professional development. Incorporating this change in the approach to education in psychiatry would be beneficial for all psychiatric specialists, because the nature and characteristics of mental states, their underlying aetiologies and required treatment and management show continuities as well as discontinuities throughout the human life span.

Rationale for change: research and theory

It is increasingly recognised that the same clinical phenotype at different ages might have different causes and treatments: unipolar depression, for example. Equally, developmental effects on mental states may mean that different presentations at different ages are in fact the same disorder: unipolar depression frequently presents with abdominal pain, head ache, irritable mood and minimal suicidality in childhood, whereas by the third decade of life negative cognitions, suicidality and depressed mood are common presenting features (Goodyer, 2003). Psychiatrists will need to be increasingly aware of these crucial life-span issues. To take examples from current routine child and adolescent practice, attention-deficit hyperactivity disorder and autism are developmental disorders with life-span implications, and adult services are now facing young adults with these presentations. In contrast, major mental illness once seen as 'adult' disorders (unipolar depression, bipolar disorder, other psychoses and somatoform disorders) are increasingly commonly recognised in childhood and adolescence. Eating disorders and antisocial disorders (particularly life-course-persistent forms) have always featured in child and adult services. All of these disorders are now recognised through-out the life span. Not only may their recognition and management at early stages influence aspects of outcome for the individual (Gilman *et al*, 2002, 2003) but this in turn may have an impact on the next generation's mental health (Ramchandani & Stein, 2003).

It is not only in recognition of the life span course of mental illnesses that such an approach may be beneficial, but also in understanding and (hopefully) management of longstanding temperament and personality problems and disorders. The categorisation systems in current use by psychiatrists of the different life stages help to create and maintain existing barriers. Thus, understanding of the early disruptions causing what a child psychiatrist might call an attachment disorder (and the interventions that might ameliorate the difficulties) rarely form part of the thinking of the adult psychiatrist, who is likely to make a diagnosis of personality disorder. Developmental disorders such as Asperger syndrome may similarly be labelled as personality disorders in adult services. Although use of these different labels may be strictly nosologically



education & training

accurate, what is lost is an understanding of the relation between normal and abnormal development over the life span. 'Personality disorder' diagnoses made from a static, non-developmental perspective are in fact likely to reflect the outcomes of marked gene–environmental interactions in the first two decades of life.

Another advantage of the life-span approach is that greater inclusiveness would maximise the potential of research across the life span: many studies are determined by current service boundaries and exclude certain age groups (for example, the exclusion of children from psychopharmacology research). A glance at the output of the College Research Unit confirms how many such artificial boundaries occur.

Rationale for change: service modernisation

The demand from both public and government is for services that are flexible, seamless, expert and effective, inclusive of users and their families. The achievement of services with these characteristics will be facilitated by a workforce able to overcome the barriers erected by the current historical service organisation. Structural barriers based on a false criterion (e.g. child services not seeing 'adolescents', adult services not treating developmental disorders) cannot be allowed to limit the expertise available to patients. Implementing a life-span approach minimises the opportunity of service transitional breakdown, for example between adolescent and adult psychiatry services, or between child and adolescent and adult services (in the case of parents with mental disorder). Improved awareness and skills in identification of problems in the offspring of those attending adult services will ensue. Similar arguments occur in other 'transitional' areas, for example management of unipolar depression or schizophrenia with onset in mid-life but developing a chronic course into late life.

Some developments already encourage this approach. Recognition of the importance of early intervention determining later outcome has underpinned Early Intervention in Psychosis services. Clearly, it will be essential for those who work in such services to have skills with the age group as well as with the disorder; this includes an ability to recognise what is unusual at different stages of development. Services for conditions such as eating disorders, addictions or Tourette syndrome have similar requirements – high-level skills with the age group, combined with disorder-specific competencies. Development of services for adolescents and young adults increasingly favours service delivery across an age range, which does not sit comfortably with current traditional age-structured service arrangements. The important change from the past is the need for special expertise in the developmental stage combined with an understanding of the way this influences expression and impact of disorder, of treatment and its social context. Specialists from the different life stages will need to collaborate closely in these areas.

The requirements for services for adults with major mental illness to increase the involvement of users, carers

and families will bring the needs of parents and children of these adults much more clearly to the fore. The most sensitive situations involving management of risk are involved here: risk to parenting capacity with relevance to child protection, as well as genetic risk. Work in these areas is likely to test the communication skills of psychiatrists with individuals and their families at different life-cycle stages, but will also detect more mental health needs – some of which are likely to exert effects on treatment efficacy of the patient. Psychiatrists are all too aware of the impact of psychosis on family life, but how many are able to assess the antecedent risk processes in the offspring of their patients, undertake a family-focused interview or determine the legal needs of minors in the household of psychotic patients? Without these skills, psychiatrists may undermanage the overarching clinical needs of their individual patients.

Finally, the growing emphasis on prevention and early intervention will bring a much stronger focus upon early recognition of mental disorders, as much for common conditions such as anxiety as for rarer conditions such as schizophrenia. Once again, models of assessment and intervention will need to take account of differences in early presentations and management of these disorders. A developmental context will be crucial in the assessment of early psychopathological disorder, as for example in the growing field of infant psychiatry (Fonagy, 2003), where assessments of adult mental health, adults as parents and infant abilities are key components of clinical evaluation.

How could a developmental approach reform training?

Developmental psychiatry could form the basis of a life-span approach to learning about mental health and mental illness, and would enable trainees to become conversant with the basic knowledge and skills that are essential to all aspects of medicine, whether with children, adolescents, adults or the elderly. We argue that little significant change would be required in basic training goals if a developmental perspective became the organising principle of all mental health training programmes for all specialties. The current learning objectives of the senior house officer grade suggests that these already incorporate many key areas; what must be made explicit is that these competencies are to be acquired and demonstrated with all age groups. What would be drastically altered would be the conceptual approach to training in mental health.

Detailed suggestions for changes in the content of training to reflect the developmental perspective are beyond the scope of this paper. However such a change to the philosophy of training in psychiatry would undoubtedly also require changes to the current structure. It would no longer be feasible to postpone experience with young people to later stages of training, and logically clinical placements should give an opportunity to follow the developmental approach.



The educational programmes and assessment method, including examinations, would require significant alteration to reflect the new philosophy. Aspects of training such as case conferences, interview and communication skills and psychotherapy training could integrate theoretical approaches, skills and interventions across life stages. Collaboration between psychiatrists specialising in different life-span stages would be essential to deliver this modified academic programme.

Would such changes answer the current concerns of child psychiatrists, outlined at the start of this paper? We believe this approach to training would, even without an extended higher training period, produce much greater integration of knowledge and experience from different placement settings and academic inputs. It would no longer be acceptable to wall off thinking about young and old people in either education or training – encouraging a broadening of frameworks used in placements such as forensic, liaison or substance misuse services. Even out-of-hours service delivery might provide opportunities to integrate knowledge and start to learn about emergency presentations of young people, if junior psychiatrists were the first point of contact for any mental health emergency presentation and supervised by consultants specialising in the relevant life-span stages. The crucial change for future child psychiatrists would be that their higher training period is underpinned by a firm developmental framework to early training experience of any disorder or age group. Higher training, whatever its length, would be built on an appropriate foundation and experienced as less separate from (and better integrated with) earlier training stages.

In summary, we believe such a developmental, life-span approach to education and training would provide a better foundation for all psychiatrists than hitherto, regardless of their eventual sub-specialty. It would

enhance mental health service provision for the future without diminishing the contribution of specialists in the various life stages. It would produce a more integrated profession, possessing skills to make better contributions to the mental health of both patients and families.

Declaration of interest

Mary Eminson was Chair of the Capsac Committee 2001–2004 and Ian Goodyer is a member. The ideas in the paper arose from Capsac Committee discussions in 2002 and 2003, but are the personal views of the authors and are not those of the College.

References

- FONAGY, P. (2003) The development of psychopathology from infancy to adulthood: the mysterious unfolding of disturbance in time. *Infant Mental Health Journal*, **24**, 212–239.
- GILMAN, S. E., KAWACHI, I., FITZMAURICE, G. M., et al (2002) Socioeconomic status in childhood and the lifetime risk of major depression. *International Journal of Epidemiology*, **31**, 359–367.
- GILMAN, S. E., KAWACHI, I., FITZMAURICE, G. N., et al (2003) Family disruption in childhood and risk of adult depression. *American Journal of Psychiatry*, **160**, 939–946.
- GOODYER, I. M. (ed.) (2003) *Unipolar Depression: A Lifespan Perspective*. Oxford: Oxford University Press.
- RAMCHANDANI, P. & STEIN, A. (2003) The impact of parental psychiatric disorder on children. *BMJ*, **327**, 242–243.
- RUTTER, M. (2002) The interplay of nature, nurture, and developmental influences: the challenge ahead for mental health. *Archives of General Psychiatry*, **59**, 996–1000.

***D. Mary Eminson** Consultant Child and Adolescent Psychiatrist, Royal Bolton Hospital, Minerva Road, Bolton, Lancs BL4 0JR, **Ian M. Goodyer** Professor of Child and Adolescent Psychiatry, Developmental Psychiatry Section, Department of Psychiatry, Cambridge University