

CHILD PSYCHIATRIC CONSULTATION AND LIAISON IN PAEDIATRICS

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ABSTRACT

Psychiatric problems are common in children with physical illness. The child psychiatrist can play a useful role in consultation, treatment and prevention of psychological problems in paediatrics. In addition, the child psychiatrist can contribute to staff support and education and research. Difficulties in liaison work are due mainly to differences in professional emphasis, deficits in communication and the stigma that is invariably linked to psychiatry.

Keywords: paediatric liaison, child psychiatric consultation, liaison psychiatry

SINGAPORE MED J 1996; Vol 37: 194-196

INTRODUCTION

Psychiatric problems are common in children with physical illnesses. Different studies estimate that up to 60% of paediatric inpatients⁽¹⁾ and 50% of outpatients⁽²⁾ had disorders in which psychological factors play a major role.

Psychiatric morbidity may contribute to the aetiology of the illness. Even if it is not the cause of symptoms, psychological factors may alter the symptoms and severity of the physical illness. Psychological distress in the child and family affects compliance to treatment⁽³⁾, compromising outcome and emotional factors may prolong the course of the illness.

In the era of sophisticated medical technology and specialisation, it is not uncommon to forget the emotional needs of children and overlook the impact of this technology on the child and his family⁽⁴⁾.

Advances in paediatric medicine have also resulted in prolongation of life. Conditions that previously resulted in early death now become chronic illnesses with emotional sequelae to the child and family⁽⁵⁾. Children with chronic illnesses live on to become adolescents with chronic illnesses with its particular set of psychological difficulties.

Much has been written about liaison and consultation services. Some authors feel that there are clear distinctions between them. Liaison refers to services for the physician and staff, and consultation refers to direct services for the patient. In good clinical practice, a child psychiatrist does both and enters into a collaboration with medical staff to provide comprehensive care for the patient and family.

THE TASKS OF CHILD PSYCHIATRIC LIAISON/CONSULTATION IN PAEDIATRICS

These are: consultation, treatment, prevention, staff support, education, research

Consultation

Requests for child psychiatric consultations in paediatrics may fall into one of the following categories:

- a. Psychiatric crisis
The most common psychiatric crisis presenting to the paediatrician is attempted suicide in the adolescent⁽⁶⁾. The child psychiatrist is called upon to assess the suicide risk and manage suicidal behaviour. Other urgent referrals include managing children and adolescents presenting with violent behaviour and acute psychosis and assessing victims of child abuse for psychological sequelae.
- b. Diagnosis
This usually happens when the paediatrician has ascertained that the child's symptoms do not have an organic basis but suspects that emotional factors may play an important role. For example, a paediatrician may refer a child with chronic persistent headaches after thorough neurological assessment do not reveal abnormality.
- c. Paediatric illnesses known to have a strong psychological component eg asthma, where issues range from dealing with stress as a precipitant of asthmatic attacks to conflicts resulting from family overprotection and the impact of this on the asthmatic child developing adequate coping skills.
- d. Paediatric illnesses that may evoke serious psychological reactions eg the diagnosis of terminal and chronic illnesses, the need for transplant surgery.
- e. Neurological diseases resulting in impairment eg head injury or infections may require neuropsychiatric assessment of assess consequence and extent of insult.
- f. Reactions to hospitalisations and clinic procedures. Children who have needle phobia have a great deal of difficulty co-operating with treatments requiring injections and immunisations. Separation anxiety in children who are admitted to hospital may result in behavioural problems in the ward necessitating appropriate management⁽⁷⁾.
- g. Co-existing psychological problems. It is not uncommon for parents to bring up worries or difficulties with the child during a paediatric consultation. Problems range from developmental issues like speech delay and learning difficulties to behavioural problems or even abnormal behaviour.

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Treatment

Treatment modalities include the whole range of psychological treatments available.

Behavioural techniques eg gradual desensitisation and positive reinforcement are invaluable in the management of needle phobias and pain⁽⁸⁾. Desensitisation involves gradually exposing the child to the feared situation eg injections. One obvious prerequisite for desensitisation techniques is adequate time for the child to be exposed to the environment, the equipment and the personnel. Not infrequently, in an attempt to 'quickly get it over with' the child's fears are suppressed only to resurface subsequently as conditioned fear responses which are difficult to deal with.

Positive reinforcement involves rewarding a child when he exhibits positive coping behaviour eg holding still during injections and presenting the situation as a challenge and an opportunity to master a difficult situation rather than an aversive experience.

Sokel et al⁽⁹⁾ described a self hypnotherapy technique incorporating relaxation exercises, mental imagery and suggestions of symptom relief for the treatment of a 9-year-old boy with habitual reflux vomiting.

Parents play an important role in children's ability to cope with medical situations. Joint parent-child interventions comprising provision of information, teaching stress management skills and facilitating contact with medical personnel are an integral part of treatment of children in paediatric settings. The diagnosis and continuing treatment of terminal, life-threatening and chronic illness has a major impact on the child as well as his family and parental counselling, support and family therapy must be provided^(10,11).

In the hospital setting, certain principles should be kept in mind.

- i) The observations of nursing and other ward staff are often very useful when assessing the child.
- ii) Therapeutic goals should be clearly and quickly communicated to medical staff.
- iii) Treatment may take place at the bedside and it is good practice to involve medical staff as co-therapist.
- iv) A comprehensive treatment plan may need to address the feelings and opinions of medical staff caring for the patient.
- v) The length of time of hospitalisation may dictate the pace of treatment.

Prevention

Psychological problems related to hospitalisations, painful or disfiguring procedures, life-threatening operations are well-known and should be anticipated. A programme to prepare children and families for these specific stresses⁽¹²⁾ would facilitate the procedure and reduce the likelihood of serious psychological sequelae.

Preparation often involves the provision of information⁽⁸⁾, which should include procedural and sensory data. Procedural data is information about the steps of the procedure, sensory data includes describing physical sensations, sound and smells that the child will experience as part of the procedure eg the child is told that the antiseptic cleansing prior to venepuncture will feel cold and smell like toothpaste.

Preparation also involves behaviour rehearsal. This allows the child to 'play doctor'. For example teaching the child to use an inhaler would mean getting the child to give her doll the inhaler, using actual equipment. Behaviour rehearsal provides information to the child and allows the child to mentally and emotionally prepare for the impending procedure.

Most preparation techniques include some or all of the following components: behaviour rehearsal, introducing the child

to medical personnel and discussion of fears, questions and the child's feelings. Systematic education through video tapes⁽¹³⁾, story and colouring books can also be useful to allay fears, answer questions and dispel myths.

Whitehead et al⁽¹⁴⁾ reports that pre-transplant psychological interviews to assess family functioning, the level of comprehension of risks involved, expectations of the operation and the emotional status of the child or adolescent, have implications on the outcome of heart-lung transplants and future compliance.

Staff Support

Daily dealings with painful issues eg imminent death and disfigurement, can take its toll on medical staff. Certain work environments, like the paediatric or neonatal ICU⁽¹⁵⁾, are particularly stressful because staff (who are likely to be parents themselves) are often confronted with moral dilemmas. The tensions of working with sick children and distressed parents often go unacknowledged and unresolved. These tensions are quite liable to find expression in conflicts among different hierarchies of medical staff or between wards. The liaison psychiatrist can play an important role in offering support and opportunities for medical staff to deal with these stresses constructively and prevent burnout.

Education

Disseminating knowledge on psychological topics raises the awareness level among medical staff of the emotional and developmental needs of children. Children may express their fears through defiance and uncooperation - medical staff who are aware of the way children think and feel will take the time to explain and reassure the child to enlist co-operation instead of reacting to outward difficult behaviour. Robertson's⁽⁷⁾ observations of the impact of separations in young children when they are admitted to hospital resulted in major changes in hospital policy so that paediatric wards now allow unrestricted visiting and overnight stay by families.

Education takes place by the bedside, on ward meetings and joint rounds, case discussions and teaching seminars. More effectively, the psychiatrist should strive to teach through example and apprenticeship. The liaison psychiatrist with his background in medicine and in adult and child psychiatry is in an unique situation to teach psychological principles to medical staff.

Research

The overlap of the soma and psyche in many disorders offers exciting areas for collaborative research. Collaborative research promotes understanding and mutual respect and leads to interprofessional goodwill. Research is also necessary to evaluate the work that is being carried out. Evaluation ensures that there is accountability of time and other resources. Objective assessment through research can decide how the services can further enhance paediatric practice, if it improves the standard of psychosocial care and if it contributes to lowering morbidity in the paediatric population.

DIFFICULTIES IN CONSULTATION/LIAISON TO PAEDIATRICS

Professional emphasis

One of the main causes of difficulties in collaboration arise from differences in emphasis between psychiatric and paediatric services. Lask and Fosson⁽¹⁶⁾, a psychiatrist and a paediatrician sum it up in their comparison of the practice of paediatrics versus the practice of psychiatry:

- a) body versus mind
- b) organ or system versus the whole child
- c) individual versus family
- d) immediate versus long-term
- e) life or death versus quality of life
- f) active treatment versus passive involvement
- g) cure versus care

When the psychiatrist and paediatrician do not acknowledge these differences and do not understand how the other professional functions, collaboration becomes difficult.

There are great variations in both professions, paediatricians have varying levels of understanding and interest in psychiatry and there are psychiatrists who do not conform to the stereotype of being vague and theoretical. It improves collaboration when an effort is made to know and understand the individuals with whom she or he is working with⁽¹⁷⁾.

Communication

Psychiatrists are often criticised for their inability to 'talk straight'. Psychiatric jargon and lengthy formulations do not improve communication, except among psychiatrists themselves, and even this is doubtful! Reports should be concise and to the point and include statements about diagnosis, outlines of aims of treatment, practical advice on management and prognosis. The paediatrician must understand the complexities of assessing and managing problems associated with dysfunctional, multiproblem families and in these cases an indication of the likely duration and course of therapy is useful. Open communication also prevents misunderstandings in the area of responsibility - whether management should be an assessment only, joint work, parallel work or hand-over can be discussed and agreed upon for each separate referral.

Stigma

The stigma that is often attached to psychiatry can make liaison difficult. Many families are hostile to psychiatry and view a referral for a psychiatric assessment as an insult or affront to them. They may feel that the medical staff is labelling their child as mad or malingering and worry that this opinion will result in medical staff ignoring or neglecting real medical problems. The difficulties involved in persuading them otherwise require time, tact and effort. Even when families agree to a psychosocial assessment, they may be doubtful or rejecting in their response. In order to be able to work further, the liaison psychiatrist will have to acknowledge these feelings and address them.

CONCLUSION

Liaison/consultation to paediatrics is an unique opportunity to bridge two disciplines with the welfare of the child at the heart of the endeavour. For it to be successful and to be of benefit, patients and families must be adequately prepared for the referral and have an opportunity for their misconceptions about psychiatric help to be discussed; the professionals involved must be committed to exercise respect and understanding of each

other's professional expertise, to identify difficulties and to communicate effectively.

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