Teaching Child Psychiatry to Medical Students: Students' Feedback

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Child psychiatry is a relative newcomer to the area of medical training. In the past teaching has focused more on the education of psychiatrists and paediatricians than on the contribution of child psychiatry to the education of medical students.[1]

Some of the issues arising in teaching child psychiatry to medical students are those of presenting a biopsychosocial perspective within the strong biomedical orientation of medical education.[2] There are, however, important specific issues that have received little attention and will be addressed here.

In an unpublished report, authors have described the teaching programmes available at London and other United Kingdom universities.[3] They have advocated an increased amount of teaching in child psychiatry and made suggestions for optimal use of the time available. However, the evaluation of the teaching programmes, though recognized as crucial, has been a comparatively neglected area. This paper describes feedback from the students on a programme of teaching child psychiatry.

Description of the teaching programme

In the academic years 1981–82 and 1982–83, and as part of the nine-week paediatric teaching, 158 fourth year medical students of the University of Manchester received child psychiatric teaching at Booth Hall Children's Hospital. The Psychiatric Unit is part of the Academic Department of Psychiatry of the University of Manchester, which organizes separate teaching in adult psychiatry.[4]

During the nine weeks' paediatric teaching at Booth Hall Children's Hospital, students attended weekly child psychiatric seminars and assessments of new patients at the psychiatric outpatient clinics. Following two introductory sessions, the seminars consisted of presentations of cases by the students themselves: psychiatric in-patients, children in paediatric wards with psychological problems, overdoses or cases they had seen at the juvenile courts (the Department of Paediatrics arranges visits by the students to the juvenile courts[5]). At the beginning of the course the students were given a handout on child psychiatry produced by the University department.

Students were also invited to watch through a one-way screen assessments of new cases by psychiatric registrars and consultants, and to participate in the discussions which followed. In the last term of the period covered in this report, weekly video sessions of interviews with children and their parents were introduced.

In addition, there were weekly professorial paediatric/psychiatric ward rounds and the students attended the monthly psychiatric case conferences in the Postgraduate Centre of the hospital. More teaching in child psychiatry took place during the adult psychiatric clerkship and as part of the fifth year revision lectures at the Medical School.

At the end of the child psychiatric teaching at Booth Hall Hospital, students were asked to complete a questionnaire to give us feedback on their perceptions of the sessions. Some of the comments will be reported here. They refer only to our weekly formal teaching seminars.

Were the students interested in our teaching?

Of the total 158 students, 128 (or 81 per cent) filled in the questionnaires, which were anonymous. The mean self-reported attendance rate was 80 per cent. When people did not attend, the reasons given were usually realistic: most frequently being delayed in paediatric out-patients, or attending the courts. Only one quarter gave subjective reasons for not attending, such as being ill or tired, and in all, 7 per cent stated that the reason was low interest. It was therefore possible to obtain both good attendance and interest in our seminars.

Learning of child psychiatry

To assess the students' understanding of basic notions in child psychiatry, they were asked to name five child psychiatric conditions; three criteria to assess the presence of psychiatric disorder in children; three of each of the following types of aetiological factors: intrinsic, parental, familial, educational and social; and three types of treatment.

Most respondents were able to answer these questions and most of the answers were adequate. Five psychiatric conditions were named by 82 per cent. Those noted most commonly (autism and schizophrenia, enuresis, encopresis, and anorexia nervosa) reflected the students' receptivity to teaching about the most severe psychiatric conditions and paediatric/psychiatric problems. Emotional disorders with school refusal and depression were also mentioned. However, this was less so for the relatively unspecific emotional conditions of children or for the conduct disorders: vague or symptomatic terms were used to describe the latter, as for example 'behaviour problems' or 'aggressive behaviour'. Since emotional and conduct disorders are conditions that many students will need to recognize as medical practitioners, it is important to think of ways of giving maximum exposure to them during formal teaching.

Most students were able to name three criteria for assessing psychiatric disorder in children: handicap or symptoms which interfere with the child's development; the history of the problem (i.e. changes in behaviour, persistence, pervasiveness and severity), environmental factors such as poor family environment or instability and abnormalities in the mental state with

psychotic type features or marked changes in mood. This indicated that students had acquired a useful conceptual framework with which to judge the severity of emotional and behavioural changes in children.

Answers to questionnaires indicated that they understood parental and family characteristics as being of primary importance in the aetiology of the children's disorders: parental characteristics (personality, health, early experiences), aspects of parenting (over-protection, discipline, abuse, general adequacy and bonding), broken homes, poor family interaction, the number of sibs in the family and their relationship with each other were mentioned.

In the area of intrinsic vulnerability in the child, personal attributes (age and sex), temperamental and genetic factors were noted. Some students appeared to have difficulty in completing this section and they mentioned here aspects of upbringing or social conditions.

The educational aetiological factor most often given was relationship with peers (bullying, unpopularity). Only about a third of respondents were able to name social aetiological factors (social class, area of residence, housing, finance, etc).

As for therapeutic interventions, they named drug and behaviour therapies frequently; case work with parents was mentioned in relatively few cases. These responses might reflect our main aim being more one of imparting knowledge about psychiatric conditions than about their treatment. It is questionable whether this balance should be redressed, or whether our present aim is more appropriate within the relatively little time available.

Psychological aspects of physical illness

Students were asked to name the psychological aspects of physical disease discussed in the seminars they found most striking. The importance of psychological factors for physical illness was stressed commonly by respondents. Interestingly, over a third of the answers referred to children's individual attitudes to illness: i.e. emotional reactions (such as feelings of depression or worry), effects on self-esteem; the possible over-accentuation of the symptoms, using them to manipulate others, or the fact that children might not recognize the psychological nature of physical symptoms. The social implications of physical illness as affecting relationships with peers and school progress, the stigma involved, and other associated stresses such as the effects of hospitalization, were also named. Some of these answers indicate a degree of empathy with the children's difficulties which was not suggested in the discussion of psychiatric conditions. When asked about the psychiatric case presentations they found most striking, the symptoms and the nature of the condition itself, family aspects and physical-psychological interactions were highlighted. The child had, as it were, been obscured by its condition. This was in line with the student's better grasp of familial than of child intrinsic aetiological factors.

It is likely that the area of psychological aspects of physical illness is a specially appropriate one in which to nurture the student's understanding of the child's inner world, his feelings and thoughts. Accordingly, teaching about interviewing children might be best initiated in the area of paediatric/psychiatric teaching.

In summary, in spite of the fact that child psychiatry is only a small part of a predominantly biomedically orientated medical teaching, students appear receptive to, and interested in our programme aimed at conveying basic notions on child psychiatry and on the psychological aspects of physical illness. Feedback from the students indicates that they learn about the severe psychiatric conditions of children, and those in which there are psychological-physical connections. This last area might lend itself particularly well to teaching about interviewing children. Finally, it is worth exploring further how to improve students' knowledge of the most common problems in child psychiatric clinics, as, for example, with more use of videos.

References

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Addendum to 'Psychosurgery and the Mental Health Act Commission'

The following addendum has been made to Paul Bridges' article, 'Psychosurgery and the Mental Health Act Commission' (*Bulletin*, August 1984, **8**, 146–48):

> So far about ten patients have been accepted for psychosurgery by the Geoffrey Knight Unit and subsequently referred for the opinion of a Medical Commissioner. Operation has been agreed for nine patients and refused for one patient. This patient died by suicide within 3 months of the veto. The present staff of the Unit do not recall any other patient who has ever died by suicide while on our waiting list for psychosurgery.
>
> This tragedy emphasizes the desperation of the patients that we deal with and clearly shows that considerable experience is required for dealing with these difficult cases. Giving a doctor a particular legal status clearly does not confer on him any special clinical experience and yet Medical Commissioners give an opinion which overrides ours and is infallible, as there is no appeal for the patient. A truly most disturbing state of affairs.