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.

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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.