Child Psychiatry for Undergraduates

A Trainee's Experience in a Teaching Programme

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Although the Academic Department of Child and Adolescent Psychiatry of the University of Glasgow came into being with the establishment of a Chair only in 1977, the subject had been taught to medical undergraduates since the early 60s. This was possible, even without a formal academic base, because of the long-established Scottish tradition that NHS consultants and their junior medical staff accept as a matter of course, and usually as something of a privilege, to participate in the teaching of medical students. As the Department of Child and Family Psychiatry was based in the main paediatric teaching hospital at the Royal Hospital for Sick Children, Glasgow, it was a natural development that this should also be the location for the teaching of the specialty, and throughout its development in Glasgow this course has been a part of the final year block placement of undergraduates for instruction in child health and paediatrics. Over the years there has also been some participation in the lecture course in general psychiatry which takes place in the fourth year of undergraduate study.

The development of the teaching programme in child and adolescent psychiatry has inevitably been influenced by certain constraints, for example, the allocation of teaching time, the large annual intake of medical students (around 200) and the available teaching strength.

Description of the course

Teaching occupies one afternoon session per week during the student's placement in paediatrics during their final, fifth year of study. As there are four teaching blocks each year this means that the cohort of students for any one course is around fifty. A pattern has gradually evolved of an afternoon session which begins with a one-hour informal lecture or lecture/demonstration followed by what are euphemistically termed 'small group sessions' but which are really three parallel workshops. Depending on the particular topic, the second half of the session may take the form of a video or film presentation or a more extended discussion session with the whole class.

Two further general points should be made at this stage. Firstly, all of these students, and especially the fourth block, are within a short distance of sitting their final MB examination and as there is yet no separate child psychiatry component this inevitably has an impact on motivation. Secondly, in recent years there has been a compulsory element in the class examination, in that the essay paper in child health contains two main questions, one relating to paediatrics and one to child psychiatry. This fact alone has probably contributed to the greatly improved attendances during recent years so that with few exceptions there is usually an excellent turnout.

Objectives and content

The main objectives of this course are twofold though complementary. For many of the undergraduates it is only in this final year of study that they encounter child patients. One of our tasks therefore, in cooperation with our paediatric colleagues, is to serve as an orientation to children's medicine, to the particular problems posed by history-taking, examination, and interviewing of children and parents, and to the impact of diagnostic and therapeutic measures on very young patients. The second, and related task is to make the students aware of the more common behavioural and psychological disturbances which they are likely to encounter in practice, remembering that many will become family doctors. Each week has a general theme, as in the following representative example of a course programme.

Week 1: Introduction to the course; the needs of the developing child; stress reactions in ordinary children. *Week 2*: Assessment procedures; interviewing parents and children (illustrated by video). *Week 3*: The child in hospital; visit to paediatric wards; discussion with ward sister and playleader; effects of hospitalization. *Week 4*: Emotional disorders in childhood; the psychopathology of family relationships. *Week 5*: Families at risk; conduct disorders; child abuse. *Week 6*: Brain syndromes—hyperkenesis, specific learning disorders, the epileptic child (joint lecture/demonstration between developmental paediatrician and child psychiatrist). *Week 7*: Children without families; children in care; fostering; adoption (joint presentation by social worker and child psychiatrist with video illustration). *Week 8*: Problems of puberty and adolescence. (This last session concludes with a feedback session on class exam essays.)

Handouts are provided for each topic giving a brief summary of the issues to be covered and providing the lecturer with a framework for discussion and illustration. *Child Psychiatry for Students* by Stone and Koupernik is recommended as a basic text, and for further reading or for those with a special interest, *Children Under Stress* by Sula Wolff, and *Helping Troubled Children* by Michael Rutter.

Small group teaching

Over the years there has been considerable experimentation in teaching groups of fourteen or fifteen undergraduates. It has not been possible to work with smaller

numbers as the teaching strength available did not allow us to organize more than three simultaneous groups. While the lecture sessions have taken place in the lecture theatre of the Department of Child Health, small group teaching takes place in the Department of Child and Family Psychiatry so that the students have some familiarity of the setting in which we work. The bulk of the lectures are given by the professor, lecturer, and consultants, but increasingly senior registrars have participated, in particular in small group teaching. Some colleagues have great reservations about presenting a child patient to such a group. Others find it possible to do so without exposing the child to unnecessary stress. A particular problem can often be highlighted very well by asking parents to meet the class and to discuss a problem—for example, caring for a handicapped child, commenting in retrospect how they coped with a school refusal, etc. More recently, role-playing has been introduced to demonstrate family interviewing techniques and this has been particularly appreciated by many students.

As Lecturer in the Department, my role was to coordinate the arrangements for each lecture course. These included the practical details—paper-work, room-booking, etc, as well as invitations to lecturers and suggestions of clinical material for the workshops. We endeavoured as far as was possible to link this clinical material with the lecture. If there was an interesting clinical problem on the unit this might be included in an appropriate part of the programme. A check list was kept of material presented to the students in order to ensure that all topics were covered by the end of the course.

We used this clinical part of the afternoon to illustrate interviewing, assessment and treatment plans. Each consultant met a group of students twice. The clinical psychologists, occupational therapists, social workers, teachers and nurses were also involved in the small group teaching.

Video presentations were an added source of clinical material. We built up a library of tapes, screening families that presented at out-patient clinics. We also made specific tapes to illustrate teaching topics, e.g. (a) children in hospital, at play and at school; (b) parents talking about their experiences having children in hospital; (c) tapes made with paediatric colleagues of joint topics of interest—e.g. 'an epileptic child'; (d) tapes made with outside agencies—e.g. 'adoption' with a team from a community agency. These videos were used as a focus for discussion of sensitive areas where it might not have been appropriate to bring in families to talk to a large group of students.

We gained experience in planning the material to be videoed, how to edit and how to present the tapes to students. We were fortunate to have the experience and patience of the Audio-Visual Department of the University of Glasgow and the Department of Medical Illustration at the Royal Hospital for Sick Children, and were able to experiment with various ways of presentation. We learned to limit the length of tapes to be presented; to introduce the students to the material to be presented; to give them tasks and questions to be answered from the tapes; to vary the methods of using tapes with sound or without sound to explore verbal and non-verbal communication. Feedback from the students was helpful in determining how to use this material to advantage.

Meetings of the clinical teachers were held once a term. This was a forum for support as there were also teachers who came from outside the Department. We examined teaching methods, students needs and how to present delicate material to students without encountering resistance. Students indicate their discomfort by giggling, talking, staying away, etc. It is inevitable that some material is emotionally upsetting. This, as well as the students' reactions, can be distressing for the lecturers and may diminish enthusiasm for participation in the course. Discussion of these issues was usually constructive.

At the end of each eight-week session we expected and encouraged feedback from the students. During the last year that I was in the Department I gave the students a handout which summarized what we expected them to gain on the course. This outlined our expectations of the concepts which we would hope to introduce during the following eight weeks. I indicated that I would be asking them at the end of the course whether our expectations had been met. Our use of this approach seemed to indicate that the students thought we had met most of our targets. This method also helped to reinforce the key points that we hoped to illustrate to the students during the course.

I have had contact with colleagues from other teaching units in the country and have been interested to learn how they went about teaching medical students in their own centres. Obviously each University Department and NHS Department is bound by the limits of numbers, teacher availability, number of hours available to them, etc. They also have their own priorities regarding content.

As a trainee I found the experience very valuable. Acting as a facilitator to my colleagues to look at teaching methods was interesting. To be able to present concepts in an acceptable way to students was challenging. I was fortunate to be part of a department where colleagues were very supportive and also fortunate to have the supervision of Professor Stone. Discussion of teaching material and methods was part of that supervision. Joint teaching sessions with senior staff were useful as a modelling experience, and served as live supervision.

Child and adolescent psychiatrists have an important role as teachers, and it is important, therefore, that trainees should have the opportunity to learn to become effective teachers. This aspect of training should not be neglected in the planning of teaching programmes.

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