A 13 YEAR FOLLOW-UP OF CHILD PSYCHIATRY TRAINING

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The graduates from two child psychiatry training programmes over a 13 year period responded to a questionnaire designed to elicit their retrospective evaluations of various aspects of their educational experience. Information is presented about areas of knowledge judged important, specific experiences which were helpful and unhelpful, and current patterns of practice of these graduates. Their attitudes toward supervision and supervisors are discussed, as are implications for recruitment of future trainees and teachers/faculty.

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The knowledge and attitudes acquired by trainees during a course in child psychiatry may be expected to substantially influence the way in which they practise the specialty during their thirty or so years of professional lifetime. The twin demands of ever increasing technical knowledge and the changing expectations of the community present those responsible for educating these consultants-to-be with a challenge: "What should be taught, and how?" The answers to these questions will depend on who is being addressed, but the decisions made have the potential to alter the clinical methods of the profession long after the teachers have departed.

Other authors have sought the viewpoints of past graduates from several programmes practising in a particular US state [1], the perspectives of current trainees throughout Britain [2], and the opinions of the Directors of child psychiatry residency programmes across the USA [3], while Mcleod [4] has surveyed the current content of programmes in Canada.

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Mrazek and Prugh [1] used a critical incident survey to study graduates of several programmes who were practising in Colorado. Actual treatment of children with regular supervision was felt to be most helpful training experience, followed by direct responsibility for care of children with a wide range of conditions. Lack of specific experiences and inadequate supervision were concerns, and the trainees' didactic and research experiences were criticised.

Garralda *et al* [2] surveyed the current full and part time trainees in Great Britain to ascertain their opinions of the breadth, duration and diversity of their experiences. Family therapy was seen as the most important intervention being taught, within an overall eclectic attitude to therapy. There was seen to be a gap between the high desirability and low availability of experience in some areas, i.e. psychiatric disorders accompanying physical illness, experience with preschool children, and management of the psychoses.

Schowalter [3] conducted a survey of Directors of 126 academic programmes of child psychiatry in the United States of America, attaining a 93% response rate. These directors were generally satisfied with existing course requirements, and favoured experiences for their trainees with older children, adolescents and parents, and the use of psychopharmacology. Least favoured experiences were cognitive therapy, research, psychological testing and teaching.

McLeod's [4] survey of career child psychiatry training in Canada sought information as to structure and content of the 15 University Medical School programmes from the faculty providing them. There was agreement on 9 objectives for knowledge and competence, with varying availability of specific areas of clinical experience. He found that the level of knowledge and skill to be acquired was difficult to discern. Skills in community consultation, advocacy for needed services and a commitment to functioning within a multidisciplinary team using a range of conceptual models were consistent themes.

Many groups within the community - public health system administrators, paediatricians, welfare agency workers and parents of future patients - may have an interest in, and opinions regarding, the education and role of future consultant child psychiatrists. However, we believed that the feedback from the immediate consumers of that education, previous trainees now in practice, would be most important, since they were in the best position to evaluate the usefulness of their educational experience at the coal face of clinical demands. We therefore undertook to survey all graduates of the past and present programmes within the State of Victoria.

The Australian and New Zealand child psychiatry training course

In Australia and New Zealand, after successful completion of four years general psychiatry training and the written and clinical ("first part") RANZCP examinations, a further two years subspecialty training in child psychiatry may be elected. Five of the six states and Auckland, New Zealand offer such programmes, which are bi-nationally co-ordinated and accredited by the Committee on Child Psychiatry Training, Royal Australian and New Zealand College of Psychiatrists. The College grants a Certificate of Training in Child Psychiatry to those who successfully graduated from these courses.

We sought the opinions of graduates from two specific courses who had completed their studies and moved into the consultant workforce over the past 13 years. These two programmes between them accounted for all the child psychiatrists who have been trained within the state of Victoria. The first group graduated between 1976-1984 from a course located within, and funded by, a busy Children's Hospital Psychiatry Department. This was imbedded in a psychodynamic context, and prepared trainees for essentially private practice. This course was discontinued at the end of 1984. The second group had participated in the Postgraduate Child Psychiatry Training Programme (Vic) between its inception in 1975, and 1988. this programme was funded directly by the State Department of Health and provided a broader based training suitable for consultants in public clinic practice.

Method

A five part questionnaire was mailed to the graduates of the two programmes whose addresses could be traced. For the Royal Children's Hospital programme (Programme A) this was 11 of 13 trainees, and of these 11, 9 responded (69% of total graduates, 82% of those sent questionnaires). For the PGCPT (Vic) (Program B), of 40 graduates, 38 could be located and 32 responded (80% of total graduates, 84% of those sent questionnaires). Differences in response rate were not significant.

The questionnaire sought information about:

1. Medical and psychiatric education prior to child psychiatry training.
2. Respondents' rating of the importance of 13 particular areas of training on a Likert 5 point scale, 1 = unimportant, 5 = indispensable, and the availability of experience and supervision in that area, 1 = not available, 5 = optimal availability.
3. The two particular training experiences remembered as most helpful and the two as least helpful (critical incident method [5]).
4. The availability in their course of supervision time, the expertise of the supervisors and the relationship between trainee and supervisors, each to be rated on a 4 point scale with 1 as least desirable, 4 as best possible situation.
5. Current patterns of practice.

Thus a total of 41 respondents represented 77% of the 53 graduates, or 83% of those located and sent questionnaires.

The more recent graduates of course B had been evaluated at 6 monthly intervals by each of their 5 supervisors in the disciplines of child, adolescent, parent, family and general psychotherapies. These evaluations rated, on a Likert 5 point scale, 1 = poor, 5 = excellent, the trainees' functioning in the areas of: relationship with supervisor, therapeutic skills and theoretical knowledge of the area. This information,

Table 1. Graduates' rating of importance of areas of training (rank order 1 = unimportant, 5 = indispensable)

Ranked 5 (indispensable) to 4 (important)
Parent counselling
Management of psychosis in childhood
Psychodynamic therapy
Family therapy
Forensic child psychiatry
Psychopharmacology
Paediatric consultation
Ranked 4 (important) to 3 (useful)
Secondary consultation
Group therapy
Behavioural and cognitive therapies
Work with mentally retarded children
Ranked 3 (useful) to 2 (optional)
Child psychiatry research

drawn from the third of the four half-yearly ratings made during the course, was available for 22 graduates.

Results

Pre-course medical education of trainees

Although the majority of trainees had graduated from the two medical schools in Victoria, the University of Melbourne, 30%, and Monash University, 44%, there were representatives of other university in Australia, 11%, and overseas, New Zealand, 5%, United Kingdom, 3%, other countries, 7%.

Entry into the general psychiatry programme was preceded by an average of 2.6 years (SD 1.8) hospital training in general and specialty medicine, and 16 of the trainees had experience of private general medical practice of up to 6 years. Mean age at completion of the general psychiatry fellowship and entry into the child psychiatry programmes was 32.6 years (SD 6.8, max 44).

Table 2. Numbers of graduates perceiving a discrepancy between high importance and low availability of training in various areas

	Course A N = 9	Course B N = 32
Group therapy [a]	1	10
Behavioural cognitive therapy		7
Research		7
Forensic		5
Mental retardation		5
Inpatient management		5
Psychopharmacology		4
Management of psychoses	1	1
Secondary consultation [b]	1	1
Family therapy [c]	1	

[a] Pearson r=12.93 p<0.01
[b] Pearson r=11.98 p<0.007
[c] Pearson r=12.28 p<0.006

High importance: 4"important" or 5 "indispensable"
Low availability: 1 "unavailable" or 2 "available by special arrangement only"

Importance and availability of areas of training

Table 1 shows the rank order of graduates' perceptions of the value of various areas of training, as well as the general group of relative importance to which each area was assigned.

Multivariant analysis showed no significant difference at the 0.01 level between graduates of the two programmes in ratings of importance of the 13 areas.

However, significant differences in perceived accessibility of experience and supervision in 3 areas emerged - course A was seen to provide a better experience in group therapy, while course B made secondary consultation and family therapy training more available.

Looking from other perspectives, we wondered which experiences might be simultaneously rated as important but of limited availability. Table 2 shows almost a quarter of respondents perceived this disparity in the area of group therapy, while behavioural/cognitive therapies, research, work with the mentally retarded, inpatient management and psychopharmacology were other areas valued by some who felt they had less than acceptable access. Those

Table 3. Response to question "two most helpful experiences"

Experience	Respondents (n)
Supervision in individual psychotherapy	24
One-way screen observation of others' work	10
Other specific clinical experience	9
Family therapy supervision	8
Community secondary consultation	5
Work with multidisciplinary team	3
Seminars and other didactic teaching	2
Forensic, personal analysis, conjoint work with consultant	1 each

Not all of the 41 respondents described 2 experiences

Table 4. Response to question "two most unhelpful experiences"

Experience	Respondents (n)
Service demands/workload	14
Supervision of individual psychotherapy	10
Clinic/hospital politics	7
Problems with clinic/hospital organisation	7
Problems with training programme administration	7
Specific other - therapies poorly taught/supervised	4
Family therapy teaching/supervision	3
Experience with mentally retarded patients	2

Not all the 41 respondents described 2 experiences

who had participated in course A were less likely to perceive this type of mismatch than those in course B. This may have been due to lack of exposure of those in course A too, for instance, behaviour therapy or research work.

Most and least helpful incidents

We next examined the respondents' brief written accounts of which two specific training experiences they remembered as being most helpful, and the two least helpful.

We found that the descriptions of each type could each be categorised into 8 groups, as presented in tables 3 and 4. Analysis of variance showed no significant difference between respondents from the two courses in their description of which experiences had been either most or least helpful.

It is interesting to note that the experience remembered by the greatest number as most helpful, supervision in individual psychotherapy of children and adolescents, was also ranked second among the least helpful by other respondents.

Supervision

Table 1 clearly indicates the high rating graduates give to areas of clinical activity that may be termed direct "face to face" therapeutic contact (parenting counselling, psychodynamic therapy and family therapy). These clinical contacts are traditionally taught by "supervision", either "live" when using one-way screens with observers, or video replays, or the classic "session review" with process notes being brought to a supervisor, for detailed discussion and review of the processes occurring in the patient and the patient/therapist relationship. This "supervised" educational experience may be contrasted with the other important areas where lectures, learning by "imitation" of senior staff and self-directed learning are more in evidence.

To define some of the elements comprising supervision, we looked at trainees' perceptions of "time available", "supervisors' expertise" and "relationship with supervisor".

It seemed that these components of supervision in general were overwhelmingly perceived as favourable (Table 5). However, we have already noted from tables 3 and 4 that supervision in individual psychotherapy was regarded as containing both the most frequently mentioned helpful experiences, 24/41=58% of respondents, and was the second most often cited source of unhelpful experiences, by 10/41=24% of respondents. This aspect of training was unique in eliciting such strongly opposing attitudes.

Examining these results in more detail, we found a degree of overlap: of 24 selecting an experience during individual psychotherapy supervision as one of their most helpful, 7 also mentioned another experience in

Table 5. Approval of supervision components

	Positive %	Negative %
Time availability (sufficient)	77	7 too much 15 too little
Supervisors' expertise	92	7
Relationship with supervisor	92	7

Sufficient time = 3 (adequate) or 4 (optimal) (5 = too much time devoted to supervision)
Expertise = 3 (adequate) or 4 (very good)
Relationship with supervisor positive = 3 satisfactory, 4 very good

the same setting as least helpful.

For example, one graduate wrote: "I always enjoyed discussing cases with Dr ...: a psychodynamic perspective is very interesting to me" but "An obviously biased or unattentive supervisor is very disconcerting, as is one who seems nit-picking and never looks at what is done well".

Comparison of this group of 7 trainees with mixed perceptions with the remaining 17 showed no significant difference as to which course had been completed or current pattern of practice (Fisher's exact text).

We next proceeded to examine whether a correlation existed in the trainee's assessment of supervision and the supervisor's evaluation of the trainee, using the data available on the subset of 22 graduates from course B.

Analysis, using Spearman co-efficients, showed a correlation significant at the 0.01 level for trainee rating of importance of family therapy and supervisors' rating of trainee's therapeutic skill in this modality. Two trends toward significance, at the 0.05 level, emerged between trainees' theoretical knowledge, and between availability of individual psychotherapy experience and relationship with supervisor as judged by the latter. These results indicate a reciprocity between trainees' and supervisors' attitudes to components of their shared activity.

Patterns of practice

Comparison of information provided about current patterns of practice (Table 6) showed that graduates of course B averaged significantly more hours in the practice of child and adolescent psychiatry, and were more likely to devote half or greater of their practice hours to work in the public sector than were those from course A. Analysis of variance showed that this difference was not explained by years since graduation being greater for group A, i.e. a drift over time toward more adult patients and private practice.

Discussion

Importance and availability of areas of training

The rank ordering by the graduates of various areas of training seemed to reflect a fairly traditional or conservative view of core skills in child psychiatry, with parent counselling, management of psychotic children and psychodynamic therapy rated highly, while behavioural and cognitive therapies and work with mentally retarded children came at the end of the list of useful experiences. Child psychiatry research was seen as least important of all, and was the only area rated "useful to optional". While it must be commented that these results represent the aggregate of graduates over 13 years, and that the content of the two courses evolved over this period, the absence of significant differences in ratings between ex-trainees from course A and B suggests that the latter group's priorities were not affected much by being trained four or more years later.

It is interesting to compare the ratings of importance from our graduates with those of the directors of American residency programmes reported by Schowalter [3]. Many of the 26 training experiences he listed on his questionnaire corresponded with those on our shorter list of thirteen. While both surveys agreed that work with parents, psychodynamic and family therapies, psychopharmacology, inpatient management and paediatric consultation were important to indispensable, Victorian graduates judged forensic experience to be in this category also. In contrast the American programme directors rated it only somewhat useful to important, but included experience with mental retardation in the highest ranked group.

Our trainees' more favourable view of forensic work may result from their structured participation in a children's court clinic which was mandatory in their syllabus, while involvement with clients at an agency

Table 6. Comparisons of patterns of practice

	Course A N = 9	Course B N = 32	Significance (Fisher's exact, 2 tailed)
Means hours public practice	13.25	30.33	0.051
Number spending more than 50% of time in public practice	1.00	22.00	0.001
Means hours in practice of child and adolescent psychiatry	17.75	34.34	0.006
Number spending more than 50% of time in child/adolescent practice	2.00	24.00	0.002
Average hours worked per week	44.6	41.50	NS

servicing the intellectually disabled was reported by some as an unhelpful experience.

Trainees from course A seemed largely accepting of its content, but some of those from course B indicated a number of areas whose importance was not mirrored by availability, especially group therapy, behavioural/cognitive therapies and research despite the overall low rating given to the last. This difference in satisfaction may reflect the situation of graduates from the earlier course proceeding into private practice and confining themselves to the therapeutic modality they had been taught, individual insight oriented psychotherapy, while those of the later group stayed in clinic based practice and came in contact with alternative therapies employed by non-psychiatric members of the multidisciplinary team.

Helpful and unhelpful experiences

The usefulness of the two-way screen as an instructional aid was confirmed by the responses in the helpful category, as was the centrality to the teaching process of individual supervision (see below). Few saw didactic teaching as especially helpful, a finding noted elsewhere (Mrazek) [1]. What was surprising to us, but on reflection should not have been, was the degree to which working conditions such as severe demands/workload, clinic/hospital politics and problems with clinic/hospital organisation and the training programme administration generated unhelpful experiences, a total of 35 out of 55 described (64%). This suggests that attention to management and leadership skills in those responsible for conducting a training programme is at least of equal importance to clinical and teaching ability. Though the teaching of administrative skills is a (minor) part of our curriculum, the opportunities to gain practical experience is limited prior to graduation, after which the competence of the new consultant in this area is assumed by colleagues in the system. Neither the survey of American programmes [3] nor its Canadian counterpart [4] mentions administrative expertise among their goals.

Supervision

Supervision, along with didactic teaching and self-directed learning, form the essential triad of a training experience. In this survey, the graduates of 2 independent training programmes with up to 13 years post-graduate experience rated clinical activities with a major supervisory component as highly important. Time available for supervision and the expertise of, and relationships with, supervisors were remembered as satisfactory to very good by the majority.

However, within this generally favourable experience of supervision, some recalled specific incidents which were unhelpful.

Given that a trainee would expect to work with a minimum of 10 different supervisors during the two years of the course, meeting individually with five of these weekly for a period of one year, it would be surprising if some interpersonal difficulties did not arise from time to time.

A supervisor's role is to monitor and contribute to both the clinical work and the professional and personal growth of the trainee. This collaboration might itself be seen as therapy of sorts, in which the senior clinician assists the junior in dealing with the demanding process of assuming the persona of a therapist and consultant. The success or otherwise of this joint endeavour can be expected to influence both the relation-

ship and each individual's perception of the other's skills. Our finding, then, that trainees who rated family therapy as important were more likely to be seen by their supervisors as skilled in this area can be seen as confirming this collaborative relationship.

Patterns of practice

Overall, the knowledge base, skills and techniques that are imparted and supervised in a training course heavily influence the subsequent options of practice patterns for graduates. With the divergent aims of course A and B and therefore the different emphasis in the training, one would expect that the outcome of supervising different activities in the training programme would result in marked differences in patterns of practice. Self selection by trainees for a particular course may also have contributed.

It was heartening to find that course B in fact tended to produce the type of practitioners that it set out to create (Table 6), and interesting to note that this was accomplished despite the majority of its supervisors being drawn from private practice. This perhaps serves to place supervision *per se* in perspective - a few hours within a week otherwise devoted to clinical work as a member of a multidisciplinary team.

Even so, only 22/32=69% of course B's graduates had continued in public practice. One of the reasons for this may be the relative remuneration available, with private practitioners able to earn at approximately twice the rate of their public clinic counterparts.

Conclusion

These findings raise the question as to how trainees are to be exposed to new therapeutic approaches and other advances in the clinical and consultation areas if the consultants instructing them, themselves trained a generation earlier, retain an allegiance to skills and priorities they internalised during a period when today's areas of rapid development were less prominent. One answer to this situation is to have teachers who are involved in research and thus who might be more likely to be critically appraising both traditional and more recent approaches. However, if the consultants gave high priority to research, they failed to impart this to the trainees (Table 1). In fact, those actively engaged in research would have been distinctly a minority within the staff of either programme. This situation is not confined to Victoria [6].

With respect of the relative unavailability of some types of training that were seen as important, group therapy was selected by a substantial proportion of graduates of course B, followed by behavioural and cognitive therapies. This information has been useful in re-formulating course requirements and currently a block of 10 seminars in each of these therapies is provided, together with supervised experiences at a number of the clinics within the programme.

The current Victorian programme, like others, has difficulty in recruiting sufficient suitable trainees to fill the available places. One solution, suggested by Beresin and Borus [6], is enhanced recruiting from those in the early years of their adult training. We are actively pursuing this approach by improving the quality of the child psychiatry experience that occupies six months in the second year of this four year course.

The results of our own study suggests another approach - better leadership and management techniques to reduce trainees' "unhelpful experiences" generated by administrative issues. These skills could be profitably imparted to both faculty and to trainees, and become a major educational objective of the programme.

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