SHORT-TERM PSYCHOTHERAPY BY MEDICAL STUDENTS: ITS THERAPEUTIC EFFECTIVENESS AND ITS EDUCATIONAL VALUE

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SYNOPSIS

This paper deals with the evaluation of the effectiveness of individual psychotherapy by students on patients' subjective symptomatic improvement and the therapeutic benefits to medical students. The results of the study indicated that student psychotherapy was of significant benefit to psychoneurotic patients, but was of dubious value in the clinical teaching of psychotherapy in the psychiatric curriculum of the medical course at the University of Malaya, Kuala Lumpur.

INTRODUCTION

Most psychoneurotic patients who come for treatment at the University Hospital Psychiatric Clinic, Kuala Lumpur, seek relief from their distressing symptoms which reflect their subjective experience in living. What is most important to the patient is the way he feels about himself and his life situation, and the initiation, maintenance, and interruption of the treatment process itself follow mainly from these feelings. Generally, the trained psychiatrist, due to a shortage of time and a full clinical, teaching and research commitment, is unable to afford the time nor the facilities to keep many patients through on-going psychotherapy, whether it be short-term supportive or long-term intensive therapy. By psychotherapy, it implied the formation of a therapeutic relationship, the working through a ventilatory process, support, transference reaction and the working through and resolution of existing conflicts (be it intrapsychic or inter-personal relationship orientated) either through the insightful, supportive or relationship process. This is further complicated by the fact that a direct relationship exists between the educational level and the frequency of acceptance of patients for psychotherapy by psychiatrists. Good candidates for psychotherapy are those patients with whom psychiatrists find it more easy to communicate with and who share similar value systems (Rosenthal and Frank, 1958).

Often what the trained psychiatrist at a medical school clinic is able to do is dole out tranquillizers and the patient remains in a state of neurosis which otherwise could have been helped through psychotherapy. Often the process of allowing sufficient time to listen to and to support the patient through the initial process of ventilation is all that may be necessary.

It almost seemed that at the University Hospital Psychiatric Clinic, the medical students' first attempt at psychotherapy perhaps offered the greatest potential for aid to the patient's welfare. Furthermore, the psychotherapeutic experience afforded to the medical student could prove invaluable in his training in his handling of patients in general.

Teaching of Psychotherapy to Medical Student

The supervision of the non-psychiatrist trained personnel by trained psychiatrists, may be a 'bruising collision.' The first step in the learning of the psychotherapeutic skill is the psychiatric interview (Sifneos, 1968) which is in itself to useful teaching instrument. It is presented as a valuable, problem-solving, data collecting technique. The central tool is the doctor-patient relationship and the understanding of this development is the central task of the psychiatrist and the supervised physician (Hartz, 1969). It consists of the patient asking for help or relief and also many half-hidden or even totally-unrecognised emotional needs. The psychiatrist brings to special alertness these feelings and the handling of 'transference reactions'.

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Since the teaching of psychotherapy to medical students is limited by time, only a brief, supportive form of psychotherapy can be taught. Yet the effectiveness of brief psychotherapy is probably facilitated by those same powerful forces which exercise a beneficial effect in more conventional forms of treatment (Barten, 1965). The healing factors in the doctor-patient transactions appear to operate independently of the theoretical framework of reference employed by psychiatrists (Frank, 1961). What is important, apparently, is the human relationship between the doctor and the patient—the personal encounter or, in Jasper's term, the 'existential communication' seems to matter (Frankl, 1967). "The warm subjective, human encounter of two persons" as Carl R. Rogers (1961) said "is more effective in facilitating change than is the most precise set of techniques growing out of learning theory or operant conditioning. Personality change is initiated by attitudes which exist in the therapist, rather than primarily by his knowledge, his theories; or his techniques ..... which is the essential characteristic of therapeutic change."

The advantages of short-term psychotherapy over long-term psychotherapy may be debated on many grounds, depending on the orientation of the psychiatrist (Wolberg, 1965); but Malan (1963) concluded that the long lasting depth changes were possible even in severely ill patients treated on a short-term basis.

Psychotherapy has been taught on a theoretical basis to medical students at the University of Malaya. During the initial years of the medical course, students were permitted to sit and observe interview sessions. The orientation of the Department of Psychological Medicine is dynamic in orientation whereby the problematic and the interactional aspects are emphasized. This was further made possible by the psychodynamic orientation of the teachers in the school. The students were exposed to seven weeks of clinical clerkship in the medical course. It was interesting that in a study of attitudes to psychiatry (Sarbadhikary and Wagner, 1967), remarkably positive attitudes towards psychiatry were significantly evident. Students also believed that there was no clear cut difference between normality and abnormality in mental illness.

Context and Aims of the Study

Throughout 1971, many psycho-neurotic patients needing some form of brief supportive psychotherapy have been assigned to medical students (year four) who underwent a five-week clerkship at the Department of Psychological Medicine. The impression was that both patient and student benefited from the experience which has been most enlightening and encouraging. It was because of this experience, that the authors decided to evaluate the effectiveness of brief psychotherapy by medical students on patients and to forsee the problems involved in student psychotherapy. Furthermore it was decided to evaluate if such an exercise also benefitted the medical student.

Briefly the aims of the study were:--

1. To evaluate the benefits derived by medical students doing psychotherapy.
2. To discover the problems, advantages and disadvantages in such a process.
3. To evaluate the patients' subjective symptomatic improvement undergoing student psychotherapy.

METHOD OF STUDY

(a) Choice of Case

Three batches of fourth year students (a total of 62) underwent five weeks each of psychiatric clerkship between September—December 1971. Patients with psychoneurosis, personality disorders or situational reactions were carefully selected by the authors for student psychotherapy. Those with mental subnormality, severe personality disorders or psychotic disorders were excluded from the study. Each case was carefully evaluated as suitable for psychotherapy and assigned to student volunteers who saw the patient for a minimum of one hour once or twice a week. There are two classes of volunteers. Some patients were evaluated initially by a supervisor and student volunteers of a particular sex or linguistic group were asked for. Some patients who were found suitable after a joint, initial evaluation of the patient by the students and the supervisors were accepted by the students for psychotherapy.

(b) Initial Instructions to Students

The authors instructed the students, as a group, on the basic principles of supportive psychotherapy prior to initiation of therapy. They were given tutorials on Psychodynamic Concepts, Mental Mechanisms of Defence and Principles of Psychotherapy. Reading handouts were given and students were made to read

up the chapter on Psychotherapy in prescribed text-books prior to seeing the patient.

The authors conferred with the students assigned to the cases and matched closely for language congruence, sex, ethnic group and age. At the initiation of therapy, the authors introduced the student to the patient and a basic contract of coming on time and the total number of sessions were drawn out between the patient and the student therapist. Thereafter the student saw the patient one hour per session at regular fixed times, usually within the same clinic session as the author who was supervising him.

(c) **Supervision of Student Therapists**

This aspect was probably the most important of the evaluation. The students were supervised a minimum of once a week in a group (for 2-3 hours of 4-6 students each). The individual sessions were read to the group verbatim, and the authors instructed on strategy and interpretation. This process of group learning was most beneficial. The type and nature of psychotherapy was left completely to the inclination of the individual supervisor. It did not matter if the supervisor utilized the object-relations model or the Rogerian model. The problems of transference, counter-transference and termination were carefully watched for, and if the student was not able to handle the case, the supervisor invariably took over the case.

Evaluation of the Study

A register of patient and student appointments was kept. The clinic receptionist was made responsible to seeing that both patient and student kept their appointments. At the initiation of therapy, the student was instructed to fill up a structured questionnaire of his and the patient's social and clinical data. The student was also asked to evaluate himself as to his interest in and attitude towards efficacy of psychotherapy. This similar questionnaire was given to the student again for re-evaluation at the termination of therapy.

Unbiased, research assistants, who were trained in interview techniques in the different languages and dialects assisted each patient to fill up a 65 item symptom evaluation questionnaire (see appendix I) (adapted from Uhlenhuth and Duncan, 1968).

This questionnaire consisted of symptoms related to:—

1. Anxiety—9 items
2. Depression—9 items
3. Anger—3 items
4. Compulsion—3 items
5. Others (which included social anxiety, introversion, various psychosomatic complaints)—36 items.

The same symptom evaluation questionnaire was given to the patient by the same research assistant immediately at the termination of therapy. Thus the patient was required to complete a self-evaluation of symptom-evaluation questionnaire on three occasions.

1. At initiation of therapy
2. At termination of therapy
3. Six weeks after termination.

(The third questionnaire was given to evaluate whether symptom improvement continued after therapy. During this period, the patient was not seen by either authors or student).

At the termination of therapy, the student wrote out his own comments on a structured questionnaire on the effectiveness of therapy. He was further evaluated by the authors on a semi-structured form.

Results of the Study

The results of this evaluation can be divided into several categories:—

1. Characteristics of student psychotherapy.
2. Patients' subjective improvement of symptoms.
3. Effectiveness of the students' subjective change.
4. The problems and merits of student psychotherapy.

General Characteristics of Student-patient Psychotherapy

A total of 30 patients underwent psychotherapy with 30 medical students. Generally students were allocated patients who were of similar ethnic groups, sexes and language concordance. Three patients who agreed to enter into therapy did not turn up after the initial assessment by the authors.

The Social Characteristics of Students and Patients were shown on Tables I and II.

TABLE I

ETHNIC GROUP OF PATIENTS AND STUDENTS ON PSYCHOTHERAPY

Ethnic Group	Patient	Student
Malay	5	5
Chinese	22	23
Indian	3	2
Total	30	30

TABLE II

SOCIAL CHARACTERISTICS OF PATIENTS AND STUDENTS ON PSYCHOTHERAPY

Social Characteristics	Patient	Student
Sex		
Male	19	27
Female	11	3
Social Class		
Upper	2	3
Middle	15	25
Working	13	2
Marital Status		
Married	8	0
Single	22	30

The main language of interaction was in English (56·7%) and the other languages and dialects were utilized according to linguistic concordance of both patient and student. The utilization of a language other than English did not interfere with patient-therapist interaction. It seemed possible that the language and vocabulary of the patient did reflect some culturally-determined attitudes and concepts within the patient's culture. However, the student therapist was always encouraged to accept the patient's cultural assumption without challenge.

The number of sessions ranged from three to ten, the mean being 5·9 sessions. Sixty-eight percent (21) of the patients were on concomitant drug therapy, as they had been on the same drugs for several months to years prior to therapy without any subjective improvement. The authors did not think the influence of medication significantly altered the results in psychotherapy.

TABLE III

DIAGNOSTIC CATEGORIES OF PATIENTS UNDERGOING PSYCHOTHERAPY

Diagnosis	No.	Percent
Anxiety Neurosis	16	53·3
Adolescent Behaviour Disorder	4	13·3
Reactive Depression	7	23·3
Obsessional Neurosis	1	3·3
Personality Disorder	2	6·7
Total	30	100·0

TABLE IV

LANGUAGE OF INTERACTION DURING PSYCHOTHERAPY

Language of Interaction		No.	Percent
English		17	56·7
Malay		1	3·3
Mandarin	Chinese dialects	3	10·0
Cantonese	Chinese dialects	5	16·7
Hokkien	Chinese dialects	3	10·0
Tamil		1	3·3

The occupational classification of the patients ranged from unskilled labourers (3·2%) to non-manual workers (19·4%), clerical groups (22·6%) and students (25·8%) who formed the bulk of the patients treated.

Three patients who were not included in the study were treated for depression and made suicidal attempts while undergoing therapy. They were admitted and treated accordingly and were taken off therapy.

Patients' Symptomatic Subjective Improvement

The evaluation of the patients' symptomatic subjective improvement was made on the unbiased scores on the 65 item structured questionnaire.

The symptoms were categorized under several clusters of anxiety, depression, anger, compulsion and others.

The scores were evaluated on three occasions throughout the therapy:

(A) At initiation of therapy

(B) Immediately after termination of therapy

(C) Six weeks after termination of therapy.

In between the period of (B) and (C) the patient was not seen by anyone. It has been the usual experience by psychotherapists that patients regress and produce more symptoms during termination at therapy due to separation anxiety. Thus the evaluation six weeks later was to evaluate if patients had actually improved with therapy or had a sustained continuous improvement.

The total score between (A) i.e. at initiation of therapy and (B) immediately after therapy was compared utilizing the correlated '*t*' test. It was found that there was a very significant improvement of overall symptoms before and after therapy, with $p<0.005$ level, df=30 (very significant).

The total score between (B) i.e. at termination of therapy and (C) i.e. six weeks after termination of therapy was compared utilizing the correlated '*t*' test. The result was very significant with $p<0.005$ level, df=30 (very significant).

One could conclude that there was much patient symptomatic improvement with student psychotherapy and that there was no relapse of symptoms after six weeks, following termination of therapy. In fact, the patients continued maintaining their improvement.

The percent improvement between A and B was 74·2% and 25·8% became worse. The overall percent improvement between A and C i.e. before and after six weeks from termination of therapy was 87·1% and 12·9% became worse.

The correlated '*t*' test for comparison between the two means of dependant scores for the various symptoms clusters showed a significant marked improvement in the component of anger and depression. Although the components of compulsion, anxiety and others were not significant, there was good (marked improvement in the score for others, which was better than the scores for anxiety. As anticipated the scores for compulsion showed the least improvement.

TABLE V

CORRELATED '*t*' TEST AND PERCENT IMPROVEMENT BETWEEN PATIENTS' SUBJECTIVE SYMPTOMATIC IMPROVEMENT BEFORE, AFTER AND SIX WEEKS AFTER STUDENT PSYCHOTHERAPY

	A and B	B and C	A and C
correlated '*t*'	$p<0.005$	$p<0.005$	—
df	df = 30	df = 30	—
sig./not sig.	very sig.	very sig.	—
Overall percent improvement of scores	74·19%	—	87·09%
Overall percent of scores showing no improv. or worse	25·80%	—	12·91%

A = evaluation of scores at initiation of therapy.
B = evaluation of scores at termination of therapy.
C = evaluation of scores at six weeks after termination of therapy.

TABLE VI

CORRELATED '*t*' TEST FOR SYMPTOM CLUSTERS OF SCORES BETWEEN (A) i.e. AT INITIATION OF THERAPY AND (B) i.e. AT TERMINATION OF THERAPY

Symptom Cluster	Correlated '*t*' (p=0·001 level)	df	Significant/ Not Significant
Anger	$p < 0.005$	df = 30	Very significant
Compulsion	$p < 0.35$	df = 30	Not significant
Anxiety	$p < 0.25$	df = 30	Not significant
Depression	$p < 0.001$	df = 30	Very significant
Others	$p < 0.025$	df = 30	Not significant

TABLE VII

CORRELATED '*t*' TEST FOR STUDENTS' SUBJECTIVE IMPROVEMENT OF INDIVIDUAL FACTORS, DOING PSYCHOTHERAPY

Student Factors	Correl. '*t*' test	df	Significant/Not significant
Understanding	p = 0·1345	df = 30	Not significant
Insight	p = 0·1311	df = 30	Not significant
Listening	p = 0·1493	df = 30	Not significant
Confidence	p = 0·1431	df = 30	Not significant
Handling patient	p = 0·1618	df = 30	Not significant
Utilize knowledge	p = 0·1296	df = 30	Not significant
Motivation	p = 0·1431	df = 30	Not significant

The results indicated that while psychoneurotic patients complained most, they improved most with respect to the affective symptoms of depression and anger, both symptoms more quickly elevated than the others. Perhaps the most striking feature of the patients' course in therapy was their failure to show a definite symptomatic exacerbation near the termination of therapy. The findings suggested that the patients did not make a strong investment in their student therapists. The inexperience of the student therapist may have contributed to this situation. The prearranged, limited number of interviews was most likely a major factor.

The results of the study were similar to those of Uhlenhuth and Duncan, 1968 and Heine, 1962, where some 75% improvement of symptoms occurred under student psychotherapy.

The Effectiveness of Medical Students' Subjective Change

The need to encourage empathy and understanding of the feelings and problems of the patient has long presented a thorny problem to teachers of medicine. Reconciling the needs of the patient and those of the student often appears an impossible task, a fact which may explain why it is so rarely discussed. The aim of this exercise was not to turn Year IV medical students into amateur psychiatrists or psychotherapists but to allow them during their medical course to experience a psychotherapeutic experience or an encounter with their special patient. This form of 'bedside' teaching allowed the self-evident prerequisites of privacy where both patient and student could express and articulate their feelings with less reserve, thereby developing and acquiring the skills and knowledge necessary for a proper doctor-patient relationship.

The exercise also developed the empathic qualities of the student, a component which is vital to the practice of psychotherapy as well as in medicine. (Strunk, 1957; Fox and Goldin, 1964). The quality of empathy was considered as a vital capacity of the therapist by which he was able to understand the patient.

The therapeutic process was made more complicated by the inter-cultural problems of communication. Several of the student therapists utilized a language other than English for interaction. Even when both patient and therapist shared the same language, there was still an inability to express themselves precisely and a difficulty in understanding each other accurately, since different languages share different cultural meanings and interpretations. While it was fairly easy to translate something which had concrete meaning, it was much more difficult to interpret emotion or symbolic language. The difficulty was potentiated in the area of non-verbal communication (Hsu and Tseng, 1972).

For rating medical students' subjective improvement, a structured questionnaire (see appendix II) of seven questions was used before and after the termination of therapy.

The correlated '*t*' test for students' subjective improvement on individual factors was not found to be significant at all. The implication was that students did not significantly find doing psychotherapy particularly helpful. The results could be related to the fact that medical students found it difficult to rate themselves in the uncertain technique of psychotherapy which dealt with subjective feelings, whereas in physi-

cal medicine, they were accustomed to deal with more concrete aspects of objectivity.

The X^2 test for social factors between patient and student therapist for those patients who subjectively improved were not significant at all. The social factors compared between student and therapist were sex, ethnic group, social class and age groups were not significant. The results implied that patients' subjective improvement occurred regardless of the social factors of the student therapist. There were no specific social factors which reduced the effectiveness of student psychotherapy.

Psychological Reactions of Student Therapists

Some students complained that they would have preferred individual to group supervision. Although it was on a voluntary basis, several students became disenchanted and frustrated half-way through, with difficult patients. Either the student was not sufficiently empathic and warm or the patient did not feel they trusted the student-therapist sufficiently. All along through the medical course, medical students were instructed that emotional problems in patients had been a kind of 'no man of man's land.' The emphasis on 'patient-orientated or patient-centred medicine' was strongly emphasized to students studying psychiatry, as opposed to 'illness-centred medicine' (Balint *et al*, 1969).

The students had a difficult time during transference reactions, as they tended to intellectualize their experiences. By and large, the female students were more involved in therapy. Resistance to the counter-transference reaction was approached by the student therapists in the role of a scientific observer of behaviour and with 'surgical coldness.'

Generally it could be concluded that although medical students pestered their tutors for training in psychotherapy, it was a cold shower and a bruising experience for them, when they were actually subjected to the psychotherapeutic experience. While students might have benefited intellectually from the teaching of psychotherapy, they were not able to benefit emotionally from their short five-week experience in intensive short-term psychotherapy. They were either unable or unwilling to speak of their emotional experiences or were too threatened by the interaction.

Much more therefore, needed to be done to change the student's cognitive and affective stance and its inter-relationship with and effect on his intellectual stance. It is still appropriate to mention that 'what we cannot speak, we therefore, confine to silence' (Pilowsky, 1973).

CONCLUSION

Thirty fourth year medical students and patients were subjected to individual short-term psychotherapy over a five-week period with hourly sessions ranging from three to ten. The effectiveness of patients' subjective symptomatic improvement was evaluated. Seventy-four percent of patients had subjective symptomatic improvement at the termination of therapy and eighty-seven percent continued to improve six weeks after the termination of therapy. There was a significant improvement in the affective components of depression and anxiety compared to the components of anger and compulsion.

While student psychotherapy benefited patients, there was no significant therapeutic changes in the medical students' attitudes towards psychotherapy. The students tended to intellectualize the benefits of psychotherapy training, but rejected to the emotional changes that occurred in psychotherapy. They were either not prepared for the 'psychotherapeutic experience', or preferred to remain 'in silence over the change that overwhelmed them.

The clinical training of psychotherapy to medical students during their short five-week clerkship is of dubious or of uncertain value to medical students.

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APPENDIX I

The 65 symptom characteristics were graded from 1—4 in terms of severity of symptoms.

Code 1 — not at all
Code 2 — a little
Code 3 — quite a bit
Code 4 — extremely

The following is the 65 item symptom evaluation questionnaire for patients:

Anxiety

1. Nervousness or shakiness inside - - - - - - 1 2 3 4
2. Sweating - - - - - - - - - 1 2 3 4
3. Trembling - - - - - - - - - 1 2 3 4
4. Suddenly scared for no reason - - - - - - - 1 2 3 4
5. Heart pounding or racing - - - - - - - 1 2 3 4
6. Dry mouth - - - - - - - - - 1 2 3 4
7. Trouble getting your breath - - - - - - - 1 2 3 4
8. Feeling tense or keyed up - - - - - - - 1 2 3 4
9. Feeling fearful - - - - - - - - - 1 2 3 4

Depression

1. Feeling low in energy or slowed down - - - - - 1 2 3 4
2. Worrying about things - - - - - - - - 1 2 3 4
3. Crying easily - - - - - - - - - 1 2 3 4
4. Blaming yourself for things - - - - - - - 1 2 3 4
5. Feeling blue or low - - - - - - - - 1 2 3 4
6. Feeling no interest in things - - - - - - - 1 2 3 4
7. Drowsiness during the day time - - - - - - 1 2 3 4
8. Feeling hopeless about the future - - - - - - 1 2 3 4
9. Thoughts of ending you life - - - - - - - 1 2 3 4

Anger

1. Feeling easily annoyed or irritated - - - - - - 1 2 3 4
2. Feeling critical of others - - - - - - - 1 2 3 4
3. Temper outbursts you could not control - - - - - 1 2 3 4

Compulsion

1. Being unable to get rid of bad thoughts or ideas - - - 1 2 3 4
2. Having to do things very slowly in order to be sure you were doing them right - - - - - - - - - - 1 2 3 4
3. Having to check and double check what you do - - - - 1 2 3 4

Others

1. Bad dreams - - - - - - - - - 1 2 3 4
2. Feeling shy or uneasy with opposite sex - - - - - 1 2 3 4
3. Difficulty in speaking when you are excited - - - - - 1 2 3 4
4. Feeling inferior to others - - - - - - - 1 2 3 4

5. Hot or cold spells - - - - - - - - 1 2 3 4
6. Feeling blocked or stymied in getting things done - - - - 1 2 3 4
7. Feeling lonely - - - - - - - - - 1 2 3 4
8. Poor appetite - - - - - - - - - 1 2 3 4
9. A lump in your throat - - - - - - - - 1 2 3 4
10. Pains in stomach - - - - - - - - - 1 2 3 4
11. Pains in lower part of the neck - - - - - - 1 2 3 4
12. Having to avoid certain things, places or activities because they frighten you - - - - - - - - - - 1 2 3 4
13. Headaches - - - - - - - - - 1 2 3 4
14. Faintness or dizziness - - - - - - - - 1 2 3 4
15. Loss of sexual interest or pleasure - - - - - - 1 2 3 4
16. Trouble remembering things - - - - - - - 1 2 3 4
17. Worried about sloppiness and carelessness - - - - - 1 2 3 4
18. Pains in heart or chest - - - - - - - - 1 2 3 4
19. Itching - - - - - - - - - - 1 2 3 4
20. Constipation - - - - - - - - - 1 2 3 4
21. Feeling confused - - - - - - - - 1 2 3 4
22. A feeling of being trapped or caught - - - - - - 1 2 3 4
23. Loose bowel movements - - - - - - - 1 2 3 4
24. Nausea or upset stomach - - - - - - - 1 2 3 4
25. Soreness of your muscles - - - - - - - 1 2 3 4
26. Difficulty in falling asleep or staying asleep - - - - - 1 2 3 4
27. Difficulty in making decisions - - - - - - - 1 2 3 4
28. Numbness or rigidity in parts of your body - - - - - 1 2 3 4
29. Trouble in concentrating - - - - - - - 1 2 3 4
30. Weakness in parts of your body - - - - - - 1 2 3 4
31. Heavy feelings in your arms or legs - - - - - - 1 2 3 4
32. Stuffy nose - - - - - - - - - 1 2 3 4
33. Your feelings are easily hurt - - - - - - - 1 2 3 4
34. Feeling others do not understand you or are unsympathetic - - 1 2 3 4
35. Bright light burning in your eyes - - - - - - 1 2 3 4
36. Wanting to be alone - - - - - - - - 1 2 3 4

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APPENDIX II

1. Do you feel you have a better understanding of the patients' illness? (understanding) - - - - - - - - 1 2 3 4
2. Do you feel you have understood yourself and others better? (insight) - 1 2 3 4
3. Have you become a better listener? (listening) - - - - 1 2 3 4
4. Do you feel more confident dealing and handling psychatric patients? (confidence) - - - - - - - - - 1 2 3 4
5. Do you feel more satisfied in handling a patient in psychiatric treatment? (handling patient) - - - - - - - - 1 2 3 4
6. Have you been able to employ your knowledge of psychiatry? (knowledge) 1 2 3 4
7. Are you motivated to spend more time in psychiatry? (motivation) - 1 2 3 4

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