

Barriers and Facilitators to Early Exposure to Psychiatry in Undergraduate Medical Education: A Qualitative Study from Central India

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Abstract

Background:

Mental health disorders contribute substantially to the global disease burden, yet undergraduate psychiatry training remains limited and often underemphasized within medical education. Early clinical exposure, including that in psychiatry, has been promoted by the national medical commission. However, research in this regard is limited. Understanding medical undergraduates' (students'), faculties, and key stakeholders' perspective is essential to identify barriers and opportunities for strengthening early exposure to psychiatry.

Methods:

A qualitative phenomenological study was conducted at a tertiary-care teaching hospital in India, involving medical students and faculty members. The research paradigm and integrity were established using Braun and Clarke's (2006) framework. Data were collected through focused group discussions and in-depth interviews until thematic saturation was achieved. Transcripts were analyzed using thematic analysis with the support of ATLAS.ti software.

Results:

Findings were organized into two overarching domains: barriers and facilitators to early exposure to psychiatry. Barriers included curriculum and regulatory constraints, institutional and faculty-related limitations, student-related factors, and stigma and attitudinal challenges. Facilitators comprised curriculum and policy-level enablers, integrated and experiential learning opportunities, institutional support and sensitization initiatives, and faculty- and student-driven engagement. Early sensitization, integration of psychiatry across disciplines, and positive role modelling emerged as key themes influencing engagement.

Conclusion:

Undergraduate psychiatry training is shaped by interrelated curricular, institutional, and attitudinal factors. Strengthening early, integrated, and competency-based approaches, alongside institutional support and efforts toward stigma reduction; may enhance student engagement and better prepare future physicians for holistic care.

Background

Mental health disorders constitute a substantial and growing burden on global public health, with many individuals living for prolonged periods with significant disability.(1) The World Health Organization estimates that 10–20% of children and adolescents experience mental disorders, making mental illness a major contributor to the global burden of disease.(2) Psychiatric morbidity is also common in routine medical practice, affecting nearly 25% of patients in general practice and about 15% in specialty clinics.(3) Current health priorities increasingly emphasize bio-psycho-social model of chronic illnesses, vulnerable populations, and conditions such as dementia, schizophrenia, and substance use disorders, further underscoring the centrality of mental or psychosocial health (mental health, henceforth) in contemporary healthcare.(4, 5)

Despite this burden, mental health care remains neglected in India, with a severe shortage of trained professionals. The psychiatrist-to-population ratio remains alarmingly low at approximately 0.3 per 100,000 population, far below global recommended levels, despite a steady increase in the number of medical graduates (MBBS) each year.(6) This workforce gap is compounded by limited undergraduate exposure to psychiatry and persistently unfavourable perceptions of the discipline among the students, larger medical community, and policymakers.(6)

Traditionally, undergraduate education in mental health has been largely confined to psychiatry postings. However, patients with psychiatric disorders frequently present in non-psychiatric settings such as primary care, emergency departments, and other medical or surgical facilities. More than half of patients treated for depression are managed by primary care physicians,(7) and up to 75% of individuals who die by suicide have had recent contact with a primary care clinician.(8) Yet, many primary-care doctors remain inadequately prepared to identify and manage mental health conditions, even the commoner ones, such as depression, anxiety, stress, problematic substance use, due to insufficient undergraduate training.(1) These identification and treatment-related gaps can be attributed to the limited undergraduate training in psychiatry and the decreasing presence of trained mental health professionals in rural areas, further restricting opportunities for collaborative care in general hospital settings.(9–11)

Concerns regarding deficiencies in medical graduates' competencies, particularly in psychosocial aspects of care, have been repeatedly raised by educators, administrators, and professional bodies globally.(4, 12) Increasing emphasis on community-based management of mental

illness places additional demands on general practitioners to possess foundational psychiatric skills.(12) However, undergraduate psychiatry education continues to be constrained by limited curricular time, inadequate assessment strategies, poor integration with other medical disciplines, and is a minor or non-mandatory subject to pass to obtain the graduate degree, at least in most countries of the Global South.

Widespread stigma toward mental illness and psychiatry, prevalent not only in society but also within the medical community, further contributes to a casual or dismissive approach to the subject among undergraduates.(13, 14) Negative narratives from faculty and senior students have also been shown to adversely influence training experiences and career intentions.(15) Evaluation methods in psychiatry remain underdeveloped, with excessive reliance on formal examinations that inadequately assess clinical competence.(4) Although the competency-based MBBS curriculum introduced in India in 2019 has expanded psychiatry exposure, however, an absence of mandatory psychiatry-specific skills for licensing reflected a persistent mismatch between disease burden and training emphasis. A modification in this was made in the updated Competency Based Medical Education (CBME) curriculum 2024, by introducing two mandatory competencies which require certification, including diagnosing and managing cases of depression at the primary care level and performing suicidal risk assessment.(3, 5)

Additional systemic barriers include shortages of trained faculty, time constraints within an already dense curriculum, conventional teaching methods, poor interdepartmental integration, and limited administrative and political prioritization of mental health.(6, 16, 17) Psychiatry's non-full-subject status, inadequate exposure to behavioural and social sciences, and unmet mental health needs of medical students themselves further contribute to disengagement from the discipline.(17, 18)

At the same time, there is growing recognition that training in psychiatry, mental health, and behavioural sciences equips medical students with essential communication skills, empathy, and humanistic values that are critical across all areas of medical practice.(3, 17) Educational reforms emphasizing integrated, community-based, and competency-oriented approaches have been advocated to address these gaps.(19–21) Recent legislative developments, including the Mental Healthcare Act of India (2017), which decriminalizes suicide and formally acknowledges the burden of mental illness, further highlight the urgency of strengthening undergraduate psychiatry education.(6)

While quantitative studies have documented deficiencies in psychiatry training, there remains a limited understanding, more so in the Indian context, of how students and faculty (both psychiatry and non-psychiatry) perceive undergraduate psychiatry education, the barriers they encounter, and the facilitators they identify within institutional contexts. Exploring these perspectives is essential to inform meaningful curricular reform. Therefore, to bridge this gap, the present qualitative study seeks to examine the experiences and perceptions of undergraduate medical students and faculty regarding psychiatry training, with the aim of identifying contextually relevant barriers and opportunities for strengthening undergraduate psychiatry education.

Methods

Study design and participants:

The qualitative phenomenological study was conducted at a tertiary-care teaching hospital in India, with participants including medical undergraduates and faculty members of the institute. The undergraduates were purposively selected from third-year students through the internship period, while the faculty members were educators from basic sciences, paraclinical, and clinical disciplines. Such wider representations were to ensure diverse and contextual perspectives from the participants on the subject under study.

Study participants:

Medical undergraduates of the institute from 6th semester onwards (with some exposure in psychiatry), 5th semester medical undergraduates who participated in the Early Exposure Psychiatry Enrichment Program (EEPEP) conducted at the same institute, and Faculty members who were actively involved in the medical education at the institute or part of the Medical Education Unit.

Research paradigm, epistemology, methods, and integrity.

The research paradigm, epistemology, methodology, and integrity were laid down following Braun and Clarke Model (2006). We followed a constructivist paradigm in our approach to the study and data collection, as there could be multiple realities/perspectives on the phenomenon being studied. We went about the research with the knowledge that psychiatry exposure is limited during the medical undergraduate period in our institute and students have limited knowledge about the mental health, and that for non-psychiatry faculty, the integration of psychiatry with other disciplines were inadequate and infrequent. We also went about the research with the awareness that psychiatry exposure can be a useful medium to enhance the Attitude, Ethics and Communication (AETCOM) training of the undergraduates, enhancing their understanding of the biopsychosocial model of medical illnesses, thus its role providing more holistic care to the patients. Moreover, better knowledge, attitude, and skills of the medical undergraduates can help them understand their own mental health, including the need for care, and explore the same in their peers and patients.(22, 23)

The relationship/role of the principal investigator (PI) with the participating students was as the coordinator of psychiatry undergraduate training and coordinator of EEPEP, a unique initiative of the department of psychiatry of the institute. Likewise, the PI had an educational or research link with the involved faculty participants of the study; however, the PI was not primarily involved in data collection or qualitative analysis.

Regarding the method of data collection, we followed phenomenological approach with no intention to form any theory based on the themes or study's findings.

The integrity of the data collection and analysis was ensured by one of the authors doing the data collection, and the investigating team doing the debriefing session following the data collection to identify any diversion in the data collection protocol, any misinterpretation or ambiguous information to ensure accuracy and reliability in data collection, themes as emerged during the interview sessions or during the debriefing session was iteratively incorporated into the interview guide and subsequent interviews. Moreover, the subjective interpretations [which could be biased based on the investigator's prior knowledge of the subject or their relationship with the participants] were minimised through mutual discussions among the study's investigators in the debriefing session.

We followed a deductive method of data collection and analysis, as the preset broad themes for data collection were ways to enrich psychiatry training of the medical students and facilitators and barriers in enriching their psychiatry training. However, codes and the sub-themes for the data set were inductive in nature, which were identified as they emerged from the phenomenological experience of the participants.

Sample size

We conducted Focus Group Discussions (FGDs) with medical students and faculty members, and In-depth interviews (IDIs) with key position-holding faculty members until saturation was attained. i.e., no new themes emerged during the data collection. The FGDs conducted with the students' group also included students who had participated in the EEPEP to obtain students' perspectives on the feasibility and effectiveness of early exposure to the psychiatry enrichment program in during undergraduate course.

To achieve the saturation, Three FGDs were conducted each with students and faculty members, with 6–7 participants in each FGD. In addition, two in-depth key informant interviews were conducted. Participants were free to use the language they were most comfortable with. All participants communicated in English and/or Hindi, which were understood by everyone involved.

Study period:

The study was conducted over 12 months (Nov. 2023 to Oct. 2024), including a literature review, data collection through Focused Group discussions (FGD) and in-depth interviews until thematic saturation was achieved, and subsequent transcription and thematic analysis.

Instruments used for data collection:

It included

Socio-demographic proforma

to obtain basic demographic details of the participants like name, age, gender, designation, address, and contact

Interview guide

The Focus Group Discussion (FGD) guide and In-Depth Interview (IDI) guide were developed by the team for the purposes of this study based on the study objectives and a review of the relevant literature. The English-language versions of the FGD and IDI guides are provided as Additional Files 1 and 2, respectively.

For the FGD, the document (see Additional File 1) outlines a structured guide for conducting an FGD on improving undergraduate psychiatry education, including onboarding, consent, confidentiality, and session guidelines. It describes the purpose as exploring ways to enhance training, assess early clinical exposure, and identify facilitators and barriers to early exposure to psychiatry. It detailed the moderator's role, ethical considerations, and discussion rules to ensure balanced participation and meaningful input.

While the interview guide for the IDIs (see Additional File 2) describes a guide for conducting IDIs with key informants to improve undergraduate psychiatry education, including introductions, consent, and confidentiality procedures. It outlines the purpose as exploring ways to enhance training, assess early clinical exposure, and identify facilitators and barriers to early exposure to psychiatry. It details moderator roles, interview structure, and ethical considerations to ensure focused, confidential, and meaningful discussions.

Study procedure

Potential participants were approached according to the eligibility criteria. Eligible participants invited for the FGDs. They were provided with detailed information sheet about the purpose of the study and their role as the participants in the study and an informed consent were obtained. Participants were free to withdraw their consent at any time during the conduction of the study, without having to provide any explanations for the same. Their identities were kept confidential. Moreover, their identity was pseudonymized following data collection (for example Faculty-1 of the FGD1, was renamed as faculty-FGD1). Furthermore, students' participation or non-participation in the study had no bearing on their psychiatry training and assessment.

The basic socio-demographic and professional/education data were collected from the participants after obtaining informed consent. The FGDs and the IDIs was conducted using the interview guide (see Additional files 1 and 2, respectively). Each FGD would last for 75–90 minutes while IDIs usually span 45–60 minutes. The interviews were conducted at a mutually convenient time for the participants and the investigators.

The conducted FGDs and IDIs essentially explored 1) ways to enrich psychiatry teaching/training of medical students, 2) facilitator-, 3) barriers-in introducing or implementing such enrichment activities in their psychiatry training. The quality of the FGDs and IDIs was further enhanced by the probes developed a priori with the help of the existing literature. The FGDs and IDIs were audio recorded for transcription and analysis.

Data Analysis

The analysis followed the **six-phase guide, recommended by Braun and Clarke (2006)**, for thematic analysis(22):

- **Phase 1: Familiarization with the Data:** The audio recordings were transcribed verbatim to ensure a rigorous "orthographic" account. The team engaged in repeated reading of the transcripts, immersing themselves in the data to identify initial patterns of meaning and jotting down early ideas.
- **Phase 2: Generating Initial Codes:** The data were systematically coded by identifying interesting features across the entire data set. This involved organizing the raw data into meaningful groups, such as stigma related to mental health or curricular constraints. ATLAS.ti software was used for coding and the subsequent thematic analysis.(24)
- **Phase 3: Searching for Themes:** Initial codes were collated into potential themes. During this phase, the researchers considered how different codes combined to form overarching themes within the preset broad categories of Facilitators and Barriers.
- **Phase 4: Reviewing Themes:** The candidate themes were refined through two levels of review: checking them against the coded extracts (Level 1) and the entire data set (Level 2). This ensured the themes accurately reflected the meanings in the data and that there was internal homogeneity (cohesion within themes) and external heterogeneity (clear distinctions between themes).
- **Phase 5: Defining and Naming Themes:** The researchers conducted an ongoing analysis to refine the "essence" of each theme. Themes were clearly defined and named, such as "Stigma and Attitudinal Challenges" and "Integrated and Experiential Learning Opportunities". Sub-themes were also identified to provide structure to complex findings.
- **Phase 6: Producing the Report:** The final stage involved selecting vivid, compelling extracts that demonstrated the prevalence and essence of the themes. These extracts were embedded within an analytic narrative that went beyond mere description to make an argument in relation to the research questions and existing literature.

Research Integrity and Rigor

To ensure the **integrity and reliability** of the analysis, the team conducted **debriefing sessions** following data collection to minimize subjective bias and ensure accuracy in theme identification. The iterative process allowed for emerging information to be incorporated into subsequent interviews. The final analysis sought to provide a **rich description** of the entire data set, balancing the analytic narrative with illustrative participant quotes to ensure a convincing and well-organized story.

Results

Data from FGDs) with students and faculty (also IDIs) were analysed to explore perceived barriers and facilitators to early exposure to psychiatry in undergraduate medical education. Thematic analysis revealed multiple interrelated themes under each domain. Though broad areas were formed a priori, we followed an inductive approach to thematic analysis, and the findings are presented under two major categories: (1) **Barriers to Early Exposure to Psychiatry**, and (2) **Facilitators to Early Exposure to Psychiatry**, with illustrative participant quotes supporting key themes.

1. Barriers to Early Exposure to Psychiatry:

Four themes were primarily identified, namely curriculum and regulatory constraints, institutional and faculty-related barriers, student-related factors, stigma and attitudinal challenges

1.1 Curriculum and Regulatory Constraints

Both faculty and students highlighted the limited weightage and visibility of psychiatry within the current undergraduate curriculum. Faculty participants described how the minimal marks allotted and short clinical postings led students to deprioritise the subject. One participant remarked, *"Students think they can score better by studying other subjects that carry more marks"* (F-FGD 3), faculty participant of the third focused group discussion). Another added, *"We need to reinvent the wheel totally because psychiatry is still not seen as a core subject within the MBBS program"* (F-FGD 2). Students also echoed these perceptions, viewing psychiatry as a "small" or "minor" subject, as one of the students stated, *"Students consider psychiatry as a minor subject, so they don't take much interest in it."* (S-FGD 2).

One faculty shared, *"They will think that why are we going to study a subject that is not going to come in the exams much?"* (F-FGD 2). Such perceptions of limited academic importance reduced enthusiasm for learning and undermined early engagement with the field. This perception is further fuelled by the limited weightage of psychiatry in Postgraduate examination entrance examinations.

Inadequate integration of psychiatry with other subjects, which limits an early exposure to psychiatry, also emerged as a prominent theme, as reflected by one of the faculty members: *"probably the biggest barrier is that integration with other subjects is not robust"* (F-FGD 3). A vast curriculum with inadequate time slots and the burden of passing exams of the major subjects such as Medicine, General Surgery, Obstetrics and Gynecology etc., also limits interest in psychiatry by the students, as chimed by a student during S-FGD 3, *"burden of passing exams also serves as a barrier in developing interest or in early exposure in psychiatry, because each year you have that burden with you."*

1.2 Institutional and Faculty-Related Barriers

Institutional constraints, including limited staffing, lack of dedicated time for psychiatry teaching, and lower prioritisation of psychiatry, were also perceived as major barriers to early exposure to psychiatry. Faculty members described challenges in organizing integrated teaching or adequate clinical exposure due to competing curricular demands. As one faculty stated, *"It is difficult to schedule clinical demonstrations or interdepartmental sessions because of the already packed timetable and limited staff"* (F-FGD 1).

In some institutions, psychiatry departments were perceived as peripheral, lacking adequate representation in curriculum committees and decision-making forums. A faculty member commented, *"Psychiatry is often the last subject to be considered when planning rotations or lectures"* (F-FGD 3). Such marginalization limits opportunities to advocate for early and meaningful exposure.

1.3 Student-Related Factors

Students' own attitudes and misconceptions about psychiatry also emerged as a significant barrier. Many viewed psychiatry as less "clinical" or procedural, leading to diminished interest. For instance, one student explained, *"Most of us think psychiatry is about talking, not real medicine"* (S-FGD 2).

Anxiety about interacting with psychiatric patients further impedes learning. *"We don't know how to talk to them or what to say. It feels different from other wards,"* one student admitted (S-FGD 1). Faculty also noted that without structured orientation or supervision, these anxieties could evolve into avoidance rather than engagement.

Lack of acceptability by students' parents leading to psychiatry being a lesser preferred branch during postgraduation reduces students' interest or motivation for psychiatry and hence they do not take the subject seriously which may in turn lead to an insufficient and delayed exposure to psychiatry. For instance, one student stated - *"Parents are bothered whether taking up psychiatry as a branch will be beneficial for their children in the future and whether it will fetch a lot of patients. Also, what effect will it have on the Psychiatrist's life who is treating depressed patients? Will it also affect their mental state?"* (S-FGD 1)

1.4 Stigma and Attitudinal Challenges

Pervasive stigma toward mental illness and psychiatry, both societal and within the medical community, emerged as a prominent barrier. Faculty participants recognized persistent biases that positioned psychiatry as a "soft" or "less scientific" specialty. *"Even among doctors, there is a feeling that psychiatry is not a 'real' branch of medicine,"* one faculty observed (F-FGD 2).

Students internalized these attitudes, associating the field with low prestige or poor career prospects. *"People think psychiatrists are also a little crazy, or that you take this subject only if you can't get others,"* remarked a student (S-FGD 2). These entrenched stereotypes perpetuated disinterest and undervaluation of psychiatry education. Misinformation, such as there being no substantial treatment for psychiatric illnesses,

perpetuates this stigma. *"I see psychiatric patients, I feel quite sorry for them because I won't be able to treat them completely,"* said a student. Such a lack of knowledge, instead of being corrected, is passed on from senior students to their juniors, preventing them from developing any interest before they are even exposed to the subject.

Teaching psychiatry to the medical undergraduates is also not seen as a priority by many of the faculty members as they perceive psychiatry to be a postgraduate (PG) subject rather than an Undergraduate (UG) subject, as remarked upon by one of the faculty key informants during an IDI, *"only a few faculty think that psychiatry is a UG subject, while everyone thinks that psychiatry is a PG subject and will be taught when the student enters postgraduation"*.

2. Facilitators to Early Exposure to Psychiatry- for perceived facilitators to early exposure to psychiatry, the following themes emerged: curriculum and policy-level enablers, integrated and experiential learning opportunities, institutional support and sensitization initiatives, and faculty and student-driven engagement

2.1 Curriculum and Policy-Level Enablers

Participants identified recent curriculum reforms and the National Medical Commission's (NMC's) directives as promising avenues to integrate psychiatry early in training. As far as the curriculum-related changes were concerned some of the faculty members suggested a preliminary sensitization on psychiatry in the second semester of Undergraduate training itself, as quoted by a faculty in F-FGD 2, *"There should be a preliminary sensitisation in these second semester"*. Students concurred with the sentiment alike as they also mentioned that this would not only help improve their understanding of the subject but also make them more empathetic about their patients, which was reflected by a student in S-FGD 2, *"I would have known this spectrum of disorders exists and if from first year I had that orientation, there are people of my age group who come to the clinics and suffer from these things. It would just make me more empathetic"*. Faculty across different FGDs as well as IDIs opined that the early sensitisation may be done in the form of exposure to behaviour sciences in the first year. *"Early exposure is in the initial years. I would consciously try to take psychiatry out of it and put behavioral sciences into it,"* opined by one of the faculty during the IDI. This sentiment was reflected upon by another faculty in F-FGD 2 who said, *"exposure in the form of behavioural sciences should come in the early case because that teaches you Communication skills. That teaches you how to empathize and teaches you your professional relationships with patients"*, highlighting the importance of introduction of behavioural sciences in the early years to improve not only the understanding of psychiatry but also to improve the students' communication skills.

Curriculum change in the form of exposing students to clinical cases first followed by theory lectures should be encouraged, *"maybe this could be reversed that first we need we get some exposure, we get to know what an interesting branch it is and then we can have the theory sessions"* (S-FGD 3). Faculty and students alike noted that one reason for ignorance towards psychiatry is the lesser weightage of marks, *"Increasing the proportion of the marks of psychiatry will motivate people to study"*, pointed out by a student (S-FGD 1). Evaluating students with a separate exam for psychiatry was proposed as another change that can be brought about in the curriculum in order to facilitate early exposure to psychiatry. One of the faculty in F-FGD 2 said, *"this is an important subject and therefore we conduct an exam"*.

2.2 Integrated and Experiential Learning Opportunities

Mandatory inclusion of psychiatric history-taking in all case discussions was viewed as another effective strategy. *"A compulsory component of psychiatric history taking should be there in every case, whether it's medicine, surgery, or obstetrics,"* emphasized a faculty participant (F-FGD 1).

Students and faculty highlighted the importance of experiential and cross-disciplinary learning to promote engagement in psychiatry. Exposure to psychiatric components during routine clinical assessments was seen as crucial for developing a holistic understanding. *"In history taking, the mental status of the patient should be included that makes you think about the person as a whole, not just the disease,"* explained a student (S-FGD 3). This was reiterated by faculty and students alike, as stated by a faculty, *"compulsory component of psychiatric history taking or assessing any patient who comes for surgery or medicine or for anything. Because many things may be related"* (F-FGD 1) and a student, *"In history taking, the mental status of the patient can also be added"*. Both groups suggested embedding psychiatric concepts across other clinical subjects to make learning more organic.

Similarly, integrating psychiatry into other departments' teaching was viewed as normalizing mental health care. *"I think every department in itself can introduce a small psychiatry component in their teaching; that way it doesn't feel separate or optional,"* suggested another student (S-FGD 3). Students and faculty suggested including history relevant to the patient's mental health and mental status examination to be included in the history taking and examination even during their medicine and surgery postings *"We have kind of compartmentalized things. Why it can't be mental health aspect in medicine also" and "compulsory component of psychiatric history taking or assessing any patient who comes for surgery or medicine or for anything. Because many things may be related"*, suggested by two faculty respectively during F-FGD 1.

2.3 Institutional Support and Sensitization Initiatives

Faculty participants emphasized that institutional commitment could significantly enhance psychiatry exposure during the UG period. Encouraging interdepartmental collaboration as suggested by a faculty during IDI 1 "let's integrate behavioral sciences into the first MBBS professional curriculum as a component of physiology" and as a part of community medicine initiatives, as mentioned by various faculties during F-FGD 3 and F-FGD 2 as *"integrate with the family adoption program to understand the mental health of a family "* and *" early training to community medicine, along with the you know, with the collaboration of these two departments"*, respectively. Supporting mental health awareness events like "administration can do is make them aware of the mental healthcare act," as suggested by a faculty member during F-FGD 1, and providing faculty development opportunities were cited as key facilitators. For instance, one participant remarked that such initiatives help *"students start realizing the importance of so many psychological factors in patient care"* (Faculty during IDI 1).

Creating visible, student-friendly psychiatry departments and providing platforms for dialogue on mental health were perceived to cultivate curiosity and acceptance. During S-FGD 1 a student noted, *"Department doors are open for the students as in they can come and sit in the OPD for as long as they want, even when they do not have their ongoing psychiatry posting"*, while another said, *"If a psychiatrist reveals how he maintains his own mental health and what psychiatry has taught him to be healthier, can be a facilitator"* and would contribute in making the psychiatry department more student friendly and approachable.

2.4 Faculty and Student-Driven Engagement

Faculty enthusiasm and mentorship were described as pivotal in shaping students' perceptions. Positive role modelling by psychiatry educators/faculty could dispel misconceptions and foster genuine interest in psychiatry. As one student observed, *"When teachers show interest, we automatically start taking the subject more seriously"* (S- FGD 3).

Peer influence also played a role; hearing positive experiences from seniors or peers who had engaging psychiatry postings often inspired others to view the subject more favourably.

Discussion

The current study aimed to explore the perspectives and reflections of undergraduate medical students and faculty regarding early exposure to psychiatry within undergraduate medical education. Specifically, the study sought to identify the perceived barriers limiting meaningful engagement with psychiatry and the facilitators that may strengthen undergraduate psychiatry training in the context of evolving competency-based medical education frameworks in India. By adopting a qualitative phenomenological approach, the study attempted to generate contextually grounded insights into how curricular structures, institutional culture, stigma, and educational practices influence students' engagement with psychiatry.

A major strength of this study lies in its inclusion of diverse stakeholders, including undergraduate students across different phases of training, faculty from multiple disciplines, and key institutional informants, thereby enabling triangulation of perspectives and enhancing the depth of understanding. The use of focus group discussions and in-depth interviews allowed exploration of nuanced attitudes and lived experiences that may not be adequately captured through quantitative methods. The findings highlight that undergraduate psychiatry training is influenced by interconnected curricular, institutional, and attitudinal factors. Key barriers included psychiatry's marginal status within the curriculum, stigma toward mental illness and the specialty, inadequate integration with other disciplines, and institutional limitations. Conversely, early sensitization, integrated and experiential learning, institutional support, and positive faculty mentorship emerged as important facilitators for strengthening undergraduate engagement with psychiatry.

Barriers

In our study, one of the major factors that emerged as a barrier to early exposure to psychiatry was the place of psychiatry in the medical undergraduate curriculum as a minor subject, carrying lesser weightage in marks as compared to the other subjects, hence rendering it less significant in the eyes of the students. This also translates into the postgraduate entrance examinations where psychiatry carries lesser marks and hence students avoid devoting adequate time to the subject. Students also echoed that the burden of the passing the exams lies primarily on the 'major' subjects (e.g., general medicine, surgery, obstetrics and Gynecology), hence subjects with lesser weightage like psychiatry get neglected. Across many countries, psychiatry receives a small fraction of total marks and time in undergraduate curricula relative to mental health burden. For instance, in Nepal, summative psychiatry assessment forms only 0.21–2.5% of total course marks despite 25–92 hours of teaching and typically only 2-week clinical rotations.⁽²⁵⁾ A welcome step in this regard has been taken by institutes such as All India Institute of Medical Sciences Rishikesh ⁽²⁶⁾ and All India Institute of Medical Sciences Deoghar ⁽²⁷⁾, where psychiatry has been introduced as a major subject with separate undergraduate assessments independent of General Medicine.

Lack of institutional elements like adequate staff, time and infrastructure dedicated to psychiatry because of its 'minor subject' status also leads to insufficient and delayed exposure to psychiatry. Similar findings have been reported in previous studies like Allison et al. and

Kallivayalil et al, that governmental and institutional under-prioritisation of mental health services and psychiatry education convey to students that psychiatry carries a low status and an optional subject. (3, 28, 29) Scarcity of tutors and trained faculty is repeatedly cited as a major obstacle to quality undergraduate training. (17, 29) Limited psychiatric beds, clinical sites that can host students, and restricted access to patients undermine bedside teaching and skill development. (30)

Various student-related barriers, such as misconceptions about psychiatry being a non-medical subject, stigma towards persons with mental illnesses, also emerged prominently in our study, which led to inadequate, delayed exposure, and lesser interest of students towards. A few students reported that they perceive fear in going to the ward or talking to the patients, highlighting interpersonal stigma towards psychiatry and patients with mental illness. The stigma also perpetuated the disapproval of the students' parents towards taking up psychiatry as a subject, hence further reducing students' interest in it. Previous studies have reported similar findings in terms of student-related factors leading to inadequate or delayed exposure to psychiatry. Negative or stigmatized views of psychiatry and people with mental illness reduce enthusiasm and career interest. (29, 31) Students report fearing mental health environments and their own ability to interact safely and helpfully with patients. (32) Perceptions that psychiatry is imprecise, emotionally draining, low-prestige, and offers little "instant gratification" also deter engagement. (29, 33)

The analysis identified stigma toward mental illness and psychiatry as a central theme, with subthemes including perceptions within the medical community and its presence in the hidden curriculum. Perceived marginalization of psychiatry emerged as another theme, reflected in subthemes such as its characterization as a "soft" or less scientific specialty and its positioning as primarily a postgraduate discipline.

A third theme, early attitude formation, included subthemes of internalized low prestige, limited career prospects, and misconceptions regarding treatment effectiveness, often shaped through informal peer transmission prior to formal teaching. Perceived professional identity of psychiatry also emerged, encompassing subthemes such as low respect, limited curricular encouragement, and concerns related to job satisfaction and personal impact.

Medical students frequently perceive psychiatry as having low prestige, poor respect in the medical community, and limited encouragement in curricula. (6, 34) Such associative stigma can deter students from choosing psychiatry and reduce engagement in psychiatry postings. (34, 35) Students also fear psychiatry harms one's own mental health, has low job satisfaction and thus, underestimate of psychiatrist's role as a doctor. (33, 35)

Facilitators

Participants viewed recent curriculum reforms and the NMC's directives as important opportunities to strengthen early integration of psychiatry in undergraduate training. Both faculty and students emphasized the value of early sensitization, as early as the first or second semester, to foster awareness, empathy, and understanding of psychiatric disorders. Early exposure through behavioural sciences was seen as particularly beneficial, not only for introducing psychiatric concepts but also for developing core competencies such as communication skills, empathy, and professional doctor-patient relationships.

Participants repeatedly emphasised the need to restructure teaching methods, advocating early clinical exposure followed by theoretical instruction to enhance student engagement and the perceived relevance of psychiatry. Additionally, the low assessment weightage assigned to psychiatry was identified by them as a key contributor to student disengagement. Increasing the allocation of marks or introducing psychiatry as a separate examination was perceived as a potential motivator and a signal of institutional importance. Some students and faculty expressed reservations, noting that additional requirements might further add to an already demanding curriculum and academic workload. A few participants also reflected that introducing a mandatory psychiatry examination could, in some cases, lead students to engage with the subject primarily from an assessment-oriented perspective rather than a deeper learning approach.

Collectively, these findings suggest that curricular and assessment reforms could play a critical role in improving undergraduate engagement with psychiatry.

Studies like Salazar et al resonate the factors highlighted during our study, like creating rich clinical exposure (patient interaction, Outpatient Department (OPD) observation, case presentations, evening postings) may act as key facilitators of learning. (36) Ghodse et al also noted that integrating psychiatry earlier and across the curriculum promotes interest of students in the subject, normalizes mental health and helps counters stigma. (37) Few studies also underlined the importance of aligning teaching with common mental disorders, assessment skills, mental health law, and primary-care needs. (31, 36, 38)

The mandatory inclusion of psychiatric, psychological, or emotional aspects in history-taking in all clinical case discussions emerged as a key strategy to facilitate early exposure to psychiatry within undergraduate training. Faculty and students emphasized that embedding psychiatric assessment, irrespective of specialty, would promote holistic patient care and counter the compartmentalization of mental health.

Incorporating mental status examination into routine history-taking was viewed to encourage students to consider patients beyond only their diagnoses and recognize the interrelationship between physical and mental health.

Participants also underscored the value of experiential and cross-disciplinary learning, suggesting that exposure to psychiatric components during routine clinical postings could enhance relevance and engagement. Integrating psychiatry into the teaching of other departments was perceived as a means of reducing its “separate” or optional status and reinforcing mental health as a core clinical competency. Collectively, these findings highlight the potential of longitudinal, integrated approaches to strengthen undergraduate engagement with psychiatry and foster holistic clinical reasoning.

Restructuring curricula to increase integration with other specialties led to better attitudes towards psychiatry, patients, and psychiatry as a career. (39) Competency-based frameworks in India and elsewhere explicitly see integration with other specialties as an opportunity to familiarize all doctors with mental health concepts. (31, 40)

Faculty participants highlighted the role of institutional commitment in strengthening undergraduate exposure to psychiatry. Interdepartmental collaboration was viewed as a key facilitator, with suggestions to integrate behavioural sciences into the first-year curriculum, particularly within Physiology, and to align psychiatry teaching with Community Medicine initiatives such as family adoption programs. Such approaches were perceived to contextualize mental health within routine medical and community-based care.

Institutional support through mental health awareness initiatives, including sensitization to the Mental Healthcare Act, and opportunities for faculty development were also identified as important enablers. These efforts were also appreciated by the participants to help students recognize the influence of psychological factors on overall patient care.

Students further emphasized the importance of visible, accessible, and student-friendly psychiatry departments. Open clinical spaces, informal exposure beyond scheduled postings, and opportunities for dialogue with psychiatrists were perceived to foster curiosity, reduce stigma, and enhance approachability. Together, these findings underscore the importance of institutional culture in shaping undergraduate engagement with psychiatry.

Other studies, like Sahadevan et al. also focused upon integration of psychiatry teaching with other specialties, like Neurology, which would lead to the strengthening of scientific basis, dispelling misconceptions and sparking early interest. (40) A study by Dube et al in 2015, also stated that including mental health aspects in family medicine and neurology would lead to an early integration of behavioral and physical health. (41) Competency-based frameworks in India and elsewhere explicitly see integration with other specialties as an opportunity to familiarize all doctors with mental health concepts. (40) A school-based mental health module during psychiatry clerkship improved empathy, communication, adolescent-focused literacy, and resilience skills via real-world contact and reflective work. (12)

Faculty enthusiasm and mentorship were identified as key determinants of students’ perceptions of psychiatry. Positive role modelling by engaged educators helped challenge misconceptions and increased the legitimacy of the subject within undergraduate training. Students frequently echoed this notion that they take psychiatry more seriously when faculty demonstrated genuine interest. Peer influence also shaped attitudes, with positive experiences shared by seniors or classmates fostering greater openness and interest in the discipline.

Inspirational, teaching-oriented psychiatrists strongly influence student attitudes and career choice. (29, 37) Faculty development programs in teaching, assessment, leadership, and research are considered crucial for maintaining standards and meeting accreditation requirements. (37, 42) Surveys and reviews from India highlight strong demand for training in teaching methods and CBME implementation; workshops and teacher forums are key enablers. (40, 43) Structured, supervised placements with clear induction, near-peer mentors, psychological safety, and visible, enthusiastic role models improve learning, satisfaction, and interest in psychiatry careers. (29, 36)

Conclusion

This qualitative study highlighted that undergraduate exposure to psychiatry is shaped by a complex interplay of curricular structure, institutional priorities, stigma, and role modelling within medical education. Positioning psychiatry as a minor subject with limited assessment weightage and clinical exposure conveys diminished importance to students, reinforcing disengagement despite the substantial burden of mental illness. Stigma toward mental illness and psychiatry, perpetuated by misconceptions, informal peer narratives, and attitudes within the medical community, emerges early in training and continues to influence students’ perceptions and career considerations. Structural constraints, including inadequate faculty strength, infrastructure, and integration with other specialties, further limit meaningful engagement with the discipline.

At the same time, the study identifies clear, contextually relevant facilitators for strengthening undergraduate psychiatry training. Early sensitization through behavioural sciences, increased and integrated clinical exposure, mandatory inclusion of psychiatric assessment across specialties, and appropriate assessment weightage were perceived as critical enablers. Institutional commitment, interdepartmental

collaboration, visible and student-friendly psychiatry departments, and faculty enthusiasm and mentorship played a pivotal role in normalizing mental health and fostering student interest.

Collectively, these findings underscore the need to move beyond isolated curricular changes toward a longitudinal, integrated, and competency-based approach to psychiatry education. Strengthening undergraduate training in psychiatry is essential not only to address workforce shortages but also to equip all future physicians with the skills required for holistic and effective patient care.

Abbreviations

- CBME - Competency Based Medical Education
- EEPEP - Early Exposure Psychiatry Enrichment Program
- AETCOM - Attitude, Ethics and Communication
- FGDs - Focus Group Discussions
- F-FGD - Faculty FGD
- S-FGD - Student - FGD
- IDIs - In-depth interviews
- NMC - National Medical Commission
- OPD - Outpatient Department

Declarations

Ethics approval and consent to participate - Ethical approval was obtained from the Institutional Ethics Committee of AIIMS Bhopal (IL071-LOP-P-2022). Written informed consent was obtained from all participants prior to data collection. Participants were free to withdraw at any time without consequence. The study was conducted in accordance with the ethical principles of the Declaration of Helsinki and all applicable institutional and regulatory guidelines.

Consent for publication - Not applicable — no individually identifiable data, images, or case details are included. All participant identities were pseudonymised.

Availability of data and materials - The qualitative data generated during the study may be obtained from the corresponding author upon making a reasonable request/providing justification

Competing interests - All authors declare no competing interests.

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Authors' contributions –

All the authors mentioned above have contributed significantly to the research that led to this paper. None of the authors has any association with any commercial sector or any agency that could be construed as a potential conflict of interest regarding the current research work.

SG and BR conceptualised the study;

SG, BR, and AK conducted data collection;

BR and SG performed thematic analysis;

BR and SG contributed to the interpretation of findings;

BR and SG drafted the manuscript;

AK, VS and AP have reviewed the manuscript.

All authors reviewed, revised, and approved the final version.

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