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The End of an Era

With this issue of Academic Psychiatry, the journal’s leadership has changed. Although a glance at the masthead will reveal that Samuel Keith has replaced Jonathan Borus at Editor, we urge you to look again, for Jon remains with the journal as former Editor. On the occasion of this transition, we wish to honor Jon not only for what he did, but also for how he did it.

By the usual outcome measures for editors, Jon accomplished a great deal. Perhaps the most important sign of this success has been a steady increase in the number and quality of submitted manuscripts. Under his direction, the journal acquired a new name (it was formerly the Journal of Psychiatric Education), new ownership (a joint venture of the AADPRT and AAP), a new publisher (American Psychiatric Press, Inc.), and an excellent working relationship between the owners and the publisher. The journal’s readership has increased, both among libraries and individuals, and there are currently over a thousand paid subscriptions. There have been substantial format changes as well, with the inclusion of a letters section, book reviews, educational abstracts, and Q&A essays. All of these developments represent improvements in the quality, design, and appeal of Academic Psychiatry. The journal is now chosen by many authors for an initial review of their works, and papers published in Academic Psychiatry are read, debated, and quoted.

Under Jon’s leadership, Academic Psychiatry adopted a tough-minded approach to the manuscript review process and dedicated itself to the task of educating its authors, as well as its audience. As a result, manuscripts and their revisions are thoroughly—and often repeatedly—reviewed. Because the editors hope that all submissions can ultimately become published articles, comments to authors are detailed and critical. Not every author has enjoyed this process or always been pleased by its outcome, but none can doubt that it is seriously undertaken. Jon set the standard for reviewing in Academic Psychiatry, and he worked hard to help reviewers improve their efforts.

As Editor, Jon was the quintessential good shepherd, organizing his flock of associate editors and keeping an ever-present eye on deadlines and unmet promises for copy. He bullied, cajoled, and seduced his charges into being consistently productive, and he managed a complex academic and commercial enterprise with energy and optimism. Perhaps more than anything else, Jon’s manner of leading and doing will be remembered and valued by his colleagues on the journal’s staff. He accepted responsibilities without complaint or fanfare, yet he always insisted that others do their share. Jon welcomed ideas, praised initiative, and never lost sight of the goal—to produce and improve the journal for psychiatric educators.

As Jon’s former deputies, we know better than anyone how much he has given to Academic Psychiatry. We also know that Sam Keith will, in his way, build on Jon’s accomplishment, and we wish him every success as the journal’s new editor.

William H. Sledge, M.D.
Phillip R. Slavney, M.D.
Special Article

Graduate Medical Education Financing in Psychiatry

Jed G. Magen, D.O.
Deborah A. Banazak, D.O.

Psychiatry residency training programs are being affected by changes in graduate medical education financing. Program budgets are increasingly being constricted. Training directors will need to be better informed about how programs are financed if they are to function effectively and to advocate successfully for training funds. The authors illustrate the present mechanisms of graduate medical education financing with examples. The possible effect of the coming reform in health care financing on psychiatry residency training is examined. (Academic Psychiatry 1995; 19:6-11)

The mechanisms by which graduate medical education (GME) is financed in the United States are very complex and prone to misinterpretation. In our interactions with other training directors and various administrators in large and small hospitals, we have observed that there is considerable misinformation about GME funding. We wrote this article to clarify the funding mechanisms and to help those involved in GME understand how hospitals' funding amounts are calculated. A number of confusing terms that are embedded in any discussion of GME funding are defined in Table 1.

Before spending the time to read an article like this, one could legitimately question why training directors should know much about financing. After all, the training budget comes from the hospital, often through the department chairperson. Presumably, the training director can do relatively little to influence funding and reimbursement. Consider, though, that to some extent, knowledge is power. Understanding the intricacies of reimbursement and budgeting may help those most familiar with programs find hidden costs or opportunities for additional income. As well, hospital or departmental financial personnel often do not have a good grasp of all the components involved in quality education or health care delivery. An understanding of the financial issues involved in GME will help training directors to more effectively advocate for their programs. Furthermore, an understanding of health care economics, especially cost-containment issues, is becoming essential to practice efficient and high-quality medicine. Training directors should be role models for residents in this area and in clinical areas. Finally, we have observed that this financial knowledge gives us more credibility when dealing with chairpersons and hospital administrators.

Health care costs are under a great deal
of scrutiny because they are consuming ever larger amounts of the gross domestic product. Clearly, the rapid escalation of costs needs to be slowed. Past steps have put pressure on GME programs and are likely to be instructive in providing a glimpse of what the future holds. The institution of diagnosis-related groups (DRG) has cut the lengths of hospital stays and revenues. The impact of these cuts has been felt in training programs in at least two ways. First, as hospital revenues shrank, so did GME budgets. Second, psychiatry programs experienced a decrease in lengths of stay on inpatient units and an increase in the number of patients with very severe illnesses (1). This markedly changed the inpatient training experience. The coming health care financing reforms will result in GME becoming a focus of further cost-containment measures. Given this background, training program costs will be examined more closely by hospitals. Financial considerations will force programs to account for their costs in detail.

**FINANCING OF GRADUATE MEDICAL EDUCATION**

Funding for GME comes from both the Medicare program and from various non-Medicare sources. The vast majority of funding comes through the Medicare program. When a teaching hospital receives payment from Medicare for inpatient services, a financial component is added to compensate the hospital for expenses associated with training. This “pass-through” comes in a direct medical education (DME) component and an indirect medical education (IDME) component.

Calculating GME pass-through revenue requires that one have some data from the hospital involved. For purposes of this exercise, we will “invent” a hospital. Our hypothetical medical center (HMC) is a major teaching hospital and has a DME cost approved by Medicare of $60,000 per resident. There are 600 beds and 400 interns and residents. The HMC has a large number of Medicare patient days and will qualify for the disproportionate share adjustment (discussed later). The calculation of DME and IDME revenue for the HMC and an explanation and calculation of disproportionate share (DSH) adjustment follow.

**Direct Medical Education Pass-Through**

This component is calculated on the basis of stipends and fringe benefits for housestaff and some salaries for teaching personnel, such as the director of medical education. The hospital essentially totals these costs and presents them to the govern-

**TABLE 1. Graduate medical education funding terms**

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tr>
<td>Medicare Utilization Rate</td>
<td>Number of Medicare patient days divided by total number of patient days during the year (will be &lt; 1).</td>
</tr>
<tr>
<td>Federal-Specific Blended Diagnosis-Related Group (DRG) Rate</td>
<td>Average payment per Medicare discharge calculated from a series of regional or national measures of costs. This figure differs by region of the country.</td>
</tr>
<tr>
<td>Hospital Case Mix Index</td>
<td>The average DRG weight for all cases in the hospital paid under Medicare prospective payment system.</td>
</tr>
<tr>
<td>Outliers</td>
<td>Under the DRG system, extra reimbursement provided to hospitals for Medicare cases that exceed the norm in terms of length of stay and result in additional Medicare payment to the hospital. As well, there will be a small additional medical education payment under the indirect medical education payment (IDME).</td>
</tr>
<tr>
<td>Full-Time Equivalent (FTE)</td>
<td>Calculating all trainee time in terms of numbers of full-time workers. For instance, two half-time residents would be counted as one FTE.</td>
</tr>
<tr>
<td>Allowable Costs</td>
<td>Costs determined from 1984–1985 base year for medical education unique to each hospital with training programs.</td>
</tr>
<tr>
<td>Aggregate Approved Amount</td>
<td>The cost per resident, approved by the federal government for training.</td>
</tr>
<tr>
<td>Medicare Utilization Rate</td>
<td>The number of Medicare inpatient days divided by the total number of inpatient days for the hospital. This ratio will be some fraction of 1, higher in those hospitals serving larger Medicare populations.</td>
</tr>
</tbody>
</table>
ment for payment. However, these costs are calculated on a 1984–1985 “base year.” Hospitals with many GME programs in the mid-1980s were able to demonstrate extensive costs. Hospitals that have expanded their GME programs since then are at a reimbursement disadvantage because they did not have as many costs during the base year. Their DME reimbursement is at a lower level than that of hospitals with higher 1984–1985 costs, even if they have equivalent training programs now. Thus, reimbursement is essentially “frozen” for each hospital. Although adding more residents results in increased reimbursement, adding other educational components will not get the institution any increase in the per resident reimbursement.

Direct Medical Education Payments. For example, the cost per full-time equivalent (FTE) resident is $60,000. The average number of FTE residents is 400. Therefore, the total allowable DME program cost is as follows: $60,000 \times 400 = $24,000,000. The total allowable DME program costs equals $24,000,000. The Medicare utilization rate equals 0.46. Then, the DME payment to the hospital is 0.46 \times $24,000,000 = $11,040,000.

INDIRECT MEDICAL EDUCATION PASS-THROUGH

This segment of GME funding is much more complex. The IDME is intended to compensate hospitals for less obvious costs of training programs, including increased use of laboratory resources and other diagnostic tests (2), increased use of personnel, more severely ill patients, and higher staff-to-patient ratios (3). Because the magnitude and distribution of these costs are not well understood, the IDME is a “best guess” formula for computing these costs (2). A measure termed the federal-specific DRG rate is multiplied by the hospital-specific case mix to come out with the hospital-specific blended DRG rate. The hospital-specific blended DRG rate is unique to each hospital and depends on the specific DRG case mix in that hospital. Next, this calculation is multiplied by the number of Medicare discharges from the hospital. Added to this figure is a sum for Medicare DRG outliers. For many hospitals, this final figure is the total IDME payment.

The calculation is made more complex by an attempt on the part of the federal government to further compensate hospitals that serve a predominantly low-income population. These hospitals are said to provide a “disproportionate share” of care to low income patients and are predominantly inner-city institutions. Accordingly, a DSH adjustment is added to the IDME payment to such hospitals.

Indirect Medical Education Payments. The IDME payments are added to the DRG payments made by Medicare to the hospital. To calculate the IDME, one has to begin with a DRG payment. For example, let us use a DRG payment to the HMC of $10,000.

Calculate the intern/resident-to-bed ratio for the hospital. In this case, that ratio is 400/600 = 0.6.

With increasing intern/resident-to-bed ratios, hospitals receive increasing percentage payments added to the basic DRG. For our HMC this means a 27.59% “add on.” The basic DRG x add on = IDME amount. In this case, $10,000 \times 27.59\% = $2,759.

For the HMC, for a fiscal year the calculation would look something like the following, based on arbitrarily selected Medicare payments of $110,000,000 for the year: Total Medicare payments = $110,000,000. IDME add on = 27.59\%. Therefore, $110,000,000 \times 27.59\% = $30,349,000.

The IDME payment turns out to be almost three times the DME payment, demonstrating how important the IDME portion of GME reimbursement is to hospitals.

Calculate the Disproportionate Share Adjustment. This is also a percentage added to the basic DRG payment. We will not pres-
ent the formula for this index. Our HMC will have a DSH index of 9.12%. Thus, the add-on for the DSH is the basic DRG x DSH = DSH adjustment is $10,000 x 9.12% = $912. The total payment to the HMC for this DRG will then be the basic DRG + IDME + DSH, or $10,000 + $2,759 + $912 = $13,671.

The direct and indirect figures are then added to calculate total GME reimbursement for each institution. Although the DSH adjustment is not intended for medical education purposes, about 70% of all DSH adjustments are made to teaching hospitals. The total for medical education payments to the HMC is calculated as follows: DME payment + IDME payment = total GME payments, or $11,040,000 + $30,349,000 = $41,389,000.

**Graduate Medical Education Reimbursement Rules**

GME reimbursement is based on numbers of FTE housestaff. There is a series of regulations on how residents can be counted. Hospitals and their associated outpatient facilities are the only institutions allowed to receive GME reimbursement. Neither medical schools, nor freestanding outpatient clinics, nor other kinds of health care facilities qualify for these funds. Thus, residents on out-rotations to clinic settings, nursing homes, and other ambulatory sites not associated with a hospital are not counted in the FTE total for DME and IDME calculations. Residents on certain outpatient rotations directly run by the hospital can qualify for DME but not IDME. Furthermore, hospitals are required to calculate GME payments for the current year based on the previous year's housestaff.

These regulations have a number of consequences. First, when residents are rotated to non-hospital-associated outpatient sites, the hospital will not obtain pass-through dollars for them. This cuts into the GME total received by the hospital and can adversely affect training programs. Although this creates an incentive to keep trainees in the hospital (4), it opposes the current push also created by government financing of health care to move treatment to outpatient sites. Training directors are faced with the dilemma of providing outpatient training opportunities that may result in less income for the program. The only means at present to both maximize GME income and to create outpatient experiences is to associate outpatient training sites with the hospital. This may or may not be possible depending on facility costs, patient mix, and other factors. Because hospitals calculate GME costs based on the previous year's housestaff, any increase in housestaff numbers will not be reimbursed until 1 year later. Stipends and other costs will therefore have to be subsidized by the institution for the current year. As discussed later, the 5-year or board-eligibility rule means that further years of training, while likely to be as expensive or more expensive, will be reimbursed at only 50% of costs.

**Non-Medicare Sources of Financing**

A small proportion of financing for some residency programs comes from sources including the Department of Veterans Affairs, various state agencies, insurance companies, and capitated or prepaid plans. There appears to be little information available on these disparate sources. A computerized literature search revealed only two articles mentioning other funding sources in connection with training programs (5,6).

Some insurance companies have traditionally included an additional payment to hospitals similar to the IDME payment. As they attempt to rein in their costs, they are eliminating this payment. Prepaid insurance plans and capitated systems sometimes affiliate with training programs. They may pay for a portion of a resident FTE working in their system and provide a psychiatrist to supervise the experience.

Other financing mechanisms depend on
departmental affiliations with various agencies. The particular financial arrangements vary widely. In considering these kinds of arrangements, there are a number of important issues to be worked out. Because residents seldom spend more than several months on any rotation, many affiliates will pick up costs for only partial FTES. Some affiliates may only be willing to pay obvious and direct costs, for example, stipends and fringe benefits. Others may pay costs of administration of the residency program, malpractice insurance, resident travel, and so on. Furthermore, the payment mechanism may vary. In some situations, residents are paid directly by the affiliate. In other instances, the affiliate reimburses the training program, which then pays trainees.

Probably the most common non-Medicare source of financing is the Department of Veterans Affairs. Many training programs are affiliated with a Veterans Affairs medical center (VAMC). It is common for VAMCs to fully or partly fund positions in training programs. Although in some cases residents are paid directly by the VAMC, it is more common for VAMCs to reimburse the departments with which they are affiliated for training costs.

State sources fund about 2.4% of the cost of all residency programs in the United States (7). There are no data available on total state funding for psychiatry residencies, but it appears that funding mechanisms and sources vary widely. Programs may be funded on the basis of some number of faculty or residency positions. Monies may come directly from the state or indirectly through state hospitals or community mental health centers.

The program in which the authors work receives a portion of its budget from the state's Department of Mental Health. The state wants to increase the numbers of psychiatrists in the state and wants well-trained psychiatrists who will work in the state's mental health system. Accordingly, the residency training program places residents in community mental health centers for various rotations. Yearly reports are made to the Department of Mental Health detailing the number of resident FTES in the community mental health system and the number of graduates practicing in the state.

EFFECT ON HOSPITALS

The net effect is some increase in income, although not necessarily profit, for the hospital running the training program. There is a great deal of debate in the literature about the true costs of training and whether hospitals' training programs make or lose money (8,9). However, institutions having large GME programs for many years are likely to be reimbursed at a substantially higher rate than those with either smaller, less elaborate programs or those with growth since the mid-1980s base year. It is also probable that hospitals engage in cost-shifting by using GME reimbursement as part of the general hospital budget and not for GME activities only.

THE FUTURE OF GRADUATE MEDICAL EDUCATION FUNDING

Two regulatory changes for 1994 involve eligibility for full DME payments. First, residents will be reimbursed at 100% of the approved costs until the time of board-eligibility or a maximum of 5 years, and 50% of costs thereafter. Fellowship trainees or those board-eligible in one specialty and entering another specialty will thus be counted at the 50% rate and bring in fewer DME dollars. Second, for the 1993-1995 years, primary care specialties and the specialty of obstetrics/gynecology will receive 2.2% increases in direct GME payments. No other specialties will get rate increases. Based on indications given by the Clinton administration, we can speculate on changes being contemplated for GME. The most important alteration may be an allocation of 55% of all training positions or programs for primary
care residents. The remaining 45% would be allocated to all non-primary care specialties. It is not clear whether 55% of positions or 55% of training programs should be in primary care specialties. With limited numbers of positions for all specialty programs, psychiatry programs are likely to be much less desirable for hospitals than the procedure-oriented specialties that provide hospitals with more income. How exactly the specialty positions or programs would be allocated is unclear. Another proposal would provide only 50% reimbursement of GME costs for specialty residencies. Again, psychiatry loses because the procedure-oriented specialties are better able to support training costs out of their much larger patient revenues. As well, fiscal intermediaries are likely to be created to dispense GME funds to medical schools, hospitals, training programs, or some mix. Psychiatry might do better under this scheme if training positions are allocated by an agency above the hospital level. Because psychiatrists are becoming in short supply (10), an exception to the 45% specialty limit is being advocated by those in the field. It is unclear how this will be received at the federal level.

In most scenarios it appears that the IDME funding is likely to be eliminated, leaving one lump sum payment for GME. The source of GME revenues is yet to be determined. At least one proposal would establish a fund to which Medicare, insurance companies, and capitated plans would contribute. This is attractive in that at least all potential patients would contribute to the education of the nation’s physicians. Whatever the final outcome, we training directors will likely be in a better position to respond if armed with some knowledge about the financing system in which we all function.

References

Regular Articles

An Observation and Group Dynamics Model for Teaching Psychoanalytic Psychotherapy

Robert L. Weber, Ph.D.
Nancy Costikyan, M.S.W.
Hal Fales, M.A.
Stephanie Morgan, Psy.D.

Teaching and learning psychoanalytic psychotherapy are complex tasks involving the necessary integration of cognitive and affective elements. A model for this process is described that uses long-term observation of the teacher-mentor conducting therapy with a single patient. This method supplements and complements the use of supervision and case conferences to train psychoanalytic psychotherapists. The advantages of the observational mode are considered as well as the dynamics inherent in the group process and the discussion that follows the observation period. Such a pedagogical method emphasizes the important integration of affective and cognitive elements. (Academic Psychiatry 1995; 19:12-21)

Teaching and learning psychoanalytic psychotherapy are difficult tasks. In an effort to use a technique he found particularly helpful in his own education, the first author (RLW) conducted a long-term psychotherapy session that was observed by a group of trainees in psychiatry, psychology, and social work at the Cambridge Hospital in the Boston area. Following each session, a discussion was held. In the judgment of the participants, this instruction method enhanced the linkage between cognitive and affective experiences that has been deemed essential to effective training in psychotherapy (1,2).

Following the 3-year observation study (1986-1989), the first author (RLW) joined with a group of trainees to assess and describe this training model. The four co-authors spent several months discussing the merits of this approach. This article describes our attempt to conceptualize the pedagogical advantages of using such a method. The article's goals are to 1) review the literature, 2) describe the model, 3) explore the specific benefits of observation and group discussion, and 4) examine some of the resistances to such a model.

Dr. Weber is instructor in psychology, Department of Psychiatry, Harvard Medical School, Boston, MA, and Director of Group Therapy, Cambridge Hospital, Department of Psychiatry, Cambridge, MA; Ms. Costikyan is with the Division of Addictions, Harvard Medical School, Boston, MA; Mr. Fales is staff clinician, Hampden District Mental Health Center, Springfield, MA; and Dr. Morgan is clinical instructor in psychology, Department of Psychiatry, Harvard Medical School, Boston, MA. Address reprint requests to Dr. Weber, 385 Broadway, Cambridge, MA 02139-1602. Copyright © 1995 Academic Psychiatry.
LITERATURE REVIEW

A computer-based search of the psychiatry and psychology literature focusing on the use of a treatment observation to teach psychoanalytic psychotherapy was conducted. Despite a thorough review, little was found in the professional literature on the topic.

Traditionally, training for psychoanalytic psychotherapy has involved didactic methods such as coursework, conferences, and supervision (3). Although direct observation of therapy is a particularly valuable way of engaging the trainee emotionally and intellectually, few reports exist in the literature describing such an approach (4,5). One wonders if this is because of the method's underutilization or because of its underreported use in the literature. If it is a case of underreporting, perhaps this article will encourage further commentary and discussion on this teaching method.

Family and group therapy programs customarily use direct observation for training and treatment. Family therapists commonly use demonstration through observation to illustrate the theory and practice of family treatment (6,7). Group therapy training also extensively uses observation to train group therapists and to treat group patients. Berkovitz and Sugar (8) believe that observation has been one of the most effective methods of teaching group therapy and refer to a variety of formats for such instruction (9–13).

Other authors have written about the role of observers (14,15) and the effects of observers on group process (16,17). Despite the impact that observation has on the group, it does not seem to prevent good treatment from occurring and it does seem to promote very solid training opportunities (2,10,11,16,18,19). Bloom and Dobie comment that "the presence of observers, which is important for training and research, is not incompatible with the goal of therapeutic change for the patients" (10, p.86). Mackie and Wood report little doubt that the "screened group is a useful method of demonstrating psychotherapeutic technique, not only in group but in individual therapy" (11, p.183).

Fielding and colleagues (19) underscore the importance of live demonstration of psychodynamic concepts in an observation group for medical students. There were three learning goals central to their use of this method: 1) introduction of dynamic material and concepts, 2) demonstration of techniques of therapy, and 3) discussion of problems of the therapist-patient relationship. They saw it as a way "to show students what was meant by psychotherapy and to rescue it from the status of an obscure and even esoteric discipline that could be talked about but never shown" (19, p.484).

Furthermore, Fielding and colleagues saw other particular advantages for the students' learning. For example, students could observe "the staff be recipients of hostile communications and still function rationally and work deliberately in a constructive way without manifest anxiety and without rejecting the patient" (19, p.487). Consequently, students were able to examine their own feelings about patients because the model provided "the detachment necessary for accurate self-assessment [which] seemed to come more easily in the relative security of the observation room than when actually confronted by an anxious or angry patient" (19, p.487).

Kritzer and Phillips (2) argued that observation facilitated the important link between the cognitive and affective aspects of learning. Their underlying assumption is rooted in the work of Ekstein and Wallerstein (1). They assume that the "learning that results in the acquisition of skill and therefore requires change necessarily involves strongly charged affective components." To "transform concepts into practice" there must be "the emotional acceptance of what is observed" (2, p.471).

Despite the reported success of this teaching method for psychotherapy, it is im-
portant to note that a fundamental reluctance to use individual therapy observation to teach psychotherapy exists. Hadden reported the general consensus in this matter when he wrote that “it is very difficult to teach students psychotherapeutic methods because of the intimate patient-physician relationship which is disturbed by the presence of another individual” (18, p.648).

Fielding and colleagues (19) were also reluctant to use individual therapy observation for several reasons. First, for purposes of broad teaching, they felt that the dyad would provide a more limited experience of the variety of psychopathology than would a group therapy observation. Second, they felt that the greater importance of nonverbal therapist-patient communication in the individual setting and the development of a particular therapist-patient language in a dyad would make the therapeutic process more obscure to observers. In contrast, within a group setting, as group members communicate more clearly to one another, they make the process clearer to the observers. Third, the fundamental reason that the researchers chose group over individual therapy observation is because they feared that the privacy of the dyad would be subject to the effects of distortion and interference, caused by the observation.

Fleischman (3), in describing and discussing the basis for his decision to start an individual therapy observation seminar at the Menninger Institute, traced the origins of resistance to this teaching method to Freud’s own comments on the subject (20). Working within the medical context, Freud recounted the importance of clinical demonstration for training physicians and noted that such clinical demonstration, even in psychiatry, “yields a series of observations which leave a deep impression on your minds... [in this way you gain] a direct relationship to what is displayed to you [and come to be convinced] by your own experience of the existence of new facts” (20, p.18).

Despite his own observation Freud wrote that such a possibility for psychoanalysis did not exist. He wrote

But in psychoanalysis, unfortunately, all this is different. In psychoanalytic treatment nothing happens but an exchange of words between the patient and the physician... Therefore, let us not despise the use of words in psychotherapy and let us be content if we may overhear the words which pass between the analyst and the patient. But even that is impossible. The dialogue that constitutes the analysis will admit of no audience; the process cannot be demonstrated.

As Fleischman noted, Freud’s opinion in this matter continues to exert a powerful influence on the pedagogy of psychotherapy training, despite the fact that psychoanalysis, as any other therapeutic technique, cannot “be learned from books and lectures only” (21). Rather than challenging this prevailing view as Fleischman did, psychoanalysts traditionally relied on the tripartite training program developed in 1922 by the International Psychoanalytic Association, consisting of the following: 1) a personal analysis, 2) study courses in theory, and 3) treating several patients under supervision for a period of time (3, p. 161). And, rather than seeking to alter this thinking, the consistent conclusion was that “there is a peculiar difficulty in the fact that it is impossible to make patients the object of a demonstration of the analytic method of treatment” (21).

A different position is evident in the work of Fritz and colleagues (5) who report on a “directly observed, continuous case conference” for the training of child psychiatrists. Their discussion seems relevant to work within an adult observation course as well. In particular, Fritz and colleagues argued that the process of such a conference achieves several learning goals: 1) evaluation of psychodynamic understanding, 2) examination of transference and countertransference, and 3) discussion of the theo-
retical and practical aspects of therapy.

Fleischman's paper (3) is the first we could find that reports on the use of such a method for working with adult patients in psychoanalytic psychotherapy. Fleischman and his associates made two fundamental assumptions that enabled them to establish a rationale for using individual observation that ran counter to Freud's caveat. First, they considered that the patient-therapist relationship is a broader and more flexible one than that stated by Freud. Second, they assumed that the patient in treatment had the ego capacity to accept the altered treatment situation. This latter assumption required two things: that the observation technique be fully explained to the patient and agreed to beforehand, and that, thereafter, the reactions of the patient to the peculiar circumstances of observation could be dealt with in the therapy session as manifestations of transference resistances.

As a result of using this method, Fleischman felt that the student-observers were exposed to "a very complex emotional experience." In identifying with the patient and therapist, feeling ambivalent toward both, experiencing empathy, and gaining intellectual understanding, students are encouraged to work on their own conscious and unconscious feelings and defensive attitudes" (3, p.163). The observers' comments and reactions to Fleischman's course had four recurring themes: 1) the emotional impact on the students of seeing theory demonstrated, 2) the students' identification with the patient, 3) the students' identification with the therapist, and 4) relief at seeing the treatment end successfully.

Fleischman also concluded that while learning from discussions was helpful, it was not as important as the primary experience of observation, which had a dramatic impact on participants. The discussion session seemed to serve three purposes: 1) gaining an understanding of the patient's behavior and to understand and accept the therapist's actions; 2) pointing out objectively what was felt and seen during the sessions but which could not be articulated; and 3) clarifying the dynamics and the techniques illustrated in the treatment.

FORMAT OF THE COURSE
UNDER DISCUSSION

The observation course was advertised with other seminars in the Department of Psychiatry at Cambridge Hospital; participation was elective. The seminar was entitled "Individual Therapy Observation" and described as follows: "This course will involve observation and discussion of a weekly, ongoing psychoanalytic psychotherapy case. Participants will observe the 45-minute treatment session, and a 45-minute discussion will follow each meeting.

"Discussion will focus on the following major topics: 1) ongoing theoretical formulation of the case from psychodynamic, self-psychological and object relations perspectives; 2) contractual and frame issues of the treatment process; 3) the theoretical basis for intervention and use of psychoanalytic techniques; and 4) the use of transference as well as countertransference. Readings will be recommended as specific topics arise in the course."

The course met early Tuesday mornings. The students and staff who participated had to be very motivated and interested given the commitment to the early hour and the year-long course duration. The trainees and staff had a variety of attitudes toward the course at the start. Most were quite enthusiastic about it, and it soon became clear that being off the "hot seat" and not having their own work scrutinized was at least part of the reason.

For the instructor (RLW), this was an important opportunity to demystify the process of therapy. Recalling his own training and learning as a therapist, the instructor valued each component of his training, the coursework and didactics, the supervision, and his own therapy. In retrospect, however,
The most valuable experience was observing his own mentor conducting therapy. So often what trainees hear about what goes on in therapy seems so discrepant with what they actually experience when doing therapy. The authors, the observed and observers, began by asking themselves what it was that made observing and being observed such a powerful teaching and learning method.

For the trainees it was edifying to have role models who were willing to expose their work. It is clear that to be effective, psychotherapy training must facilitate the link between both the cognitive and affective experiences of the trainees (1,2). Two particular elements of this course were most salient to the fact that a therapy observation course enhances the link between the cognitive and affective dimensions to learning. The first is the observational phenomenon, and the second is the group context for processing the observation.

CONTRIBUTIONS OF OBSERVATION

Observation creates and enhances an emotional involvement of the observers with the psychotherapeutic process that mere discussion or reporting does not. It is difficult for trainees not to become engaged in the emotional and cognitive dynamics of the treatment process while observing an ongoing treatment. In some ways it is like watching a good drama that invites vicarious audience participation in the ongoing lives of the characters.

Therapy is an ongoing story, a story of the interaction of two lives in a professional context, where one person is telling his or her story and attempting to edit or replay it in the context of the therapeutic relationship. The immediacy of the observational experience maintains an authentic and intense emotional engagement that may be lost during presentation to a supervisor. Trainees reported thinking about what was going on in the therapy between sessions and spoke passionately of their reflections.

Another significant change that occurs through observation is the student's gradual identification with and use of the therapist-teacher as a model. The students reported modeling sessions with their own patients based on their observations of the instructor. At times this took the form of the trainees modeling and imitating the way the mentor listened and responded to a patient. Some of the students even began to imitate the kind of statements the instructor would make to the patient. By repeating those statements, the students later reported being able to comfort and soothe their own patients, particularly during difficult sessions. While they did not chose to mimic all aspects of what they observed, they were encouraged to think, explore, and experiment with what they saw and learned by applying the theory and technique to their own work.

The process of identification and modeling elicited several particularly salient characteristics in students. These include 1) a deepened curiosity about and interest in the patient, his story, and his psychodynamics; 2) an expanded capacity for empathic engagement and resonance with the patient; 3) a greater attention to the theoretical basis for treatment interventions, that is, establishing the connection between theory and practice; and 4) a heightened attention to frame issues, a term first coined by Milner (22) and elaborated by Langs (23) who calls the frame "the ground rules of therapy." These frame issues include attention to details of the therapeutic process such as lateness, absences, and bill nonpayment.

Frame issues often cause considerable discomfort for the beginning therapist and may not be as readily accessible to scrutiny in the supervisory situation. Often a supervisee is mainly concerned with providing good interpretive comments, which results in neglect of frame issues. However, breaks and interruptions of therapy sessions during the observation period cannot be avoided. Such occurrences as lateness or absences are
inevitable during long-term treatment. During observation their importance is highlighted by the impact they have on the entire observation group.

The participants typically responded in a variety of ways to the patient's unannounced absence. These included the following: anxiety ("Where is the patient? Why isn't he here?"); fear ("What could have happened to him?"); anger ("I am up early! Why isn't the patient here?"); disappointment ("He was discussing such important issues in his life, I wanted to see where it would go."); and even despair ("I wonder if he will ever return to treatment."). Such occasions afford important opportunities for teaching about the powerful impact of resistance, acting out, transference, and countertransference, particularly as they are manifested in breaks such as absences.

Even something as simple as when the session begins is emphasized by the attention to the boundaries of the therapeutic frame. For example, starting and ending on time, sometimes even in mid-sentence, offers an opportunity to explore issues of transference and countertransference. The importance of this to the consistency, predictability, and reliability of the therapeutic context and, therefore, to the patient's sense of safety is demonstrated and discussed. For example, it is not uncommon for a patient to present important material as the session ends to avoid lengthy exploration by the therapist. If the therapist allot more time to allow for further discussion, this may actually heighten the patient's anxiety above the person's current comfort level. Ending on time reinforces the patient's sense of safety by underlining the consistency and predictability of the therapeutic frame. Such seemingly counterintuitive and unsociable actions by the therapist are especially distressing to some beginning therapists who consider therapy, in part, as an act of kindness or whose efforts to be kind are actually less therapeutic.

Through observation and the immediate discussion that follows the session, students are able to become more emotionally engaged in the vicissitudes of the treatment. They also come to see the importance of the psychological states of both the therapist and the patient in the process. Memories of the observed session remain strong in the post-session discussion because the participants—teacher and students—have watched the same events within the last hour.

SIGNIFICANCE OF THE GROUP CONTEXT

Having trainees learn through both group observation and discussion with the senior clinician and among themselves adds important dimensions. Groups bond, and, in so doing, group members also bond, and a process of resonance and amplification of the participants' affective and cognitive experiences occurs. As the group bonds, trust develops, and freedom increases—a safer and more exciting environment in which to learn is created.

A therapy observation group enhances the important affective component for learning therapy. Because the group is affected emotionally by the observed therapeutic interaction, the students find a powerful vehicle in the group interaction for understanding the dynamics of the therapeutic process, the therapist's reactions, and their own responses to the observed session discussed later. Furthermore, the group provides a context in which to frame the cognitive and theoretical elements of psychoanalytic psychotherapy.

The group format and context enhance the learning process by amplifying the emotional experience of the trainees and by encouraging students to take risks in learning. Students are invited to explore their thoughts and feelings about what they have observed in an environment that encourages an active dialogue with their colleagues. This dialogue serves to elucidate the dynam-
ics of the therapeutic process in its theoretical and technical aspects, thereby encouraging the trainee's own theoretical and technical knowledge to evolve and develop, both intellectually and affectively.

While the supervisory process is certainly an essential aspect of psychotherapy training, it can become antiseptic because it can blunt or preclude important affective elements so crucial to learning. Supervisees can be more preoccupied with making a good showing rather than with actually learning. Their primary agenda may be more to save face and avoid embarrassment and shame than to explore the possibilities for clinical growth (24). With observation in a group setting, these pitfalls are attenuated once the group becomes able to work together openly and honestly.

The group context enhances the trainee's learning process in five ways. First, the protective nature of the group setting sustains the student through the narcissistic injuries and developments as a trainee, that is, by providing a context that is safe enough for learning. Brightman (25) emphasized the narcissistic vulnerabilities that are normal for trainees and the necessary evolution from what he called "the grandiose professional ego ideal" to a more realistic professional ego ideal. This development requires the attenuation of the therapist's grandiosity surrounding his desire for omnipotence, omniscience, and total benevolence toward the patient and the resolution of his vulnerabilities in the face of failing to sustain his grandiose ideals. During the observation course trainees have the opportunity to explore their own professional ideals relative to the treatment they observe. They also have the chance to see and hear the mentor discuss his own development in this regard as it manifests itself in working with this particular patient.

The therapists-in-training may not appreciate the extent to which shame and narcissistic injury are significant to the patient. Kohut (26) noted that narcissism was both the driving force and the resistance to therapy. By discussing these issues in the observation group, the trainees seem to gain a deeper understanding and appreciation of such issues for the patient. In fact, just as the group setting may be the best place for resolving patient shame, it may also be the best place for dealing with the shame some trainees may feel (27).

Second, the group context offers ample opportunity to observe, sort, and understand the myriad projections and projective identifications that occur in treatment. Buffered from the patient's more intense and disturbing drives and affects, the trainee is able to observe how the mentor manages to deal with the drives and affects and the accompanying projections and projective identifications. Distance from the immediacy of the hour allows the trainee to gain a clearer understanding of the patient's defenses and their usefulness, and provides an opportunity to practice dealing with such defenses vicariously. Third, the students and the teacher use the group phenomena of contagion and amplification of affect to enhance the student's understanding of the patient and his own countertransference reactions. Furthermore, the group provides a much more stable and secure base from which the student can explore the blind spots of one's own functioning as a therapist and the countertransference elements stimulated by the patient's particular dynamics.

Fourth, a learning contract is used to build a context within which to engage the training around psychotherapy. At the start of the course, each student is encouraged to express his or her hopes and goals for the course for the purpose of developing a learning contract that is explicit both to the student and mentor. Invariably, this will change during course participation as new opportunities and insights occur. In particular, by removing the student from the evaluation and accountability that exist de facto within the supervisory relationship and the institutional setting, the trainee is freer to
learn by taking risks. This is done by delineating clearly the roles of the mentor and trainees. For example, our course instructor was not involved in the assessment and evaluation of the student’s performance as a therapist in that person’s training program.

Fifth, the group observation provides the distance the student needs and helps the person develop an “observing ego” to use in actual therapy. Group observation enables the student to observe the worlds of the patient and the therapist, explore individual thoughts and feelings about the work, and take a variety of cognitive and affective positions while imitating and identifying with the mentor who serves as a role model. Trainees are thereby able to obtain a more fully rounded sense of the total treatment context. Not only do they expand their understanding of the patient’s dynamics and the impact of being in therapy, but they also begin to see the parallel struggles in the therapist, such as the potential for shame and humiliation in exposing oneself to another.

The dynamics of the group process amplify the student’s affective experience of the patient, the therapist, and the treatment. The group becomes a “hall of mirrors” for students much as the therapy group does for patients (28). Each observer brings a new perspective to the overall picture.

**DISCUSSION**

We challenge the basic assumption that therapy observation should not be used to demonstrate and teach psychoanalytic psychotherapy. In fact, any session that occurs in a training institution or setting is “observed” via the supervisory process and case conferences, and this in itself affects the interaction between patient and therapist. Patients in such settings know that they are being observed in this manner. The difference with an observation course is that this fact is made explicit to observers, therapist and patient alike, and that the observers are actually present.

Based on our experience, it seems useful to extend the traditional model of teaching psychoanalytic psychotherapy by including an observation component in the curriculum for trainees. Using this method ought to be considered in a more favorable light based on two trends in the current context for mental health services: 1) the increasing pervasiveness of managed care, and 2) the incidence of professional malpractice. In the case of managed care, clinicians are being asked to explain and justify their work to others. Such a teaching technique fosters such clarification early on in training. In recent years, the professional, ethical, and malpractice issues surrounding unobserved work have made headlines in the media; given these realities, perhaps an environment that is more open to revealing and sharing one’s work is safer for patients and therapists alike. It will be important in working with our trainees to emphasize the importance of avoiding isolation in our work by modeling collegial involvement in our approach to training them.

The observation model of teaching and learning psychoanalytic psychotherapy engages the students in a powerful way that encourages exploration of treatment both cognitively and affectively. In effect, the process parallels their own future therapy experiences of thinking on one’s feet, integrating theory and practice, and finding a theoretical basis for one’s clinical interventions.

The observation format provides a collegial forum for externalizing the trainee’s internal debates about clinical judgments, psychodynamic formulations, treatment interventions, and transference and countertransference issues. Such a context encourages students to move away from their observations and toward a conceptualization of their own theoretical formulations. Furthermore, the model fosters discussion and debate about the merits of their conceptualizations and those of their colleagues and mentors.

The learning model we are proposing
encourages the student to step back and examine the treatment process from a different objective position than that afforded by supervision, case conferences, or didactic instruction. It is encouraging to observe a mentor whose work can be modeled. This fosters a more positive attitude toward the scrutiny of one’s work and instills a greater confidence in the theoretical basis for the work by demonstrating its applicability in an actual treatment setting.

This approach attenuates the expert-nonexpert model in a useful way as well. At first, students are apprehensive about being invited and encouraged to exchange and discuss their ideas and observations, to challenge the therapist-instructor’s approach in a given moment, and to debate the rationale for his or her specific intervention. Customarily, it seems, students operate on the basis that there is one right answer that only the supervisor has. The observational context allows each person to formulate an individual opinion and conceptualization of the situation. At the same time each has the opportunity to juxtapose this view with that of the therapist-teacher in the service of clarification, elaboration, and assimilation. Students are not coerced into agreement; they are invited to consider the particular theoretical perspective of the therapist and to search for alternative explanations and consistent approaches to the patient. Controversy is encouraged in the service of learning.

For those teachers inclined to offer such a course, the biggest resistance may be a reluctance and fundamental uneasiness about exposing one’s own work to observation and scrutiny. Ironically, this is precisely what senior clinicians ask trainees to do at each case conference or supervisory session. The teacher who decides to offer such a course and is anxious and fearful of humiliation should remember that these fears mirror the often perplexing and exruciating emotions felt in therapy by patients and students-in-training. But these are worthwhile risks that serve the development of our future psychoanalytic psychotherapists.

The authors thank Drs. Anne Alonso and Edward Jacobs for their helpful comments on earlier drafts of the paper.

References

16:49–54
Providing Residents With a Comprehensive Educational Program in Outpatient Psychiatry

Integrating an Outpatient Curriculum Into Outpatient Management Teams

Vivien K. Burt, M.D., Ph.D.
Joel Yager, M.D.
John Lundgren, M.D.

As part of their efforts to prepare psychiatry residents for comprehensive, practical outpatient psychiatric practice, the authors have established an organized training program in ambulatory psychiatry. The program consists of outpatient management teams that run from mid-PGY-2 to PGY-4, a specified minimum number of mandatory outpatient hours for continuity patient care, and suggested guidelines for residents’ outpatient experiences. An outpatient management team curriculum has been designed for team leaders and trainees that consists of specific topics in outpatient care, associated learning objectives, and readings for each topic. This curriculum, which supplements our previous program of conferences, individual supervision, and a yearlong psychotherapy seminar series, has been refined over the past 5 years. The authors describe the program and the topics included in the curriculum. (Academic Psychiatry 1995; 19:22–33)

As the use of inpatient settings has declined, the need to train residents in the outpatient management of the psychiatrically ill has become increasingly important. Because health care systems are likely in the future to even further emphasize outpatient rather than inpatient care, psychiatric residents will need to be trained in a substantial, comprehensive, and effective array of clinical skills for use in outpatient settings.

Recognizing the importance of outpatient care, the Accreditation Council for Graduate Medical Education has stipulated that essential requirements for general psychiatry residencies must include at least 1 year in an organized and well-supervised outpatient program, access to a diversity of psychiatric disorders and treatment modalities, and a sufficient number of outpatients who are treated at least once a week...
for 1 year or more (1).

In preparation for a workshop on a curriculum in outpatient psychiatry presented at the 1993 meeting of the American Association of Directors of Psychiatric Residency Training, we conducted a survey of psychiatric training programs across the country. Of the 98 responses received from adult psychiatry training programs, 91% stated that their programs offer a discrete clinical rotation in outpatient psychiatry, and 61% provide such a rotation as a major part of the PGY-3. Eighty-six percent of the respondents indicated that they offer a distinct training program in outpatient psychiatry, apart from individual supervision. However, only 69% of the training directors indicated that their residents received either a reading list in topics specifically designated as useful for outpatient psychiatry or a list of objectives and/or outline in relevant topics needed for training in outpatient psychiatry.

Over the past several years, the adult psychiatry program at the University of California at Los Angeles (UCLA) Neuropsychiatric Institute and the West Los Angeles Department of Veterans Affairs (VA) Medical Center has been making increased efforts to provide a cohesive program in outpatient psychiatry. This has been particularly challenging because UCLA, like so many other psychiatry training programs across the country, provides outpatient training over the course of the residency, from PGY-2 to PGY-4 in addition to a specific 3- or 6-month rotation during the PGY-3. Before implementation of our outpatient management program, outpatient training consisted of individual supervision, a series of case conferences, and a yearlong seminar series, which included sections on psychodynamic psychotherapy, brief psychotherapy, family therapy, interpersonal psychotherapy, and cognitive-behavioral therapy. Individual supervision of psychiatric management, which continues to be a valued part of our outpatient program, is often accomplished by a variety of methods, including modeling and apprenticeship, teaching by questioning of oneself and the resident (the "Socratic" method), direct observation of residents' interviews, role playing, provision of multiple supervisors for the same patient, case conferences and group supervision, and assignment and discussion of clinically pertinent reading assignments (2).

In an effort to further strengthen outpatient training at UCLA, while retaining individual supervision, case conferences, and core seminars, we organized a program of outpatient management teams. These teams, which include residents and psychology interns as members, are headed by a faculty of psychiatrists and psychologists. The teams, described in detail previously (3), have been the vehicle through which the residents have been provided with an opportunity to consolidate their diverse training experiences and to learn about complex practical, integrative, and dynamic aspects of outpatient psychiatry.

One outgrowth of the outpatient team system has been the design of an outpatient team management curriculum for team leaders and trainees that clearly defines the minimum number of hours of outpatient work required for graduation from the residency program, expectations of team leaders, recommendations for types of patients and experiences with a variety of therapeutic modalities, a systematic curriculum in outpatient psychiatry, and associated objectives and reading materials. This article describes the process by which this curriculum was developed and discusses the benefits of the program. An evaluation of the team experience has previously been described (3).

<table>
<thead>
<tr>
<th>OUTPATIENT MANAGEMENT TEAM CURRICULUM</th>
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<tr>
<td>Outpatient Treatment</td>
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<td>Expectations for Residents</td>
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Like most other programs, we have wrestled with the problems of weaving out-
patient training into a very busy 3- or 4-year program in which we try to give adequate attention to core inpatient, emergency, consultation, geriatric, child and adolescent, and substance abuse rotations, and to individual elective opportunities in administration, community psychiatry, research, and other activities. Because residents routinely start to pick up continuity outpatients (i.e., patients seen longitudinally over a span of at least 1.5 years) in PGY-2, we clearly needed to provide mechanisms for comprehensive training, supervision, and case monitoring of outpatients at that stage. We also recognized that to ensure full outpatient training, the program would have to enable residents to experience a diverse and extensive outpatient caseload.

In response to these forces, the training directors, director of outpatient services, and resident representatives met on numerous occasions to formulate guidelines that would accurately designate a fair minimum outpatient requirement for residents over the course of their training. The final draft was submitted to the hospital director, who was asked for document approval because stipulations for outpatient caseloads would have a marked impact on services the institution provides. The draft was also reviewed and endorsed by our residents' council. After final modifications, the guidelines

<table>
<thead>
<tr>
<th>TABLE 1. Minimum clinical guidelines for outpatient training</th>
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<td>The following reflects the number(s) and kinds of patients whom residents are expected to see over 3 years. In general, of course, residents are encouraged to have as large and diverse a caseload as possible. They should see men and women with different diagnoses, of every age group, different ethnicities, individuals, couples, and families, etc. They should also have a chance to use different treatment modalities, including pharmacotherapy; use medications in all the major medication classes; conduct brief, insight-oriented, and supportive therapy; and practice cognitive and behavioral techniques. More specific guidelines include the following:</td>
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<td>Treatment duration and format</td>
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<td>Long-term treatment: 3 years</td>
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<td>Brief therapy: several cases (3–4) over 6 to 12 weeks</td>
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<tr>
<td>Conjoint therapy: several couples and families</td>
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<td>Group therapy</td>
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<td>Diagnostic guidelines: the following represent those diagnoses that should be included in the caseloads of residents over the course of their psychiatric training:</td>
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<td>Major mood disorders</td>
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<td>Anxiety disorders</td>
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<tr>
<td>Schizophrenia</td>
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<td>Borderline and/or narcissistic personality disorder</td>
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<tr>
<td>Eating disorder</td>
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<tr>
<td>Substance and/or alcohol abuse</td>
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<tr>
<td>Dual diagnosis patient</td>
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<tr>
<td>Other recommended categories of patients</td>
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<tr>
<td>Chronically medically ill patient</td>
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<td>Patient from a different culture</td>
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<tr>
<td>Geriatric patients (at least 2)</td>
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<td>Adolescent patient</td>
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<td>Children (Those residents who do not rotate through a child inpatient ward are expected to accumulate a minimum of 24 child outpatient hours, whereas those who do have an inpatient child psychiatry experience are expected to accumulate a minimum of 12 child outpatient hours.)</td>
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were submitted to and approved by the residency education committee. The resulting document comprises three main parts. The first part describes the expectation for clinical experience in continuity-care outpatient psychiatry. In particular, part one specifies that residents are expected to see no fewer than 620 hours of ongoing, continuity outpatients over the course of the PGY-2–PGY-4; residents not taking an administrative chief residency or research fellowship in their PGY-4 (clinical track residents) are responsi-

**TABLE 2. Outpatient case reviews**

<table>
<thead>
<tr>
<th>Name of resident:</th>
<th>Patient's name:</th>
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<tr>
<td>Current date:</td>
<td>Identifying data:</td>
</tr>
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</table>

Initial chief complaint:

Brief summary of history of present illness:

Principal DSM-III-R diagnoses:

Treatment modality(ies) to date:

Assessment of therapeutic progress to date:

Any urgent or troubling problems, issues you would like to discuss:
ble for accumulating no less than 940 outpatient hours during PGY-2 to PGY-4. The requirements are over and above specific outpatient rotation experiences involving brief evaluations and the management of medication clinic patients. The document addresses the details of "banking" hours from year to year and credits given for different types of outpatient experiences. It is emphasized that "these are minimum hours" and therefore are viewed by the training program as "adequate," but "are not considered optimal for residents intending to pursue careers that will involve significant amounts of individual outpatient work." The outpatient document also specifies clinical guidelines for the numbers and kinds of patients residents are expected to see during 3 years (Table 1).

**Outpatient Management Team Expectations for Faculty**

In 1988, when the outpatient management teams were devised, team faculty leaders were given three main objectives: 1) to provide a coherent and comprehensive training program in outpatient psychiatry, 2) to longitudinally follow and review the new and ongoing cases of the trainees, and 3) to ensure the good care of all the outpatients from both university and VA sources. Thus, the understanding has been that, similar to that for an inpatient program, an organized outpatient program in psychiatry has educational, administrative, and clinical functions. The outpatient management teams represent authorized administrative and clinical quality-management teaching bodies charged with integrating the various tasks that comprise a cohesive outpatient program.

The entire program involves eight outpatient teams. PGY-2 teams begin in the middle of the residency year, at a point when the residents are picking up their outpatients. PGY-3 and PGY-4 residents participate in senior teams throughout their last 2 residency years. Each team is led by two psychiatrists, and the senior teams are also staffed by a psychologist and a social worker. The PGY-2 teams are composed of 4 residents, whereas the senior teams comprise 4 to 6 psychiatry residents and 1 or 2 psychology interns. The entire team structure depends on faculty who are devoted to the educational goals of the program and are comfortable with the explicitly stated administrative goals as well.

The faculty team leaders are responsible for maintaining running accounts of all the outpatients seen by residents on their teams. They keep current with the status of these outpatients by compiling dossiers with written accounts of each patient provided by the residents at the start of each year. Discussions about outpatients are summarized by written accounts that are updated weekly during the year. New patients are added to the dossiers, and those patients who are no

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<th>TABLE 3. Outpatient management team checklist</th>
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<tr>
<td>New patients?</td>
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<tr>
<td>Patients terminated, discharged?</td>
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<tr>
<td>Suicide attempts?</td>
</tr>
<tr>
<td>Suicidal phone calls; pervasive suicidal ideations?</td>
</tr>
<tr>
<td>Medication side effects; medication errors?</td>
</tr>
<tr>
<td>Patients refusing treatment?</td>
</tr>
<tr>
<td>Repeated no-shows?</td>
</tr>
<tr>
<td>Accidents/mishaps?</td>
</tr>
<tr>
<td>Hospital admissions: expected, unexpected?</td>
</tr>
<tr>
<td>Abnormal/excessive laboratory values?</td>
</tr>
<tr>
<td>Documentation: Is it clear and complete?</td>
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</table>
longer in therapy are noted (Table 2). In the case of patients who have been discharged from outpatient treatment, the conditions under which treatment has been terminated are described, and follow-up plans are clearly indicated.

At the start of each weekly, 90-minute team meeting, the faculty team leaders review a checklist of clinical issues to which the team's attention needs to be directed (Table 3). This exercise reinforces the quality-management charge of the teams, which are responsible for the ongoing care and welfare of outpatients seen by the trainees. The team leaders thus function as role models for residents, emphasizing the need to continually re-evaluate the ongoing progress of patients and attending to first things first.

Outpatient Team Topics and Readings

In addition to maintaining some centralized control over the administrative and clinical care of patients, we were equally interested in ensuring some degree of standardization for the educational objectives and learning tasks of the outpatient management teams. To the greatest extent possible, we hoped to address important topics at developmentally appropriate times in training, that is, when the residents needed to learn about them, as these issues came up in their day-to-day clinical work with patients. This was a particularly difficult task to do outside of individual supervision, since our residents engage in outpatient experiences longitudinally over the last 3 years of training. Because our residents see outpatients from the PGY-2 onward, caring for patients from a variety of inpatient and outpatient sites and referral sources, and because our core PGY-3 outpatient block rotation also combines work at two different institutional sites, addressing the residents' outpatient educational needs in a timely, yet systematic fashion is a challenging task.

To assess educational needs common to all residents, in 1989 after the first year of the management team program we surveyed faculty team leaders to determine what topics were actually taught in the outpatient team meetings and how useful they were for the residents' training. This early survey was based on a list of more than 50 topics and problems in outpatient management generated by the authors, together with open-ended questions.

The residents were also surveyed for their assessment of the usefulness of these topics for their training. The results of these surveys were integrated, and a revised list of topics perceived as useful and important for training was developed (Appendix 1). While some of these topics transcend the care setting, many are best addressed in the context of outpatient psychiatry.

Over the last 4 years, the various topics have been refined into an organizational outline, and associated key concepts and educational objectives have been devised. At the beginning of each year faculty team leaders, many of whom are new to the program, are given these materials and readings that pertain to the topics. The leaders are asked to note those topics that have been covered during the academic year so that they can assess the extent to which the educational objectives have been fulfilled. Quarterly reviews with the director of adult outpatient services provide the basis for revision and modification of the curriculum, objectives, and reading list for the next year.

Appendix 2 lists the current version of the reading list of articles, chapters, and books that pertain to the educational topics designated as essential in the outpatient curriculum and that have been found useful by the teaching faculty of the outpatient management teams at UCLA. A copy of each of the articles cited on the list is given to the faculty, who distribute to team members copies of those readings that are relevant to reviewed cases. Books and chapters are included in a list of additional recommended references. The readings are used both in conjunction with relevant clinical case dis-
cussions and for general discussion of important topics for which no clinical cases may have yet been presented. Each year, team leaders and residents are surveyed to determine which of the topics listed in Appendix 1 have been covered. Discussions are held each year to review with team leaders which topics have had limited coverage, and leaders are encouraged to cover these topics over the course of the subsequent year. In our experience, over the course of their team experience, trainees are exposed to at least 85% of all of the listed topics.

Each team tends to develop its own style of operation. Some provide structured didactic presentations for 45 minutes of each 90-minute weekly meeting; other teams teach around the clinical cases presented by the residents. One team sometimes brings patients to the meetings for an interview by one of the faculty leaders, with the ensuing discussion focused on one or more of the topics in the curriculum. Despite the diverse ways in which these materials are applied, providing a curriculum outline, objectives, key concepts, and reading list has helped us focus the goals of the outpatient program. All residents also receive several hours per week of individual supervision that complement the team meetings by providing opportunities for more intensive private discussion of alternative styles, management options, and countertransference issues related to specific problems presenting in their clinical work.

**DISCUSSION**

The difficulties in developing a cohesive and comprehensive training program in outpatient psychiatry are in part related to the fact that skills in outpatient management are generally taught and acquired in a longitudinal fashion, usually scattered through other clinical assignments, for a good part of the 3- or 4-year period of psychiatry residency training. The challenge is to match the educational concerns of the residents with instruction that is developmentally appropriate and well timed to their needs and those of their patients. This is true despite the fact that most programs provide discrete rotations in outpatient psychiatry, usually during the PGY-3. In addition, individual supervision, a backbone of outpatient instruction, does not by itself suffice to substitute for a comprehensive program of lectures and seminars, case conferences, group supervision, and clinical teaching rounds.

In 1986, the American Psychiatric Association Task Force on the Quality of Psychiatric Residency Training emphasized the need for ongoing evaluation of residents' "knowledge, skills, and attitudes over the course of the residency" as a way to pinpoint "strengths and weaknesses so that remediation for the latter can be provided." (4) Obviously, in most traditional outpatient psychiatric training this is not easily assessed in any organized manner. The outpatient management team method helps provide a vehicle for such assessment. Requiring a minimum number of certified outpatient hours for graduation from a psychiatry residency program sends a clear message to trainees that outpatient psychiatry is a valued and valuable component of a full and comprehensive residency program.

Providing a systematic course curriculum, complete with objectives, key concepts, reading lists, and reprints, helps provide the coherence and comprehensiveness to a portion of training often taught in a fragmented mode by a large number of diverse faculty members. Furthermore, using outpatient management teams to focus on a specified curriculum is one way in which training can be provided in a timely, concentrated, and diligent manner. The use of a core textbook and continuous case conferences over and above individual supervision has been affirmed as an important way of implementing psychodynamic psychotherapy training for residents (5). However, contemporary outpatient psychiatry requires skills that ex-
tend far beyond psychodynamic psychotherapy. The organized outpatient management team approach is one way to help systematically attend to developing these broader skills.

References

APPENDIX 1.  Topics in outpatient psychiatry

I. Issues of confidentiality
   Phone calls from relatives
   Communication with other M.D.'s
      Is it necessary to get authorization (written or verbal) from the patient?
      What and how often do you get back to a referring physician: phone call? written note?
      Getting in touch with a patient's other physicians: how much do you share/reveal?
      How many notes and of what type do you keep for what purpose?
      Do you ever audiotape sessions? Videotape sessions?
      When and how do you tell a patient that you would like to see or phone a family member?
      What can/should you say to a family member who is seeing you individually, with your patient's permission? What do you reveal, not reveal?
      When do you get a live consultation/second opinion for a long-term outpatient?
      How do you handle a patient's request for either a second opinion or to be referred to another therapist?

II. Financial issues
      When and how is it appropriate to charge for missed sessions?
      Is it ever appropriate to lend a patient money?
      How do you set or modify fees?
      How do you deal with the patient who doesn't pay?
      How do you deal with a patient who wants to bend the rules for insurance purposes?
      What about seeing a family member? Whom do you charge?

III. Late/missed sessions
      When do you phone if a patient misses a session?
      How do you deal with repeated lateness: extend the session? "demand" an explanation? What is the therapeutic value in exploring this issue and if so, how is this done?

IV. Boundary issues/self-disclosure
      When do you initiate a phone call to a patient at home or work? And how do you identify yourself?
      Physical touching: handshakes, hugs, etc. When are these appropriate?
      Gifts, cards, invitations to special events: how do you handle these?
      Pictures on your desk?
      Seating arrangements
      Lighting in your office
      When you get sick or have a personal problem, do you ever share information about these events?
      How much do you reveal about yourself (e.g., marital or parental status, age, specific vacation plans, etc.) and in what circumstances?
      When do you ever extend sessions beyond your usual time (e.g., if a session is particularly "fruitful," if you were late because of another emergency, etc.)?

V. Counseling vs. psychotherapy
      What is the difference?
      Giving "advice": when, if ever, is it appropriate and how is it done?

VI. Therapeutic style
      Use of affect by the psychiatrist: do you ever get angry, enthusiastic, express affection?
      What do you say to a patient at the start of therapy? Do you explain about the nature of psychotherapy, about the role of the therapist, the patient? Do you "educate" the patient about the process of psychotherapy?
      How do you select the appropriate mode of therapy for a given patient (e.g., brief or long-term psychodynamic, interpersonal, cognitive-behavioral, couple, family, group)? How do you formulate a therapeutic contract?
      How does a psychiatrist dress?
      How do you explain specific psychodynamic therapeutic techniques to a patient: silences, refusal to direct questions, and other behaviors that on the surface look strange to the uninitiated?

(continued)
APPENDIX 1. Topics in outpatient psychiatry (continued)

Is there ever any justification for expecting patients to figure out rules of psychotherapy on their own, or are they entitled to patient education and informed consent as in all other medical treatments?
How do you explain to a patient that you would like to do a mental status exam and the reasons for it?
Silence in psychodynamic psychotherapy: when, how long, how “pregnant,” who ends it?

VII. Medication issues
How do you incorporate pharmacotherapy into a dynamic therapy?
What techniques are useful for “medication management” when treating patients who are being treated in an expressive therapeutic mode? How do you conduct “medication management” in the context of nonexpressive psychotherapy?
What strategies are used when the psychiatrist acts as a medical consultant for patients in psychotherapy with non-M.D. therapists?
What are the psychodynamic aspects of medication management?
How do you deal with issues related to medication consent in outpatient psychiatry?
What issues arise and what strategies are used with outpatients who are having medication side effects?
How do you deal with patients who are noncompliant with medications?

VIII. Suicide/assault/legal issues
How you deal with suicidal threats in therapy: veiled and unveiled?
How do you deal with patients who are angry at you?
How do you deal with patients who make a veiled (or open) threat toward you or someone else?
What do you do when a patient reveals child abuse?
What do you do when a patient reveals illegal activities such as drug dealing, theft, fraud?
What do you do when you learn that a patient is using or abusing substances or alcohol?

IX. Countertransference/transference issues
How do you handle your own hostility to patients?
How are you affected by and how do you respond to patients considered boring, kvetchy, selfish, immature, abrasive, oppositional, condescending, controlling?
Borderline rage in the therapy hour: how much destruction or abuse do you tolerate? How do you respond?
How do you handle your own attraction to patients, and patients’ attraction to you?
Countertransference to patients with characterological problems (e.g., narcissistic, borderline, histrionic patients)
How do you handle the exhibitionistic patient?
What do you say (do) when a patient reveals sexual thoughts about you?

X. Dreams
How do you respond when a patient mentions his/her first dream?
How do you educate patients about the use of dreams in therapy?
What is the place of guided imagery in psychotherapy?

XI. Termination
Planned
Abrupt
Patient-initiated
Therapist-initiated
When do you try to talk an ambivalent patient into staying in therapy? When don’t you?
APPENDIX 2. Reading list for outpatient psychiatry

<table>
<thead>
<tr>
<th>Number</th>
<th>Title</th>
<th>Author(s)</th>
<th>Publisher</th>
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<tr>
<td>1</td>
<td>Applebaum PS: The right to refuse treatment with antipsychotic medications: retrospect and prospect.</td>
<td>Am J Psychiatry 1988; 145:413-419</td>
<td></td>
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<tr>
<td>31</td>
<td>Ogden T: The mother, the infant, and the matrix in the work of Donald Winnicott, in The Matrix of the Mind. New York, Jason Aronson, 1986</td>
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(continued)
APPENDIX 2. Reading list for outpatient psychiatry (continued)

New Idea

Stress and Adaptation in Learning and Practicing Medicine

An Elective Course for Medical Students

David Barton, M.D.

In their pursuit of careers in medicine, medical trainees and practicing physicians frequently endure significant levels of biopsychosocial distress. Psychiatry can play an important role in providing education about successful adaptation to a medical career and how to avoid dysfunctional states. The author describes a course designed to provide instruction to help medical students improve their adaptive skills. The course emphasizes preventive methods for maintaining well-being throughout a medical career. Both didactic and experiential methods of instruction are used to teach the course. The course targets a number of topics considered important for adaptation and well-being, using small group discussion to help students explore their ideas and experiences. By use of a concept referred to as the "longitudinal analogous experience," current experience is explored to provide insights that hopefully will lead to more effective adaptation in the future. The instruction encourages the medical student to develop and use adaptive coping styles and skills to maintain an effective level of overall functioning throughout the training and practice years. (Academic Psychiatry 1995; 19:34-43)

The resident, "Fats's" Law Number III:
At a cardiac arrest, the first procedure is to take your own pulse.

The House of God, Samuel Shem, M.D., Ph.D.

Although the high levels of adaptive distress experienced by persons pursuing a medical career are well documented in the literature (1-6), there are relatively few educational approaches in the literature designed specifically to teach about adaptation to stress in the context of learning and practicing the art and science of medicine.

Balint outlines the work of a case-oriented seminar that uses ongoing group discussion about patient care to provide insights into the often trying interactional subtleties and psychosocial aspects of physician-patient relationships, patient-illness relationships, and physician-physician relationships (7). Rosenberg describes a group experience with first-year medical students that enabled them to gain increased insights into their emotional encounters during the first year of medical school (8). Hilberman et al. present a model for support groups for first-year female medical students in which the participants discuss a variety of problems confronting professional women (9). Webster and Robinowitz describe the work of an ongoing group that
Offered the part iculate the pare nts techniques of to specific dent. Adjustment the medical they stress structu re. Stress-management tech niques, stress-manage ment techniques, a large number of trou bled physicians, dis cusses a number of topics that the physicians wished they had been taught in training. Other authors have reported the use of stress-management education for medical students.

These writings provide approaches, techniques, and teaching components for instruction related to student or physician stress and adaptation, but with the possible exception of the Dickstein and Elkes effort, they do not provide a format for an extensive medical school course designed to address the wide range of adaptive tasks, specific stressors, and contemporary challenges to adjustment encountered by the medical student. The literature contains relatively few specific instructional techniques to help students develop a lifelong, ongoing approach to adaptation.

I describe an elective course for medical students organized to teach the broad range of tasks involved in adapting to the process of learning and practicing medicine. It offers techniques to manage stress and enables students to use their current experiences to prepare for the management of future stress. Offered by the Department of Psychiatry, the course has been included in the curriculum at Vanderbilt University School of Medicine for 5 years. It is my hope that over time courses of this kind will become an integral part of medical school education and that this article will provide guidelines for the development of such courses.

COURSE DESIGN AND FORMAT

"Stress and Adaptation in Learning and Practicing Medicine" is an elective course offered to first- and second-year medical students. Class size has been limited to 12 to 15 students to facilitate interaction and open discussion. The course meets once a week for a semester. Initially the weekly classes were 1 hour and later were expanded to 1.5 hours to allow more time for discussion. Male and female students have been about equally represented in the course, as have been students from the first and second years. To date 59 students have taken the course. As the elective became better known, in some years it was oversubscribed, and a lottery was required to determine its members. The course provides instruction in both didactic-cognitive and experiential dimensions. I alone taught the course for 4 years, but in the fifth year a psychiatric resident assisted with the teaching. Focal presentations targeting a wide variety of specific topics direct the class’s attention to important subjects. Brief lectures, prepared handouts, and relevant papers provide direction in some classes, while patient presentations and guest speakers provide the focus in others. In recent years, a number of the articles used in the course have been made available to the students. (A list of the articles used in the course may be obtained by writing to the author.)

In the course, extensive group discussion enables students to explore in depth their individual experiences related to the topics. Students learn to integrate their past and current experience with the material considered. The class discussion provides a group learning experience that involves interaction, expression of opinion and views, sharing of similar experience, support and problem solving, altruistic aid, and legitimiza tion of distress. The focal presentation and experiential small group discussion method used in the course is similar to one I used earlier to instruct students about dying and death.
Class instruction also uses a specific technique developed by me, the "longitudinal analogous experience." This refers to an experience or stressful situation encountered in the present that represents an analog of an experience or stressor that the student, trainee, or practicing physician will likely encounter in the future. Understanding maladaptation or effective adaptation in the present is used to teach the student how to maximize adaptive abilities when the analogous experience or stressor is met in the future.

Numerous opportunities are presented to the class to illustrate, explore, and learn from longitudinal analogous experiences. Repeated themes emerge that may be scrutinized to develop effective adaptive approaches for the future. The difficulty in allocating time for the demands of various courses in the early months of medical school is analogous to balancing the time demands of a busy, multifaceted practice. The informational overload the student experiences early in his or her studies is similar to what they will encounter later in medical practice. The medical student's tendency to forgo all leisure and recuperation in favor of studying is closely akin to being unable to leave the office or hospital and forgoing one's own and one's family's needs in later years. Deriving all one's self-esteem from overwork and taking on too much responsibility in the early years of training may become ingrained as a way of life and compromise the development of other sources of self-esteem later on. Developing the ability to override fatigue and depletion in training may become a prelude to ignoring distress and failing to take care of oneself in the later years of a medical career.

The following vignettes illustrate some types of longitudinal analogous experiences encountered in the course:

Student A anticipated a weekend visit by her male friend with ambivalence and anxiety. The weekend preceded an examination in a major course, and she felt torn between her desire to be with her friend and to study for the examination. Recognizing the conflict, she was able to plan ahead to effectively manage her time, arrange a comfortable schedule with her visitor, and reduce her anxiety. She was able to see that the pull between work and significant relationships would be recurrent and require active attention throughout her career, and she began to develop adaptive approaches to the dilemma.

Student B reported that an antihistamine prescribed for allergies was causing a degree of drowsiness that interfered with his ability to concentrate. Because of a demanding class and study schedule, he felt unable to go to student health services and request a less sedating medication. To compensate for his compromised concentration and to fulfill his desire to study to an extent he felt appropriate, he reduced his sleep time in favor of his studies. Caring for himself was given a low priority, and he became progressively more fatigued and even less able to attend to his work. This maladaptive response was discussed and related to the problem that can occur later in a medical career, when practice demands may delay or may seriously interfere with caring for oneself and in turn caring for patients.

Student C solved his problem of the need to study and a desire for leisure time by combining the two. He decided that he would take his anatomy textbook with him and study while fishing in a nearby lake. The student's approach was discussed as a method of adaptation that might be useful at times, but one that has the potential for excessive use. For example, later in the person's career, to legitimize leisure time, the physician may be tempted to always combine recuperative time with a scientific meeting or medical course and feel guilty when recuperating in a manner some might deem nonproductive.

Student D, who had barely begun medical school, was immediately given what amounted to the role of a consulting physi-
cian when a family member became ill. Ambivalent about the role, but reluctant to express her limitations, she felt burdened by the family’s dependency on her for guidance and information while at the same time deriving considerable self-esteem from her position of authority and caregiving. She was able to discuss her situation and mixed feelings in the class and came to understand that recognizing limits—especially in treating and advising family members—would be necessary throughout her career.

The course is not designed to be a therapy group or provide psychotherapy per se; however, group discussion and reaction, self-scrutiny, and discussion of current adjustment difficulties by the students is facilitated and encouraged. In the context of the dialogue, maladaptive configurations of dealing with stressors are revealed, and better methods of adaptation are considered. Thus, though not designed specifically as a therapeutic experience, this kind of instruction promotes self-awareness and encourages more effective problem-solving efforts and adaptive methods.

TOPICS OF INSTRUCTION

Many of the targeted topics are presented as scheduled specific presentations, but a number of areas covered in the course are addressed as they emerge in the discussion. Attempts are also made to topically accommodate the needs of each particular student group and to shape the content and direction of class discussion appropriately, but this is done against the backdrop of the course structure.

1. A Preventive Framework for Adaptation

Early classes provide a framework for adaptation and encourage discussion of current experience. Approaches to adaptation are presented in developmental or process terms, thereby establishing the need to view adaptation to a career in medicine as an ongoing, proactive, dynamic process rather than a fixed endpoint.

The framework provides a common language with which to discuss adaptation. Actual mental disorders and impairment are considered, but the scope of the course is significantly broadened to consider a spectrum of adaptation ranging from physical, emotional, and social adaptation and relative well-being to actual dysfunction. Successful adaptation is achieved when the student or practitioner is physically intact, possesses a sense of relative well-being, experiences a sense of a reasonable level of mastery, is able to maintain satisfactory interpersonal relationships, and feels engaged with the social context. Adaptive dysfunction occurs when physical, emotional, or social function is compromised. This may take the form of excessive fatigue, depletion, disenchantment, persistent overwork, interpersonal strain, isolation, or states of adaptive failure when the person’s functioning is definitely compromised. It may extend to the development of physical exhaustion, stress-related physical illness or depression, anxiety disorders, and substance abuse. Impairment may occur at various levels on this spectrum.

Course instruction focuses on a preventive strategy to foster effective adaptation. This approach addresses matters of primary prevention (self-education, identification of stressors, developing effective coping strategies); secondary prevention (early identification and appropriate management of signs of dysfunction and effective management or treatment); and tertiary prevention (reduction of residual dysfunction). Doyle and Cline have discussed the use of a preventive approach to improve physician adaptation (18).

2. Personality Traits and Coping Strategies

Avoiding dependency; striving for independence, perfectionism, and competitiveness; seeking control and mastery; having
low tolerance for uncertainty; relying on achievement for self-esteem; assuming extraordinary levels of responsibility; and placing an emphasis on productivity are traits discussed in terms of how they interact with medical learning and practice. The student learns that while these are potentially useful traits, capable of fostering high levels of performance and quality patient care, they may, when used inflexibly or relied on excessively and inappropriately, contribute to maladaptive behavior patterns (19).

Specific stressors met in the learning and practice setting are discussed. These include the strain of the uncertainty that must be dealt with in medical school and later in practice (20), the time demands of the medical environment and the accompanying sense of loss of freedom, the inability to master information overload, continual exposure to intense levels of charged feeling, the frustration of one's idealized view of medicine, and the struggle for the preservation of personal identity in the face of the demand for professional conformity.

Discussion of markers of effective adaptation helps to define attainable goals for the student-physician. Students learn to monitor their perfectionism, recognize their limits, and maintain appropriate boundaries between their medical work and personal lives. They are encouraged to develop and maintain self-esteem through activities outside of medicine.

Throughout the course, the student is helped to develop effective coping strategies. For example, the use of Vaillant's high-level coping strategies—anticipation, altruism, sublimation, suppression, and sense of humor—is encouraged to improve adaptation, and less effective mechanisms, such as denial and projection, are shown to be problematic (21).

3. Stress and the Care of the Self

Building on the framework outlined, later classes expose students to a number of topics relevant to stress reduction. The class learns about physiological models of stress, autonomic response, and the physical concomitants of stress. Biofeedback apparatus is used to demonstrate these concepts tangibly. Benson's relaxation response is introduced to the students as one way to manage stress (22). Progressive muscle relaxation techniques are demonstrated to the class as a method of stress control. The students are helped to see that taking care of oneself, with emphasis on good nutrition, exercise, adequate sleep, recreation, and recuperation, is imperative to sustain an individual's well-being.

The need for the student and practitioner to remain connected with the environment outside of medicine throughout one's career is emphasized. Toward this end, the student's attention is directed to books, magazines, and newspapers cataloging available activities (athletic events, interest groups, drama, music, art shows, etc.) in the community. The student is encouraged to subscribe to at least one leisure or special interest magazine and to keep up with current events by reading a daily newspaper, a weekly news magazine, or watching a TV news program every day.

4. Relationships and the Affective Context of Medical Learning and Practice

A schema for understanding professional and personal relationships is presented. Attention is focused on relating to peers and dealing with authority. The class focuses on the doctor-patient relationship and the feelings aroused in both routine and difficult care situations (23–25).

The students discuss the high levels of feeling evoked by patients with life-threatening illness and patients who are suffering, hostile, disturbed, overly dependent, or seductive. Maintaining appropriate boundaries while retaining sensitivity and concern is discussed as a problem in adaptation. The student learns that excessive emotional dis-
6. The Changing Terrain of Medicine

Extensive attention is given to the impact of shifting medical directions on a future practitioner’s adaptation (27–29). Economic trends, alternative delivery systems, increasing external controls, quality assurance issues, managed care, and marketing and business influences are considered. Other subjects such as understanding HMOs and preferred provider organizations, the impact of advancing technology, continuing medical education needs, increasing medical school tuition, and concerns about financial obligations incurred during training are included. The students also discuss their concerns about working with AIDS patients. Time is spent addressing contemporary medicolegal issues such as malpractice, obligation to warn, and matters related to confidentiality.

The students are encouraged to keep abreast of current articles in the media and journals relevant to changes in medicine. The roles of local, state, and regional medical societies and national associations in the physician’s life are considered.

5. The Practice Setting

Specialty choice is discussed, and the student is given information on available resources for learning about the specialty in which the person is interested (26). They learn that each specialty fulfills different personality needs and requires varying adaptive abilities. The class also addresses the choice of settings in which a medical career might be conducted (private practice, group, health maintenance organization [HMO], academic, institutional, military); types of practice; specialty and setting-related lifestyles; and practice differences in various geographic areas. Attitudes about medicine as a business are explored, and the need for financial planning and competent financial advice is emphasized.

7. Women in Medicine, Dual Careers, and the Family

Issues related to women’s professional identities as physicians and problems specific to women in the medical learning and practice setting are discussed (30). Attention is focused on women physicians’ concerns about pregnancy, child-rearing, child care, and the maintenance of meaningful family lifestyle during training and in practice (31,32).

The students learn that female trainees’ adaptive difficulties are increased when they are treated as “invisible” on ward rounds by their male colleagues. The male students are encouraged to look at ways in which they might collaboratively assist women in their adaptation. The effects on men of the presence of more women in med-
icine is discussed. Learning how to relate to women as professional equals, managing feelings of heterosexual attraction, and the pros and cons of dating classmates have been topics of discussion.

Physician's marriages and the life and adaptation of the medical family are discussed (33-35). Related issues such as dual careers, the adaptation of the physician's spouse and children, and the dangers inherent in the physician providing medical care for family members are discussed.

8. Value Systems, Ethics, and the Heritage of Medicine

Ethical dilemmas related to technology, right-to-die issues, and AIDS patients are discussed. In one class, a pastoral counselor presented a class on the interface between religion and medicine. Consideration of the role of personal value systems in an individual's medical practice is encouraged.

9. Identifying and Caring for Physical and Emotional Dysfunction

Handouts and class discussion emphasize early recognition of signs and symptoms of physical, emotional, and social dysfunction, and the need for early, effective care. Taking care of oneself physically and emotionally is presented as a vital part of being a physician.

The inherent difficulty of being a physician in the patient role is addressed (36). A physician's ability to get adequate attention for his or her own symptoms can be compromised by denial or a false sense of invulnerability. On the other hand, a disabling fear of contracting disease and hypochondriasis can also affect the physician and medical trainee. The students discuss their feelings about obtaining care for emotional difficulties, and attempts are made to help them overcome resistance to seeking psychiatric treatment.

10. The Rewards of Medicine

Discussion of the stressors in the medical profession should not obscure a focus on the positive and rewarding aspects of the physician's career. Among the rewards discussed in the course are the potential for ongoing emotional and intellectual development, the vast diversity and opportunity in medicine, the depth of relational experience with colleagues and patients, financial security, and the physician's altruistic contribution to society.

COURSE EVALUATION

A detailed course evaluation questionnaire is provided to each student at the end of the course. The questionnaire seeks responses to specific open-ended questions and was designed to provide feedback on how to improve the course and identify areas the students found most valuable. At the end of the course, each student is also asked to write a brief paper on how the course was useful in his or her adaptation and how the learned skills might be helpful in the future. Over its 5-year history, 50 of the course's 59 students returned their questionnaires, and the thematic information obtained from both the questionnaires and papers has been used to evaluate, shape, and refine the content of the course.

The most frequently listed strength of the course was its informal setting and atmosphere, which allowed the students to interact and openly discuss personal concerns and feelings. The students also found the guest speakers (primarily female physicians discussing women's issues in medicine and balance between home and work); the patient interviews; the broad range of topics covered; and the instructor's interest and involvement in the class to be the course's strong points. Lack of structure, organization, and clarity of goals were listed most frequently as the course's weaknesses. The students also found some classmates' non-
participation in the discussions to be another weakness.

Frequently cited "most important single lessons learned" in the course were the recognition of the need for recuperative time and a life outside of medicine, the importance of establishing priorities and boundaries to balance personal and professional life, appreciation of the need to make active choices for effective adaptation, and recognition that other students experience similar stresses and concerns.

Achieving a balance of didactic and experiential components preferred by the students has been a continual challenge. Questionnaire responses indicate that the majority of the students felt the level of didactic material included in the course to be adequate, but some wanted more. Focal presentations of specific topics appear necessary to direct the course, yet students highly value the flexible, open discussion time in the class. The students seem to want an open forum and simultaneously desire a structure and a definite class direction consistent with their other course work. Too much discussion was felt to be too much like "group therapy," while too little produced the perception that the class was simply another "lecture."

The students' essays provided further insights into medical school adaptation and the learning process in the course. A student reported that the class helped her remember "to be a person and not just an automaton memorizing tons of facts." Another reported that the act of simply setting aside some time each day for oneself had allowed her to preserve a sense of personal identity. One student said the class helped her recognize and manage the discomfort of her significant other as she became "married" to a new career. A second-year student spoke of his ability to use the class setting to discuss a situation where it became necessary for him to leave the room in response to a patient's suffering during the performance of a painful diagnostic procedure. The class discussion enabled him to achieve a balance between empathy and distance. A first-year student felt that the second-year students' presence in the class was particularly useful in providing practical suggestions, reassurance, and hope. A male student commented that the class helped him gain a better understanding of the dilemmas and concerns of women in medicine.

In their evaluations and reports, the students have consistently viewed this kind of educational experience as extremely useful in their adjustment to the medical learning process. This positive feedback has served to energize the enthusiasm of the instructor about the project.

Twenty-eight of these students have now graduated from Vanderbilt. After graduation, 10 students entered medicine, 5 selected surgery, and the rest selected a variety of specialties; only 2 are known to have chosen psychiatry as a specialty.

DISCUSSION

Faculty interest in providing students with methods and models for adaptation to the stresses of medicine, and the legitimization of concern with the well-being of medical trainees and practitioners, can be reflected by the inclusion of these subjects in the medical school curriculum. Psychiatry departments can play a vital role in medical education by designing and providing instruction in this area. Biopsychosocial adaptation should be presented as a proactive, ongoing process, rather than a single task that can be accomplished at one point of the physician's career, which must be nurtured, reviewed, and revised throughout a career in medicine.

The need to teach students to care for patients in a manner that extends beyond science and procedural technologies is an ever-challenging role for medical educators. Current biomedical trends in medicine promote a reductionist approach to patient care and threaten to compromise a more holistic
view of the patient (37). Learning to care for oneself provides a model for providing similar care of one's patients (38,39). A course such as the one I have described also contributes to that part of a physician described by Zabarenko and Zabarenko as the "para-cognitive" aspects of physician development (40). Among these aspects of physicianhood are matters related to balancing objectivity and empathy, dealing with uncertainty, and developing a professional identity.

The course also exposes students to a "systems" approach in which the physician is seen as functioning in a series of interrelated systems involving personal and family life and interaction with colleagues, patients, institutions, and the changing medical world. This approach fosters an appreciation of the myriad of intertwined determinants and interconnections of adaptation in which changes in one component affect all other components. The students also see that their patients live within systems and that patient functioning is influenced by the same myriad of interactive forces.

The students report finding this instruction extremely useful and frequently question why it is not more available as part of their medical training. Student enthusiasm, however, often exceeds that of the faculty and administration for such courses, and limitations or funding seem to deter expansion of work in this area. I believe that educational efforts and programs in the area of medical student stress and adaptation should be supported by the medical school rather than by psychiatry departments alone.

The course design reported here lends itself to broader applications. The course could be taught to an entire class, rather than as an elective, by supporting and training additional group discussion leaders. Instructors from nonpsychiatric fields might usefully be included as co-instructors with psychiatrists. In keeping with the increasing number of women entering medical school, female physicians should be included as instructors. While the course had been designed for first- and second-year medical students, it could be an effective part of the medical student curriculum over all 4 years of medical school, with presentation of topics keyed to specific stresses in each academic year. Finally, similar courses using this format could be provided as ongoing educational experiences for residents, practicing physicians, and other health care providers.

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Residency Education, Work-Related Issues, and Organizational and Occupational Psychiatry

SIR: That work is linked to mental health is not simply a theoretical precept in psychiatry, but also a reality of clinical practice. The increasing number of corporate mergers and acquisitions, downsizing, and job loss (or fear thereof), as well as the proliferation of employee assistance programs (EAPs) and health maintenance organizations have greatly influenced psychiatry and mental health practice. Organizational and occupational psychiatry (OOP)—also called industrial, workplace, or corporate psychiatry—is that area of psychiatry that focuses on the link between work and mental health. OOP recognizes both the psychopathology that individuals bring to work and the psychopathology that results from work, as well as organizational and job-related factors that may negatively affect workers' mental health (1,2).

How familiar are psychiatry residents and faculty with the psychiatric implications of the work? What formal education and clinical training do residents have in organizational and occupational psychiatry? And how involved are faculty in workplace issues? These questions led to the development of a survey instrument whose purpose was to determine the type and extent of education in work-related issues in psychiatric residencies. It also sought to determine the extent to which residents were taught and expected to include work history data in their evaluations and reports, as well as the degree to which residency faculty practice in workplace programs.

The questionnaire was mailed to all 404 members of the American Association of Directors of Psychiatric Residency Training (AADPRT) members in Fall 1992. One hundred ninety-nine questionnaires (49%) were returned, of which 189 (47%) were usable. One hundred twenty-five respondents (66%) identified themselves as involved with general residency programs, 50 (26%) with child residency programs, and 14 (8%) as department chairs.

In reply to the question "Does your program have any formal teaching of organizational and occupational psychiatry?" 38 respondents (20%) answered "yes," 141 (75%) "no," and nine (5%) did not answer. Among the didactic exercises described were both seminar series and occasional lectures. Ten respondents listed clinical rotations (four required, six elective) that focused on organizational and/or occupational issues. Not surprisingly, EAP-managed care were the most common of these rotations, though one program reported an elective experience in organizational consultation with public agencies. Several respondents commented that, given the large number of topics to be covered during residency, occupational psychiatry had a low priority.

In reply to the question "Are residents taught and expected to include work history data in psychiatric evaluations and reports?" 163 (87%) answered "yes," 14 (7%) "no," and 11 (6%) did not respond. The comments of those who answered in the affirmative ranged from "not very well done" to "90% of our patients are unemployed" to "mandated by state department of mental health."

In response to the question: "Are faculty in your department directly involved with workplace issues?" 80 (42%) said "yes," 93 (50%) said "no" and 15 (8%) did not respond. The most common type of involvement noted was in EAP or managed care settings.

A final open-response question was included: "Any other comments on this—organizational and occupational psychiatry—matter?" Responses ranged from "organizational and occupational psychiatry is overlooked in residency education" to "organizational and occupational psychiatry is central to psychiatry."
Given that work is a significant factor in mental health, the results of this national survey suggest that residency education may not be providing sufficient didactic and rotation experiences in work-related topics and issues. Granted, the survey finds that a majority of residency training programs subscribe to the belief that the information about work history is a necessary part of a psychiatric evaluation, but does this information inform decisions about treatment goals and intervention? If so, how is this taught and learned? Unfortunately, psychiatry's current knowledge base about work dimension—work dynamics, dysfunctions and disorders, and treatment strategies—is limited. The first book-length treatise on psychotherapeutic treatment of work dysfunctions has only recently been published (3). Lowman contends that if clinicians are not formally taught to recognize and treat work-related issues, the issues tend to go unrecognized and untreated.

Although the return rate of this survey of AADPRT members was fairly good, and the results interesting, the data would have been more compelling if they represented a comparative program-by-program analysis of OOP teaching and training expectations and experiences. Additional research on this topic is needed and will hopefully aid residency education directors and groups like the Residency Review Committee and the AADPRT in establishing the competencies and training experiences in work-related and mental health-related issues that psychiatry residents need in our changing health care environment.

Len Sperry, M.D., Ph.D.
Department of Psychiatry
Medical College of Wisconsin
Milwaukee, WI

References

Psychiatry Department Retreats: Uses and Benefit

SIR: Psychiatry departments have an ongoing problem of communicating consistently with their faculty and establishing and maintaining a sense of departmental identity and faculty commitment. Departments may function at many different clinical sites, have to deal with staff turnover, and have multiple goals, which may divide psychiatric faculty. Primary department goals include funding (from multiple sources); providing training to residents and medical students; performing basic and clinical research; directing and developing generic and specialized clinical services; supporting professional academic advancement; providing adequate salaries and fringe benefits for faculty and staff; and playing appropriate roles in the medical center at large, in the hospitals, and in the community. Department retreats are one way that some psychiatry departments have tried to improve staff communication. By working together within a time-limited framework, department members can review goals, plan for the future, and improve their department's identity and faculty commitment.

Although there are no reports in the literature on psychiatry department retreats, such reports exist for pediatric department and medical student retreats. Kling and Frost (1) report on pediatric faculty-house staff retreats to reduce residency stress; Winter et al. (2) report on pediatric department retreats to foster resident growth, motiva-
Given that work is a significant factor in mental health, the results of this national survey suggest that residency education may not be providing sufficient didactic and rotation experiences in work-related topics and issues. Granted, the survey finds that a majority of residency training programs subscribe to the belief that the information about work history is a necessary part of a psychiatric evaluation, but does this information inform decisions about treatment goals and intervention? If so, how is this taught and learned? Unfortunately, psychiatry's current knowledge base about work dimension—work dynamics, dysfunctions and disorders, and treatment strategies—is limited. The first book-length treatise on psychotherapeutic treatment of work dysfunctions has only recently been published (3). Lowman contends that if clinicians are not formally taught to recognize and treat work-related issues, the issues tend to go unrecognized and untreated.

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tion, and program development; and Plaut et al. (3) report on medical student-faculty retreats that use intensive support groups to foster interpersonal communication. Books and articles describe retreats in the health care field (4), the business world (5), and the ministry (6).

The psychiatry department at the University of Texas Southwestern Medical Center at Dallas has conducted biennial 1.5-day off-campus retreats for the full-time faculty since 1978. Department faculty, key administrators, representatives of each resident training year and from each psychology Ph.D. training year are invited to take part in the retreats; attendance is not mandatory. For the last three retreats, average attendance of invitees has been 87% (N = 84). The retreats are held from noon Friday to mid-Saturday afternoon (1.5 days) at an out-of-town site. The program and out-of-town setting are designed to provide and encourage interaction. Paired rooming, shifting dining room seating, and planned social activities emphasize and facilitate ad hoc, informal communication. Issue-oriented small- and whole-group meetings provide the opportunity for attendees to exchange views with the senior faculty and, in particular, the department chair. The attendees have consistently evaluated the retreats as worthwhile. Our 10 years of experience conducting retreats encouraged us to survey other psychiatry departments to research their use of retreats.

A 1-page questionnaire was mailed in September 1992 to the chairmen of all the psychiatry departments in the United States and Canada (N = 148). The questions focused on length and frequency of retreats, staff attending, costs, location, topics discussed, format, recreational and social activities, satisfaction rating, and effect on the department. A follow-up mailing was sent in November 1992 to nonrespondents 8 weeks after the initial mailing.

In all, 118 (80%) of the 148 psychiatry chairmen responded to the questionnaire. Fifty departments (42%) reported sponsorship of a department retreat. Attendees included faculty (100% of departments), administrative staff (58%), and residents (40%). A majority of departments (69%) held their retreats in town on campus, at a conference center, or at a local hotel or resort. A minority (22%) had retreats out-of-town at a hotel or resort. A small number (9%) held their retreats both in- and out-of-town. The majority of retreats lasted 1 day or less (66%). The rest lasted 1.5 days (22%), or 2 days or longer (12%). Retreats were held every year (41%), every other year (18%), and at various other time intervals (41%).

All 28 possible topics of discussion listed in the questionnaire were checked one or more times, and 21 departments also listed subjects under the “Other Topics” rubric. The most commonly discussed topics were 1) the clinical faculty’s meeting of service demands without neglecting academic commitments (50%); 2) the use of research to facilitate training and of training to facilitate research (50%); 3) funding problems/salary increments (52%); and 4) resident recruitment (48%). The topics listed most often under the “Other Topics” category were residency education (16%), medical student education (10%), and department mission and future planning (8%).

Department chairs were asked to rate how well their retreats were received by the participants. Forty-four chairs (88%) answered this question. Most department chairmen felt the participants found the retreat to be a valuable experience. Their comments focused on improved communication and networking of faculty, long-range planning, and program recommendations for the department. Three chairs commented that the effect was “minor” or too early to determine the full effect.

A national survey of psychiatry department chairmen in September 1992 showed that 50 departments (42%) conduct retreats and that most of these are in-town and last 1 day or less. Most department chairs report-
ing on the effect of their retreat stated that the experience was of benefit to their department. It is our belief that with careful program planning, as we have outlined, other psychiatric departments could benefit from conducting retreats.

Lawrence Claman, M.D. 
Deborah A. Miller, Ph.D. 
Kenneth Z. Altshuler, M.D. 
Department of Psychiatry 
University of Texas Southwestern Medical Center at Dallas, Texas

References


Q and A

Frequently Asked Questions About an Added Qualification Certificate in Consultation-Liaison Psychiatry

Charles V. Ford, M.D.
Russell Noyes, Jr., M.D.
Troy L. Thompson II, M.D.

The official recognition of consultation-liaison (C-L) psychiatry as a subspecialty has been viewed by a large number of authorities in the field as a goal of increasing importance over the past several years. The American Psychiatric Association (APA) recommend to the American Board of Psychiatry and Neurology (ABPN) that a certificate for added qualification (CAQ) in C-L psychiatry be established for those already certified in general psychiatry (1). With approval of this added qualification certificate, the Residency Review Committee of the Liaison Committee of Medical Education would establish accreditation standards for C-L fellowship programs.

The APA General Assembly voted overwhelmingly in favor of the recommendation to the ABPN that consultation-liaison psychiatry be approved for a CAQ. This recommendation was ratified by the board of trustees. However, at its meeting in the summer of 1993, the ABPN voted against developing such a certificate at that time. The board was influenced in its deliberations by gathering sentiment against medical specialization among national policymakers. Nevertheless, as changes in the health care delivery system are contemplated, C-L psychiatric services to medical and surgical patients grows in importance. Accordingly, the APM will modify and resubmit its application for a CAQ. In the interim the APM has established standards for fellowship training in C-L psychiatry and is providing letters of approval for those programs that are essentially in compliance with the standards (2).

At the request of the APA Commission on Subspecialization, a series of questions and answers concerning a CAQ in C-L psychiatry has been developed with input from many sources. These questions and answers are included in this issue of Academic Psychiatry because they address issues of interest to many psychiatric educators. In fact, one of the driving forces in defining C-L psychiatry as an official subspecialty is the need to increase the quality of teaching at all levels of medical education, including programs for medical students, psychiatric and other types of residents, practicing physicians, and C-L fellows.

Q: What is a Certificate of Added Qualification in C-L psychiatry?

A: A CAQ in C-L psychiatry is designed to recognize general psychiatrists who have additional knowledge and skills in the evaluation and treatment of medical/surgical patients with psychiatric disorders. These psychiatrists are equipped to handle com-
plex problems arising on units such as those devoted to transplantation, renal dialysis, burns, trauma, AIDS, and cancer. They recognize the somatic presentations of psychiatric disorders and the psychiatric manifestations of medical and surgical diseases. C-L psychiatrists keep up-to-date on drug interactions and the psychological effects of technological procedures.

Q: Is the need for psychiatric services to hospitalized medical/surgical patients being met?

A: No. This group of patients is psychiatrically underrecognized and underserved. It is estimated that from 30% to 60% of patients in general hospitals have diagnosable psychiatric illnesses that interfere with optimal care, yet only 1% are currently being seen in psychiatric consultation. The existence of a sizable population whose requirement for psychiatric services is unmet points out the need for more well-educated, hospital-based C-L psychiatrists.

Q: Why should C-L psychiatry be officially recognized as a subspecialty?

A: More and better-educated psychiatrists are needed to meet the demand for psychiatric services among patients in general hospitals. Official recognition of C-L psychiatry will, by creating national standards for education and certification, raise the priority given in all psychiatric education programs to this vital area of professional identity. Further, increased research in C-L psychiatry will follow subspecialty recognition, and should improve the capabilities of all psychiatrists who treat medical/surgical patients.

Q: How many C-L psychiatrists are there in the United States?

A: Approximately 6,000 members of the APA have indicated that C-L psychiatry is an area of interest. Of these, it is estimated that 1,000 devote a significant portion of their time to C-L activities. This estimate is based on membership in organizations supporting C-L psychiatry (e.g., the APM, American Psychosomatic Society, Association of General Hospital Psychiatrists), on the number of hospitals reporting C-L services, and on a recent survey of psychiatrists interested in the field (3).

Q: Will C-L psychiatrists with an added qualification compete with general psychiatrists?

A: No. C-L psychiatrists complement and support the activities of, and are a source of increased referrals to, general psychiatrists. The presence of C-L psychiatrists serves to increase recognition by other health care providers of psychiatric problems among general hospital patients. However, in order to preserve their ready availability, C-L psychiatrists typically limit ongoing contact with such patients and refer most of them to general psychiatrists for further care. Even with the development of an added qualification certificate, most consultations will be performed by general psychiatrists, though. C-L psychiatrists would be available to assist and collaborate with general psychiatrists when requested. Within the hospital, C-L psychiatrists collaborate with medical teams and families to improve their understanding and treatment of psychiatric disorders. By maintaining familiarity with newer medical and surgical technologies and intensive care environments, C-L psychiatrists offer an important resource in the care of seriously ill medical and surgical patients.

Q: How will certification in C-L psychiatry affect reimbursement?

A: Just as there is no reimbursement differential between board-certified and non-board-certified psychiatrists, changes in reimbursement based on this added qualification are not expected. Similarly, it is not
anticipated that an added qualification certificate will influence eligibility for hospital staff membership. No such changes have occurred with the Certificate of Added Qualification in Geriatric Psychiatry.

Q: What will be the malpractice liability of psychiatrists who care for medical/surgical patients but who do not have an added qualification in C-L psychiatry?

A: Malpractice liability is related to the quality of medical care provided. Improved communication and the use of consultation tends to improve care and reduce risk. In most situations there is no difference in premiums or risk assumed by board-certified as compared with noncertified psychiatrists.

Q: Will applicants for this added qualification certificate be required to take an extra year of fellowship education?

A: Probably not for the first 5 years. Those psychiatrists who have significant experience treating medical/surgical patients with psychiatric disorders will be eligible to sit for the certifying examination. The extent of the required experience and how it should be documented will be determined at a later date. After 5 years, it is anticipated a 1-year fellowship beyond the usual 4-year residency will be needed for certification.

Q: How can applicants prepare for an added qualification certificate in C-L psychiatry?

A: There are currently 44 C-L psychiatry fellowships in the United States (4). In addition, there are plans to develop a detailed syllabus containing basic information and questions similar to those likely to be included in a written examination. Courses will be offered at APA’s annual meeting as well as by subspecialty organizations such as the APM and the Association of General Hospital Psychiatrists. These courses will assist psychiatrists with an interest in C-L psychiatry to increase their knowledge and prepare for an examination that would be administrated by the ABPN. Textbooks (5,6) and lists of reading materials are already available for practitioners who are interested in C-L psychiatry.

Q: How are C-L psychiatrists funded?

A: A variety of funding models for C-L psychiatry have emerged during the past several years. Many draw on a combination of sources, including patient fees and salaries from hospitals, group practices, and medical schools. Financial support is also derived from case-finding activities that directly benefit hospitals and from consultation activities that indirectly benefit hospitals by reducing length of stay (6).

Q: How will educational programs in C-L psychiatry be funded?

A: Some funding is based on the need for medical schools and hospitals to have educational programs in the behavioral sciences. These programs are supported by a variety of sources, including patient fees, hospital and/or department funds, and extramural grant support. With official subspecialty status, increased support from hospital administrations and granting agencies is anticipated. The lack of an officially sanctioned subspecialty, with certification and accreditation, has been used by some hospital administrators to deny funding for C-L psychiatry fellowships.

Dr. Ford is professor, Department of Psychiatry, University of Alabama, Birmingham; Dr. Noyes is professor, Department of Psychiatry, University of Iowa, Iowa City; and Dr. Thompson is professor and chair, Department of Psychiatry, Jefferson Medical College, Philadelphia, PA.
These questions and answers were developed from the contributions of a large number of persons including, among others, members of the Executive Council of the Academy of Psychosomatic Medicine, and members of the APA Commission on Subspecialization, chaired by James M. Trench, M.D.

References

Educational Abstracts

Abstracted by
Dorthea Juul, Ph.D.


Norcini JJ: Examining the examinations for licensure and certification in medicine. JAMA 1994; 272:713–714


These articles address gender differences in pre-medical school and medical school performance. In addition, Dawson and her colleagues also looked at ethnic differences, and Hojat et al. extended the gender comparisons beyond graduation.

Performance on the National Board of Medical Examiners (NBME) Part I Examination was the focus of the study by Dawson et al. The subjects were first-time takers who sat for either the June 1986, 1987, or 1988 administrations, were seeking NBME certification, and expected to graduate in 2 years from a medical school accredited by the Liaison Committee for Medical Education (LCME). There were more than 10,000 examinees each year who met these criteria.

Prematriculation data included Medical College Admission Test (MCAT) scores, science and nonscience grade-point averages (GPAs), number of credit hours in science and nonscience subjects, and an index of the selectivity of the student’s undergraduate institution. Demographic variables were age, gender, and racial/ethnic background (white, black, Asian/Pacific Islander, and Hispanic). About one-third of the subjects were women, and 85% were white, 9% were Asian/Pacific Islander, 5.5% were black, and 3.5% were Hispanic. Analyses were done separately on each of the three cohorts and yielded similar results. Results for the 1988 cohort (N = 10,403) were presented.

The Part I Examinations consisted of 900–1,000 multiple-choice questions distributed about equally across seven basic science subjects: anatomy, behavioral science, biochemistry, microbiology, pathology, pharmacology, and physiology. The internal consistency reliability exceeded 0.95, and the mean was set at 500, with a standard deviation of 100. The passing score was set at 380.

For the 1988 cohort, the mean score on Part I was 492 for men and 455 for women, with a pass rate of 87.2% for men and 79.4% for women. Compared to white students, during the 3 years of the study Asian/Pacific Islander students had mean scores that were 15–20 points lower. Hispanic students scored 60 points lower, and black students scored 100–120 points lower. In 1988, the pass rates were 88% for whites, 84% for Asian/Pacific Islanders, 66% for Hispanics, and 49% for blacks.

There were prematriculation differences between the gender and ethnic groups. The men had higher mean MCAT scores than the
women for biology, chemistry, physics, and quantitative skills, whereas the women had higher reading scores. Asian/Pacific Islander students had higher means than the other ethnic groups on all MCAT scores, except for reading (white students had the highest mean score). The white students had higher mean scores than the Hispanic and black students on all MCAT scores.

The men had higher science GPAs than women, whereas the women had higher nonscience GPAs. The Asian/Pacific Islander and white students had similar science and nonscience GPAs, and the Hispanic and black students had lower GPAs.

Multiple regression analysis indicated that 37% of the variance in Part I scores was accounted for by entry-level and demographic variables, with MCAT scores explaining more of the variance than the other indicators of undergraduate performance.

Analysis of covariance was then used to adjust the Part I scores for differences in academic credentials, and it was found that the differences between the white men and the other gender-ethnic groups were not eliminated by adjusting the Part I scores. The mean scores of Asian/Pacific Islander, Hispanic, and white women, and Asian/Pacific Islander men continued to differ significantly from that of white men. However, the Hispanic and black men performed about the same as the white men who had the same MCAT scores and undergraduate performance characteristics.

The authors concluded that "there are both ethnic and gender differences in Part I performance, and... prior academic performance is sufficient to explain a large part of the observed differences among underrepresented racial and ethnic groups but not between men and women." (p. 677) They did not present any strong hypotheses about what happens in the first 2 years of medical school to depress the Part I (basic science) performance of women and Asian/Pacific Islander men and express concern that these groups may be less competitive for highly selective residencies that rely heavily on Part I scores in their selection process.

In his related editorial, Norcini discussed several issues about medical licensing and certifying examinations that this study raised. He suggested that while the results may not be generalizable to all such examinations, this type of research is an important component of any testing program.

Case and her colleagues reported on a similar study of gender differences on both the Part I and Part II NBME Examinations. Their subjects were 11,324 medical students who were seniors at an LCME-accredited medical school in the 1991–1992 academic school year, took Part II for the first time in September 1991 or April 1992, and had prematriculation data available (MCAT scores, undergraduate GPAs in science and nonscience courses, and an index of the selectivity of the student's undergraduate college). There were 7,234 men (64%) and 4,090 women (36%) in their sample.

The prematriculation data for this sample were similar to that reported by Dawson et al., with higher mean scores for the men on all MCAT scores, except reading. However, the science GPAs of the men and women were almost identical for this sample, and the women again had a higher mean nonscience GPA.

The Part I results were also similar to those of Dawson et al. The men performed better than the women, with means of 488 and 459, respectively. The men also performed better on five of the seven subtests: anatomy, biochemistry, microbiology, pharmacology, and physiology. The two groups performed similarly on behavioral sciences and pathology.

The Part II examination is a multiple-choice test, with high reliability that assesses knowledge of the clinical sciences. The men and women performed almost identically, with means of 198.8 and 199.1, respectively. The women scored higher on the obstetrics-gynecology, pediatrics, and psychiatry subtests, whereas the men scored higher on the
When differences in prematriculation measures were controlled for, the observed differences between the men and women on Part I total scores decreased but were not eliminated. For the Part II scores, controlling for these differences reduced or eliminated the observed differences on the subtests where men performed better and enhanced the differences on the subtests where women scored higher. When Part I scores were added to the regression equation, the adjusted differences favored the women on the subtests where the observed scores were higher for the men. On the subtests where women did better, the adjusted differences were even greater.

The authors note that these results were the same as those reported two decades earlier in the medical education literature.

Despite a dramatic increase in the number of women attending medical school, despite other changes that might be hypothesized to affect the role and status of women in society, and despite changes in the examinations, the relative performance of men and women on prematriculation measures, Part I and Part II, appears to be almost unchanged from that observed 20 years ago. (p. S27)

The study by Hojat et al. compared the performance of the men and women before, during, and after medical school for graduates of one institution. The sample consisted of 3,541 men (76%) and 1,121 women (24%) who entered Jefferson Medical College between 1970 and 1990. The pattern of gender differences on the prematriculation variables for their sample was similar to that reported in the other two studies.

The results for NBME Part I were similar to those of Case et al.: the men scored higher than the women on the total score and on the anatomy, biochemistry, microbiology, pharmacology, and physiology subtests. The women scored higher than the men on behavioral sciences, and there was no difference on pathology.

For NBME Part II, there were no differences between the men and women on total score and pediatrics. The women scored higher than the men on obstetrics-gynecology and psychiatry, and the men scored higher than the women on medicine, public health, and surgery. There was no difference between the men and women on total score on NBME Part III.

On the postgraduate ratings of clinical competence obtained from residency training directors, there were no significant differences between the men and women for data-gathering and processing skills and interpersonal skills and attitudes, but the women were rated higher than the men on socioeconomic aspects of patient care. There were some gender differences in specialty choice: more men went into surgery and the surgical specialties, and more women entered pediatrics, obstetrics-gynecology, and psychiatry. There were no differences for anesthesiology, emergency medicine, family practice, internal medicine, ophthalmology, pathology, and radiology. Sixty-four percent of the women and 74% of the men were board-certified; the authors don’t know if this is due to a differential failure rate or lower rate of applying for board certification. It was also noted that the women had lower income expectations than the men, regardless of specialty.

Hojat et al. concluded that the gender differences observed in prematriculation and basic science performance narrowed or disappeared later in medical school and in residency.

These studies create a detailed picture of the performance of men and women on premedical and medical school variables for two large national samples and for a large sample from a single institution. Their findings suggest that medical schools and testing agencies need to further assess the impact of their education programs and examinations on different groups of trainees.
Principles and Practice of Forensic Psychiatry
Edited by Richard Rosner, M.D.
New York, Chapman and Hall, 1994
635 pages, ISBN 0–442–01118–0,
$125.00

Reviewed by Robert Rollins, M.D.

This book is encyclopedic in scope and
sets out to “review the entire field of
forensic psychiatry at a level consistent with
the needs of subspecialists.” Within psychi-
atriy there has been debate as to the need for
a subspecialty of forensic psychiatry and a
subspecialty board. Principles and Practice of
Forensic Psychiatry affirms the view that
there are complex psychiatric legal issues
beyond the practice of general psychiatry
that require specialized knowledge and
training. Publication comes just as the Ameri-
can Board of Psychiatry and Neurology
(ABPN) has established a subspecialty ex-
amination for “added qualification in foren-
sic psychiatry.” This work is intended for
ABPN candidates, fellows in forensic psy-
chiatry training programs, mental health
practitioners, and attorneys.

Designed as a foundation work in the
field, this textbook’s great strength is its in-
structional approach, which is an extension
of a formal training program conducted by
the Tri-State chapter of the American Acad-
emy of Psychiatry and the Law (AAPL),
whose members edited this publication.

The text is organized into eight topical
sections divided into chapters with multiple
authors, who are recognized experts in the
field. The content follows the Accredit-
ation Council on Fellowships in Forensic
Psychiatry’s Standards for education and
training in psychiatry and the law.

Rosner required each writer to adhere to
a uniform conceptual framework for analysis
of problems in forensic psychiatry, which
provides a generally uniform approach to
the broad topics covered. This 4-step con-
ceptual framework of identifying the issue, the
legal criteria, the relevant data, and explain-
ing the reasoning process is consistently em-
phasized throughout the text. Rosner and
Dr. Robert Weinstock, who initiated the idea
for this text, also strongly emphasize med-
cal and psychiatric ethics, which is another
of the book’s strengths.

Rosner is the founding president of the
Tri-State chapter and editor of their 7-book
series, titled “Critical Issues in American
Psychiatry and The Law.” One of the vol-
ums, Ethical Practice in Psychiatry and The
Law (1), which he co-edited with Weinstock,
is an outstanding resource. Ethical issues
relevant to the practice of forensic psychiatry
are at the core of the book and provide in-
valuable guidance in dealing with the de-
mands of the medical and legal professions.

The 4-step approach to analyzing the
forensic psychiatric problem is a practical
technique for reaching psychiatric-legal
opinions and facilitates dealing with com-
plex issues. Step One of the approach, assur-
ing that you understand the specific legal
question, will prevent forensic psychiatrists
most common failing, answering the wrong
question. The next step, determining the re-
levant legal criteria as they apply to the ques-
tion in your jurisdiction is key, since legal
standards may vary from one judicial jur-
sisdiction to another. The third step, obtaining
all relevant information concerning the legal
question, is a good example of the difference
between general and forensic psychiatry. In
forensic psychiatry, the patient’s perspective
must be assessed in light of information from
other sources, which is a shift from the ther-
apeutic alliance with the patient. The last
and critical step is to be able to explain how
the data supports your opinions and to ex-
plain it in a way juries can understand.

The first section, “History and Practice
of Forensic Psychiatry,” presents the theory
and practice of meeting legal needs and
maintaining medical and psychiatric ethics,
report writing, courtroom testimony, and
training. This material is basic to the practice
of forensic psychiatry and must be mastered.
From that standpoint, this is the book’s most important section. This section was edited by Weinstock, and out of the 15 chapters, 7 are written by Rosner or Weinstock, including Weinstock’s excellent “Ethical Guidelines.”

Section Two, “Legal Regulation of Psychiatric Practice,” is a thorough discussion of the legal standards applying to psychiatric practice, including informed consent, competency to make decisions, hospitalization, commitment, right to treatment, treatment refusal, confidentiality, duty to protect, and treatment boundaries. The area of confidentiality is better covered in “Guidelines on Confidentiality” (2), a position statement of the American Psychiatric Association.

Section Three, “Forensic Evaluation and Treatment in the Criminal Justice System,” is an excellent discussion of the traditional forensic issues of criminal competence and criminal responsibility. This is the only section with an introduction, which contributes to cohesiveness. The issues of voluntary intoxication in relation to responsibility and intent and the defense of automatism or unconsciousness could be developed further.

Section Four, “Civil Law,” covers malpractice, disability, psychological injury, testamentary capacity, and guardianship. The chapter on malpractice is incomplete because the principles of tort law are in Section Eight. Otherwise, the section is excellent. The chapter on “Death and Dying” is especially sensitive and thoughtful. However, competence to contract and hold a job are in another section under “Geriatric Psychiatry,” and competence to marry and divorce are not discussed. Competence to commit a tort and the tort liability of the mentally impaired are located in Section Eight. An additional chapter titled “Civil Competence” would allow all these issues to be covered together.

Section Five, “Family Law and Domestic Relations,” covers child custody, parental rights, abused children, elder abuse, juvenile delinquency, confidentiality, posttraumatic stress disorder, suicide, and violence. The chapter titled “Fetal and Infant Forensic Psychiatry: A New Frontier” is especially well done. “Discussion of Harassment of Psychiatric Evaluators” is a reminder that our forensic opinions please one side and displease the other. The chapter on “Parental Competence and Termination of Parental Rights” is not as concise as other chapters.

Section Six, “Correctional Psychiatry,” describes standards in correctional mental health care, suicide prevention, and the psychosocial basis of prison violence. “Psychiatric Ethics in the Correctional Setting” is an example of the special emphasis on ethics by Rosner and Weinstock. Adherence to ethical standards is the salvation of clinicians coping with the varying demands of inmates, correctional staff, and public opinion.

Section Seven, “Special Clinical Issues in Forensic Psychiatry,” is a collection of outstanding chapters that covers malingering, antisocial personality disorder, violence, culture, and ethnicity, hypnosis, sex offenders, multiple personality disorder, and AIDS. Missing topics are mental retardation and substance abuse, conditions commonly evaluated by forensic psychiatrists.

Section Eight, “Basic Issues in Law,” is an introduction to legal philosophy, civil procedure, and criminal and tort law. This is intended as an introduction and is not definitive when compared to other sections. Consequently, it is the weakest section.

Section Nine, “Landmark Cases,” documents the relationship between case law and the regulation of psychiatric practice, and reminds us that litigation has brought about significant improvements in the delivery of mental health services to consumers, for example, right to treatment. These landmark cases help us understand the reasoning behind judicial decisions, which some may perceive as intrusive or overregulation, as in civil commitment and duty to warn. Board candidates may wish to obtain the 3-volume Landmark Cases set of 1,711 pages from the AAPL (3). The set provides the entire text of
now 92 landmark cases, some added since publication of Principles and Practice of Forensic Psychiatry.

An area not adequately developed is the possibility of therapist-influenced beliefs in satanism, multiple personality disorder, sexual abuse, and recovered memories. This merits emphasis in a forensic psychiatry textbook, where maximum objectivity is essential and where the conflicting roles of treater and evaluator are discussed in our code of ethics. This whole area, however, is more prominent in forensic literature of the past 2 years.

Greater use of subheads and a more detailed index would facilitate quick reference. All encyclopedias must be updated periodically, and the next edition of the book likely will include “Psychiatric Abuse in North America,” discussion of fraud and exploitation by some corporate psychiatric hospitals. The present “Death Penalty” chapter should assess the 60 new federal capital crimes recently established from the 1994 Crime Bill. “Criminal Competence” should include Godinez v. Moran, 1993 (4) which, surprisingly, sets the standard for competence to plea or waiving right to counsel as the same standard as competency for standing trial.

This is an excellent, comprehensive, well-written text on the subspecialty of forensic psychiatry, which is published just in time for the first American Board of Psychiatry and Neurology examination for “added qualifications in forensic psychiatry.” This textbook is essential for all forensic psychiatrists. We owe the editors and authors a resounding vote of thanks and look forward to the next edition.

References

Dr. Rollins is clinical professor, and director of the Forensic Psychiatry Fellowship Program, Department of Psychiatry, University of North Carolina, Chapel Hill, NC; clinical professor, Department of Psychiatric Medicine, East Carolina University, Greenville, NC; and director of the Forensic Psychiatry Division, Dorothea Dix Hospital, Raleigh, NC.

Textbook of Geriatric Neuropsychiatry
Edited by C. Edward Coffey, M.D., and Jeffrey L. Cummings, M.D.
Washington, DC, American Psychiatric Press, 1994

Reviewed by Jarrett Barnhill, M.D.

Coffey and Cummings have assembled an excellent collection of authors for this third edition of neuropsychiatric texts from American Psychiatric Press, Inc. The book’s format is similar to previous neuropsychiatric texts, presenting a broad range of recent neuroscience and clinical literature. The book is divided into five sections that encompass epidemiology and neurobiology of aging; a review of assessment tools and techniques; an overview of neuropsychiatric disorders; neurobehavioral aspects of primary neurological disorder; and a section devoted to treatment interventions.

Section One is devoted to epidemiology and basic neurobiology. Cummings opens the text with an overview of the relationship between neurology, behavioral neurology, psychiatry, and neuropsychiatry. Although the term “neuropsychiatry” can be used somewhat euphemistically, the authors directly attack the core issues germane to the complex transactional relationship between brain and behavior. For geriatric clinicians, this delicate balance between social and psychological life adjustments, aging-related changes in neuronal function, systemic organ changes, and disease states is a daily challenge. The art and science of teasing out
now 92 landmark cases, some added since publication of Principles and Practice of Forensic Psychiatry.

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the clinically relevant aspects of this complex dance is the prime directive of geriatric neuropsychiatry.

The chapter on epidemiology addresses the sociocultural aspects of this rapidly growing population. Subsequent chapters systematically explore the developmental changes in neuronal activity and brain function that accompany normal aging. This emphasis is driven by a need to understand the neurobiology of normal aging as one attempts to assess for pathology. The editors close this section with a chapter that emphasizes basic brain-behavior interrelationships. From their perspective, the days of "lesionology" are being replaced by concepts such as neural networks, brain-neurotransmitter systems, neurophysiological coherence, and disconnection syndromes.

Section Two focuses on the various assessment approaches to geriatric neuropsychiatry. In spite of our impressive technology, a good history, physical examination, neurological examination, and neuropsychological testing remain as key elements. Each technique defines areas of dysfunction and attempts to integrate these clinical findings with life circumstance and adjustment. To date no machine has replaced this art. A thorough examination raises suspicions and theoretical explanations of observed behavior. At this point the tool box of our expanding technologies can be opened. Standard approaches with EEG and neuroimaging have been supplemented by functional MRI, MRS, SPECT, PET, magnetoencephalography, quantified EEG, and neurophysiological marvels. This textbook attempts to bring these technologies to bear on clinical problems.

Section Three provides an overview of "functional psychiatric disorders." It is apparent in this neuropsychiatry text that the notion of functional psychiatric disorders is an obsolete metaphor. Chapters on mood and anxiety disorders focus on the impact of age-related CNS changes on both the clinical course of symptoms and variable treatment responses. Late-life psychoses get similar attention. Other chapters address much underrecognized substance abuse; changes in sleep physiology and pathology; pain syndromes; and acute brain failure or delirium. The neurobiology of each "functional illness" is considered a part of the developmental aspects of normal and pathological aging.

Section Four returns to more traditional "neurological disorders." Chapters include a review of neurodegenerative disorders; dementias; movements disorders; cerebrovascular disease; traumatic brain injury; epilepsy; and infectious, neoplastic, and demyelinating disorders. The section concludes with a chapter on the neurobehavioral complications of medical therapies. This section also reiterates the idea that our traditional disease concepts are in need of a major overhaul. The relationship between mood, anxiety, and psychotic disorders and brain dysfunction makes this observation readily apparent. The realization that hemispheric, subcortical, and systemic disorders produce psychological and cognitive deficits created the field of neuropsychiatry. The relationship between brain dysfunction and neurobehavioral complications is the gist of this section, and an important restatement of this concept.

Section Five addresses therapeutic interventions. The pharmacokinetic and pharmacodynamic changes associated with aging are the bane of many clinicians. Changes in receptor sensitivity and increased vulnerability to polypharmacy are critical issues in the care of the elderly. Dosages adjustments and tolerance to side effects create a complex treatment environment for physicians. ECT as a treatment modality can be a godsend for the severely depressed, or medically compromised, depressed patient. Once a treatment of absolute last resort, ECT has become a safe and effective intervention. Coffey et al. summarize the great strides in the neurosciences and treatment techniques associated with this somatic therapy.
No textbook is complete without a review of psychotherapy and psychosocial interventions. As our base of knowledge on aging has expanded, traditional psychodynamic and systems therapies have been increasingly applied to geriatric patients. This rekindled interest has generated more creative interventions and a gradual waning of the earlier stereotypes of inflexibility, lack of psychological mindedness, and resistance among the elderly to expressive psychotherapies. Perhaps, we have neglected such interventions, falling prey to vestiges of “ageism,” as we have limited access of many older patients to these interventions. This text awakens and challenges clinicians to research and application of psychosocial therapies.

This textbook also contains a chapter on the vicissitudes of neuropsychiatry within the residential care system.

Coffey and Cummings have done a great service to geriatric neuropsychiatry. Although a multi-author format can produce a variable product, this edition has captured the essence of the field at a time of great transformation. Aging is a complex developmental process that involves change as significant as at any point in the life cycle. This text brings together the diversity of current neuroscience and clinical wisdom in a readable format. The textbook is a reference volume that is well written and referenced. Specialists in narrow aspects of gerontology may find some sections limited in depth. For clinicians dealing with the reality of geriatric medicine and neuropsychiatry, the breadth of material is impressive. As each of us age, the importance of geriatric neuropsychiatry comes increasingly closer to home and of growing importance. Coffey and Cummings have eased the angst and burden of understanding our patients and our own life.

Behavioral Science for Medical Students
Edited by Frederick S. Sierles, M.D.
Baltimore, MD, Williams & Wilkins, 1993

Reviewed by Lesly Tamarin Mega, M.D.,
Douglas H. Finestone, M.D., and
Joseph A. Franklin

In 1972, the National Board of Medical Examiners (NBME) popularized the term “behavioral science” by creating a section for this topic on Part I of the Boards. This gave psychiatry “legitimate” access into the first 2 years of the medical school curriculum, but heightened the challenge to educators to determine what and how behavioral science should be taught to first- and second-year medical students. A 1990 survey revealing 50% of U.S. medical schools revealed that at least 35 texts were being used to teach behavioral science.1

In 1993, to address more uniformly this curriculum challenge, the Association of Directors of Medical Student Education in Psychiatry, led by Frederick Sierles, and with the collaborative effort of 46 scholars representing 43 medical schools, created Behavioral Science for Medical Students, a book with 455 pages of text, 7 sections, and 35 chapters. The text’s content adheres to the NBME’s comprehensive definition of behavioral science and includes topics ranging from neuropsychiatry, to life cycle development, to clinical assessment and treatment, to ethical-legal-economical-societal issues, to research and statistical analysis.

The text begins with the section “Approaches to Behavior.” This section conveys the message that psychiatry is a medical science involving the systematic study of neuroanatomy/chemistry, genetics, learning and psychoanalytic theories, medical aspects of sociology and evolution, and biostatistics in research. The first chapter, “Acquired Immunodeficiency Syndrome: A

Dr. Barnhill is clinical associate professor, Department of Psychiatry, and director, Neuropharmacology Clinic, University of North Carolina School of Medicine, Chapel Hill.
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Biopsychosocial Paradigm of Illness,” establishes the book’s embrace of the biopsychosocial model, using AIDS as a prototype. Although the discussion of the biopsychosocial model, highlighted with clinical vignettes, is excellent, the extensive information on AIDS serves as a distraction. The “Basic Research and Statistical Methods” chapter is complete and understandable but could be illustrated by psychiatric examples. The “Neurology of Behavior” chapter effectively correlates anatomy to functional deficits but could be improved by simplifying the detailed brain anatomy diagrams, more clearly relating the limbic system to psychopathology, and lengthening the discussion of cerebral lateralization. The “Neurochemistry of Behavior” chapter is written clearly and includes up-to-date findings by neural scientists such as Kandel and Schwartz. The “Genetics of Personality and Psychiatric Illness” chapter well summarizes the concept of how genes effect behavior and psychiatric illness, but the reviewers debated the inclusion of Cloninger’s biosocial personality theory.

The last four chapters in “Approaches to Behavior” discuss more traditional “behavioral science” topics. The “Learning and Behavioral Modification” chapter introduces the important preventative medicine topics of smoking cessation and weight control but does not clearly coordinate theory and therapeutic technique. The “Psychoanalytic and Psychodynamic Theories” chapter presents an accurate historical perspective and a well-written explanation of the role of intrapsychic conflict in symptom formation. However, the lists of multiple theorists might better be replaced by summaries of important theories. The chapter on “Medical Sociology” is understandable and pertinent to the doctor-patient relationship. Much of the “Evolutionary Biology and Human Behavior” chapter is too advanced, and perhaps it could be improved by expanding the ethology portion.

Chapter 6, Section II, “Development,” appropriately begins with pregnancy and ends with death. It boldly addresses the emotionally laden topics of contraception, abortion, gender psychology, and family violence, and also deals with the pregnant physician and physician reaction to a patient’s death. Especially empathetic are the “Geriatric Development” and “Dying, Death and Bereavement” chapters. As a whole, this section’s chapters are well written; include important, practical information; and maintain a humanistic and biopsychosocial orientation. In only 19 pages, “Child and Adolescent Development and Psychopathology” skillfully compresses this vast topic; however, it is without an adequate explanation of developmental tasks and continuity between developmental stages. Since every sentence conveys an important fact because of limited space, the wonders and joys of childhood seem lost. More explanations, tables, and clinical vignettes might rectify these problems but would require more pages. Perhaps the chapter’s special situation topics on adoption, hospitalization, divorce, child abuse, and childhood psychiatric syndromes might better be divided into a separate chapter.

Section III includes four chapters on “Assessment.” The excellent “Interviewing” chapter provides concrete, “how-to” knowledge, but the psychiatric evaluation chapter is too detailed and overflows with complex tables. The chapter “Psychological Testing” clearly describes various tests and their usefulness, reinforced by illustrations. Although the “Brain Imaging in Psychiatry” chapter represents an important topic, it needs a decreased focus on technology and increased emphasis on the clinical applications of research findings.

Chapter 5, Section IV, “Neuropsychiatric Disorders and Their Treatment” often constitutes a separate book. Inclusion of it in this text would be better served by approaching this topic as an introduction or review. The “Psychopathology” chapter is overly ambitious with 475 references and is
too long. It might be better to divide the schizophrenic, affective, anxiety, and personality disorder sections into separate chapters. The chapter on “Dementia and Delirium” contains a fine section on the principles of psychosocial and environmental management but needs less detail as to the etiology of dementia. The chapters on “Substance Abuse,” “Psychotherapy,” and “Psychopharmacology and Electroconvulsive Therapy” are well written, comprehensive introductory chapters enlivened with well-chosen clinical vignettes.

Section V consists of three chapters on “Destructive and Injurious Behaviors.” The chapter on “Accidents” has useful sections on accident vulnerability, correlation of accidents to demographic factors, and accident prevention but contains an overpowering number of statistics in its introduction. The chapter on “Suicide” excellently addresses psychodynamic and biological etiologies of suicide, includes well-described case studies, and reviews how to assess and treat the suicidal patient. The chapter on “Violence” provides interesting background information and practical advice on prevention of violent behavior by patients.

Section VI, “General Health,” is comprised of 5 chapters that address the important topics of sleep, sex, psychoimmunology, chronic disease/disability, and amputation. “Sleep and Sleep Disorders” concisely describes normal sleep anatomy, physiology and phenomenology, and abnormal daytime and nighttime sleep disorders. “Sex and Sexual Dysfunctions,” understandably the section’s longest chapter, provides a fine overview of normal sexual functioning and sexual dysfunctions. The chapter on “Psychophysiology and Psychoneuroimmunology” contains a superb vignette, supported with MRI illustrations of a man whose tumor “disappeared,” to dramatically demonstrate the relationships among mind, immune system, disease, and healing. In the chapter “Chronic Disease and Disability,” clinical vignettes foster the student’s ability to understand how it feels to be chronically ill or disabled and provides concrete advice on how to interact with chronically ill or disabled patients. The chapter entitled “Limb Amputation,” although informative, is narrowly focused and could better use limb amputation to introduce the factors involved in the loss of a variety of body parts or functions.

The third and final chapter section, Section VII on “Behavior and Society,” includes the “hot” topics of medical ethics, forensics, and health care financing and delivery, all of which are included on the Part I of the Boards. These chapters certainly address the pertinent information in each field. The “Medical Ethics” chapter is highlighted by enlightening discussions on the history of medical ethics, issues concerning informed consent and duty to protect/report, and a review of unethical behaviors by physicians. The “Forensic Medicine” chapter uses vignettes with a psychiatric focus to effectively explain the doctor-patient relationship in forensic medicine. The text’s final chapter on the complex topic of “Health Care Financing and Delivery” is written in a scholarly and straightforward fashion, but it is too long and at times assumes students know a great deal about the finances of medicine.

Besides reviewing each chapter of the text, the reviewers used three attribute clusters taken from tables contained in a 1992 article from Academic Psychiatry (1) to rate Behavioral Science for Medical Students (BSMS) and compare it to three other behavioral science texts. The attribute clusters consisted of theoretical points of view (e.g., psychodynamic), specific subject areas covered (e.g., brain and behavior), and selected attributes (e.g., ease of understanding at a medical school level). In the majority of areas, we found BSMS to be equal to or better than the three behavioral science texts that previously had been rated: Understanding Human Behavior in Health and Illness (UHB) by Simons and Pardes (1985), Synopsis of Psychiatry: Behavioral Science and Clinical Psychi-
atry by Kaplan and Sadock (1987), and Review of General Psychiatry by Goldman (1988). BSMS was competitive in presenting an integrated point of view, superior in its coverage of brain and behavior, epidemiology and social psychiatry, interviewing techniques, geriatric development, human sexuality, and substance abuse. It was better than all but UHB in discussing the doctor-patient relationship, but weaker than all in explaining child development and theory. In addition, BSMS was superior in regard to accuracy, emphasis on detail learning, and preparation for the Boards.

Thanks to the conscientious work of 45 authors and Sierle’s vision and meticulous editing, we have a most comprehensive, relevant, and excellent text for our first- and second-year medical students. We look forward to the next edition.

Reference
1. Mega LT, Rand EH, Ritter KE: Textbooks and software used to teach behavioral science and clinical psychiatry to medical students. Academic Psychiatry 1992; 16:14-23

Dr. Mega is professor and director of Medicine Student Education in Psychiatry, Dr. Finestone is associate professor, and Mr. Franklin is a second-year medical student; all are in the Department of Psychiatric Medicine, East Carolina University School of Medicine, Greenville, NC.
Academic Psychiatry (formerly the Journal of Psychiatric Education) publishes material describing educational efforts for and by psychiatrists as well as articles addressing other issues relevant to the academic missions of departments of psychiatry. The journal provides a forum for work which furthers knowledge in psychiatric education and stimulates improvements in academic psychiatry.
Information for Contributors

The American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry have joined together to sponsor Academic Psychiatry, a peer-reviewed quarterly journal published by American Psychiatric Press, Inc. Formerly the Journal of Psychiatric Education, Academic Psychiatry is dedicated to the publication of work concerning educational efforts by and for psychiatrists, and articles addressing teaching, research, administrative, clinical, organizational, and economic issues relevant to the academic missions of departments of psychiatry. The Editors invite high-quality submissions that further knowledge in psychiatric education and stimulate improvements in academic psychiatry.

Peer Review: All submissions are reviewed by at least two experts to determine the originality, validity, and importance to the field of their content and conclusions. Reviewers of a manuscript will be blind to the authors' identity, and authors will be sent reviewer comments that are judged to be useful to them. Academic Psychiatry has initiated a rapid review procedure, and authors can expect to receive notification of the Editor's decision regarding their submission within three months of receipt of the submission by the journal office. To foster rapid publication, any required revisions are expected to be accomplished by the authors within an additional two-month period.

Manuscript Specifications: Manuscripts must be prepared according to the manuscript specifications of The American Journal of Psychiatry. All manuscripts will be edited for clarity, conciseness, and conformity to journal style.

Original Articles: Original reports of empirical research or critical analyses of important topics in psychiatric education or academic psychiatry may be submitted in one of the following formats. Special Articles are overview articles that bring together important information on a topic of general interest to academic psychiatrists. Authors who wish to write a Special Article are advised to check with the Editor to ensure that a similar work has not already been submitted or invited. Special Articles may not exceed 6,250 words (25 double-spaced pages), including tables, figures, an abstract of no more than 100 words, and no more than 100 references. Regular Articles may not exceed 3,750 words (15 double-spaced pages), including references, tables, figures, and an abstract of no more than 100 words. For all articles, a table or figure that fills one-half of a vertical manuscript page equals 100 words of text; one that fills one-half of a horizontal page equals 150 words of text.

New Ideas: This section includes descriptions of innovative programs, curricula, teaching strategies, techniques, and technologies worthy of broad dissemination to the field. Generally, the programs being described should have been implemented, and some form of evaluation should be reported. Submissions for the New Ideas section are limited to 3,750 words (15 double-spaced pages).

Commentary: Submissions for the Commentary section should be tightly reasoned opinion pieces not exceeding 3,750 words (15 double-spaced pages) that address an important issue in psychiatric education or academic psychiatry.

Other Communications: Brief letters will be considered if they include the notation "for publication." Editorials and pertinent notices and official actions of the sponsoring organizations will also be published.

Submission Procedure: The original typescript, three copies, and a cover letter specifying the section of the journal for which the submission is intended should be submitted to Samuel J. Keith, M.D., Editor, at the address at left. Upon acceptance of an article, the author(s) will be assigned copyright ownership in writing to Academic Psychiatry. All inquiries should be directed by mail to the address at left.
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Department of Psychiatry and Behavioral Sciences
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Atlanta, Georgia

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We look forward to their active participation in the AAP Annual Meeting to be held March 1–4, 1995, at the La Mansion del Rio Hotel, San Antonio, Texas; their ongoing commitment to the pursuit of excellence in psychiatric education; and their future involvement in the AAP.