

A Resident's Guide To Surviving Psychiatric Training 2nd Edition

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Dedication

To our families...

For giving us minds hungry for knowledge and hearts eager to share.

Thank you for your love and support.

and

To future psychiatry residents...

May you find as much satisfaction in your careers as psychiatrists as we have found in ours.

Tonya Foreman, M.D.

Leah J. Dickstein, M.D., M.A.

Amir Garakani, M.D.

April 2007

PREFACE TO THE SECOND EDITION

Tonya Foreman, M.D.

In the spring of 1999, twenty-five psychiatry residents met in White Plains, New York, to begin a two-year term as Sol Ginsburg Fellows with the Group for the Advancement of Psychiatry (GAP). As Ginsburg Fellows, we were invited to attend biannual meetings of the GAP and serve on standing GAP committees with distinguished psychiatrists from around the United States. In addition, we were asked to develop a Ginsburg Fellows' project. We spent several hours scratching our heads and wondering what we, as psychiatry residents, could contribute to an organization filled with the nation's psychiatric leaders. "We're not experts at anything yet," we told each other. "We don't have anything to contribute." Then it dawned on us – we were experts at being psychiatric residents! We represented training programs from Hawaii to Kansas to Canada. Collectively, we formed a rich tapestry of experiences as psychiatric residents and as individuals. During the evolution of this project, members of our group completed a variety of fellowships, discovered the challenges of parenthood, struggled through divorces, and graduated from residency to take "real jobs!" And yes, we are even paying back our student loans.

As this book progressed, we collaborated with members of the American Psychiatric Association's Committee on Women in order to insure that our project addressed the needs of women and minorities. We are grateful for their assistance and for their sensitivity to issues that affect many residents. In 2006, Amir Garakani, M.D., an APA/GlaxoSmithKline fellow, approached staff at the APA about producing a second edition of the book. He believed strongly that in addition to using excellent on-line resources, psychiatric residents wanted a handbook that they could actually hold in their hands, drop in their pockets, and read at their leisure. His tireless pursuit of the project led to the publication of this, the second edition of The Resident's Guide to Surviving Psychiatric Training. Dr. Garakani's thoughtful appraisal of the first edition prompted the creation of several chapters that make this edition more timely and complete.

The authors who contributed to this book realize from firsthand experience that the vicissitudes of everyday life do not stop because you are a struggling resident. Even though you are emotionally, intellectually, and physically exhausted by the demands of training, your dog will still have to go to the vet, your car will break down, and the dirty laundry will inexplicably multiply in your hamper. As a

resident, you will be asked to spend much of your time and energy tending to the needs of others. As some of your own needs go unmet, you may become disillusioned or cynical. In order to complete residency and become the physician you envisioned when you filled out your medical school application, you will have to develop skills and coping mechanisms that allow you to manage your own life as you take care of others.

This book was written by psychiatric residents for psychiatric residents. We tried to pool our collective experiences to produce a handbook that would help you with the day-to-day challenges of psychiatric residency. This is not a clinical handbook – many excellent clinical handbooks already exist. This book contains the kind of advice we'd give to you if we could sit together over a cup of coffee and a stale donut in the hospital cafeteria. We have traveled the path you are now taking. We hope that we can provide some encouragement and advice to make your trip a bit easier.

Tonya Foreman, M.D.
April 2007

PART I:

LEARNING CURVES: HOW TO MAXIMIZE YOUR EDUCATIONAL EXPERIENCE

- Psychiatrists are “Real Doctors” Too: Finding Your Place in the World of Medicine
- How to Maintain Your Basic Medical Skills
- A Resident’s Guide to Keeping up with the Literature
- List of Psychiatric and Related Journals
- A Reading List and Reference Guide for Psychiatric Residents
- Sleepless in Psychiatry: How to Survive on Call
- How to Get the Most Out of Your Psychotherapy Supervision
- Finding and Developing a Relationship with a Mentor
- Doing Research as a Resident
- Getting Published During Residency
- Residents and the Pharmaceutical Industry

**PSYCHIATRISTS ARE “REAL DOCTORS” TOO:
FINDING YOUR PLACE IN THE WORLD OF MEDICINE
Monica Radford Green, M.D.**

In all likelihood, each person who chooses to enter the field of psychiatry realizes immediately that there is a bias against mental illness and its treatment in our society. Despite our hopes that four to six weeks of exposure to psychiatry during the third year of medical school will underscore the importance of psychiatry, we often find that medical professionals have no greater understanding of mental illness than society at large. We could spend endless hours ruminating over the reasons for this, including the defenses employed against the fears of self-revelation. We could spend even more hours analyzing the manner in which much of psychiatry has isolated itself from the rest of the medical community. Instead, more can be gained from a practical discussion of improving relationships with other specialties in order to “find our place” in today’s medical world.

The Physician Inside

First and foremost, let us remember that we are physicians. We invested many years in studying medicine, worked just as hard as other students on third year rotations, and made a conscious decision to enter the field of psychiatry. Entering psychiatric training, we are expected to have at least four months of general medicine or pediatrics and two months of neurology. Many psychiatric residents prefer to do these months of general medicine and neurology first, as they believe their skills in these specialties are fresher immediately after medical school. If you reflect on your days on the general medicine wards, you may remember feeling fairly confident about your skills at that time. So what is the transition that occurs? Often, psychiatric training focuses on the mechanisms of the mind and brain so much that we stop using our basic medical skills, skills we spent many years developing. (Although this is also true of many of the subspecialties, it is frequently noted in psychiatry.) Some psychiatric units encourage consultation for every general medical question that arises. Reasons for this may vary from liability concerns to pure workload consideration. In more analytically-oriented settings, concerns about transference and countertransference with regard to the physical exam lead to excessive consultations. In all psychiatric settings, of course, there are concerns about boundaries and how the violation of these may lead to a disrupted therapeutic alliance, especially when psychotherapy is involved. As our skills as

psychiatrists develop, our physical examination, diagnosis, and treatment skills often atrophy. (See section entitled “How to Maintain Your Basic Medical Skills” for a more complete discussion).

The Psychiatric Island

Another factor that frequently contributes to the increasing isolation experienced by psychiatric residents is the physical placement of psychiatric units. Often, psychiatric training facilities are freestanding facilities (such as state psychiatric hospitals). When incorporated as part of a university or general hospital, psychiatric wards are frequently located in a separate building. Even when a psychiatric unit is located in the main hospital, the units are usually locked and not in a main corridor, for obvious reasons of elopement risk and the potential for dangerous or disruptive behavior.

Your contact with other services might be limited to time spent on consultation-liaison services or self-initiated interaction, such as establishing friendships or moonlighting in facilities where other specialties are present. Didactic courses, as with most specialties, are taught to psychiatric residents only. In-services are provided between many other disciplines in the hospital (such as social work sessions with nursing), but less frequently does a collaborative exchange of knowledge occur between specialties of medicine. “Curbside consults,” though friendly, are limited in their ability to cultivate relationships between services.

Building Bridges

Working on the consultation-liaison service may help you establish your identity as a part of the hospital. Even in psychiatric programs where white coats are not worn, consultation-liaison psychiatrists typically don the stereotypical attire of “doctors.” More visible to the remainder of the hospital through their work on other units, the CL psychiatrist comes to represent the psychiatric service to the other physicians. This is reinforced by the role that the consult clinician plays in facilitating transfers to inpatient units. However, the CL clinician can sometimes feel isolated, as he or she is neither a member of the psychiatric service nor the consulting services, existing somewhere in-between.

“Real Doctors”

So how can you maintain your identity as a “real doctor?” Many of the suggestions that follow are more completely discussed in the section entitled “How to Maintain Your Basic Medical Skills.” Specifically, we should all maintain the knowledge base that we spent

four years developing. Performing physical exams, handling basic medical problems, and reading about your patients' medical conditions can help you retain and expand your medical knowledge base. Still, maintaining your skills in isolation from the rest of the medical community can only do a limited amount to establish your identity as a "real doctor."

Don't forget that psychiatry IS a biological science that is becoming increasingly technical. We develop our psychotherapeutic skills not as a means of separating ourselves from the rest of medicine, but in order to provide comprehensive care for the patient. Although it is difficult to use double-blinded, placebo-controlled studies to demonstrate the efficacy of some psychotherapeutic techniques, this does not mean that we must hide away in our little corner of the hospital. Instead, we should try to educate other medical professionals about the unique treatments we have to offer. This means that we must work to develop our own specialized knowledge and skills set so we can be effective teachers. For example, the orthopedic surgeon does not propose to be best equipped to treat an unusual skin rash, turning instead to the dermatologist for help. (The surgeon knows he or she will be able to contribute something valuable when the dermatologist's patient fractures her arm.) Likewise, when we have honed our own psychiatric skills, we will more readily establish relationships with other services and can find our place in the world of medicine.

HOW TO MAINTAIN YOUR BASIC MEDICAL SKILLS

Monica Radford Green, M.D.

Maintaining our basic medical skills is becoming more and more essential in today's world, where psychiatrists may find themselves in the role of primary care physician (for example, in many of the nation's VA hospitals). But, even if we do not function as primary care physicians, modern psychiatry demands that we integrate general medicine with mental health.

Daily Exposure

As with all learning, you will maintain your medical skills most easily when exposure is consistent. In other words, "Use it or lose it." The academic training facility provides many excellent opportunities to maintain the knowledge base that you acquired in medical school. The medical center environment is one of teaching and learning, where just walking down the hall, you can overhear the attending physicians of other services teaching their own residents. Most medical schools publish schedules of grand rounds and departmental presentations. "Outsiders" from other services are usually welcome, and you should make it a point to attend presentations that interest you.

Participation on the psychiatric consultation-liaison service is a good way to update your medical knowledge. Making helpful recommendations to the consulting service requires an understanding of the mechanisms of the patient's disease, the relationship between the medical problem and mental illness, and drug-drug interactions. Each consult provides an opportunity to review general medical topics that you may not have considered recently, as well as to learn new information. As we all know, a fact learned because of its relevance to a particular patient is more easily remembered than when it is memorized in order to pass a test. Similarly, when you request consultation from another service, take time to talk to the consultants and ask them questions. They are likely to be impressed and flattered when you show a genuine interest in their areas of expertise. This interaction can form the basis of collegial relationships and sometimes, new friendships.

Reading

How do you find time to keep up with the literature? It seems impossible to keep up with assigned reading for didactic courses, not to mention all the journals that appear in our mailboxes each month. Be selective and remember that many of the "free" psychiatric

journals are pharmaceutical-supported and may include studies that are not peer-reviewed or are biased. However, as residents, we do receive a few good “free” basic medical magazines that are worth looking at (before they become part of that artsy magazine-stack end table that has developed in your living room). One periodical, Resident and Staff Physician, often includes self-assessment and review articles that are relevant to our daily practice. Hospital Physician: Medical Practice for Staff and Residents has similar articles. Finally, as members of the AMA, we receive JAMA weekly. Each of these journals has a plethora of pharmaceutical advertisements. Although the ads are marketing vehicles whose claims must be viewed with a discerning eye, they at least provide an opportunity to learn about new drugs and their clinical interactions with psychotropic medications.

Another way to keep your knowledge sharp is to read review texts, such as the Current series, published annually, that discuss the most up-to-date information regarding diagnosis and treatment. Although it is difficult to find time to read large sections of these texts, it is helpful to read about the specific medical disorders that our patients have. This provides an opportunity to review diagnosis and treatment, with an eye towards drug-drug interactions and potential psychiatric manifestations of illness. If the expense of buying additional books is too great during training, you can always go to the library or utilize previously purchased texts such as Cecil, Harrison, or the Washington Manual. But, don't forget that with medical advances and the explosion of knowledge, those expensive texts you purchased during medical school might already be out of date!

Finally, consider utilizing the CD-ROM based system UpToDate. The information provided is updated on a regular basis (in terms of months, not years), and the information is obtained quickly and easily. This is a tool that you can utilize in a matter of minutes and feel that you have studied the disease process for hours!

Practice!

As with anything else, “practice makes perfect” (or, at least, prevents loss of skill and perhaps resulting incompetence). Unfortunately, many medical centers operate with a division of labor such that psychiatrists – even those in training – do not have to perform physical exams, do lumbar punctures, or draw blood. However, it is potentially of great benefit for you to volunteer to help out with these tasks when you have time. Doing so will also increase the sense of camaraderie within the hospital. (It also could be

extremely rewarding when the staff asks you, a psychiatrist, to draw blood because you have earned a reputation as “a good stick.”)

Another opportunity to utilize your basic general medical skills is by moonlighting. In moonlighting positions, the admitting psychiatrist often performs the admission history and physicals, as well as handles all general medical emergencies. Although generally not required in psychiatric training, it is advisable to remain BLS/ACLS/PALS certified. Some psychiatry residents moonlight in a general emergency room in order to keep up their skills. Though challenging, the work can provide an opportunity to earn extra money while maintaining skills, add variety to the work week, and establish relationships with other services. One caveat is worth mentioning: never try to handle a medical problem that is “out of your league.” If you feel uncomfortable diagnosing or managing a problem, GET SOME HELP! Your desire to maintain your medical skills should never place the patient in jeopardy.

Finally, maintaining basic general medical skills of physical examination, diagnosis, and treatment will also lead to improved relationships with other services. As psychiatrists, we are aware that self-confident individuals instill confidence in others and more successfully establish equal relationships. When we have maintained our basic skills, we convey to other specialties our competence and more readily obtain for each patient the care that they deserve. We likewise increase the probability that patients under the care of these other services will be given a psychiatric consult should one be indicated. Finally, we give to ourselves the satisfaction of providing good general medical care to patients who may be limited in their abilities to seek out such care themselves.

A RESIDENT'S GUIDE TO KEEPING UP WITH THE LITERATURE

Jason Wuttke, M.D., M.P.H.

Amir Garakani, M.D.

The scientific psychiatric literature is expanding at unprecedented rates. There is no possible way for anyone to read everything that is being published. As novices in the field, residents have an exceptionally difficult time distinguishing what is important from what can be discarded. They start off optimistically inclusive, are quickly overwhelmed, and, as the joke goes, soon eschew reading entirely to eat dinner or sleep instead. Journals, texts, and newsletters are expensive, and the residents' cash, like their available time, is quite limited. However, reading and assimilating newly published science is the cornerstone of continuing medical education and is essential for all physicians. Residency is the best time to develop strategies for this life-long task, since the habits we acquire now are those likely to remain with us. Developing an efficient approach to keeping up with the literature is critical to avoid misguided attempts at studying everything, inevitably leading to paralyzing frustration. This chapter offers suggestions on how to approach the four main aspects of the task: access, selection, evaluation, and management.

Accessing the Literature

Computer bibliographic databases have made accessing the literature less onerous. Residents should, at the very least, become familiar with comprehensive methods for article searches on Medline. Academic center librarians are invaluable resources in this process and can also coordinate ongoing personalized search programs for narrower areas of interest. Still, for many residents, routine trips to the academic medical library are inconvenient. An alternative, albeit less thorough, way to access the majority of leading journals is to subscribe and have them delivered right to your home. While this is an expensive proposition later in your career, as a resident, it is inexpensively accomplished by joining the APA or other professional organizations.

Selecting the Literature

Given the limited time available, you should be highly selective in what you choose to read thoroughly. The most useful selection strategy is routinely to peruse articles printed in reputable, peer-reviewed journals. The importance and relevance of a medical journal is often judged by its **impact factor**, a number that is published yearly by Thomson Scientific. It is calculated over a three-

year period by counting the number of times articles from the journal were cited, divided by the number of articles published during that time. In 2005, the ten psychiatric journals with the highest impact factor, in descending order, were: Archives of General Psychiatry, Molecular Psychiatry, American Journal of Psychiatry, Biological Psychiatry, Neuropsychopharmacology, Journal of Clinical Psychopharmacology, Journal of Clinical Psychiatry, Psychotherapy and Psychosomatics, British Journal of Psychiatry, and Sleep. To access the complete list, arranged by subject (e.g. Psychiatry, Neuroimaging, Neuroscience, Psychology, Geriatrics and Gerontology, Substance Abuse), please go to Journal Citation Reports (isiwebofknowledge.com). Keep in mind that impact factors are not considered by all experts to be the best judge of a journal's importance.

Some publications that publish summaries of recent, relevant findings include: Psychiatric News (pn.psychiatryonline.org), Clinical Psychiatry News (www.eclinicalpsychiatrynews.com), and the Psychiatric Times (www.psychiatrytimes.com). The Carlat Psychiatry Report (www.thecarlatreport.com) is a monthly newsletter that provides reports on various areas of psychiatry. It is "unbiased" in that it receives no money from the industry. There is also Journal Watch: Psychiatry (psychiatry.jwatch.org), a publication providing a review and commentary of articles in over 50 journals. Faculty of 1000: Medicine (www.f1000medicine.com) is an online site providing brief synopses and ratings of journal articles in all areas of psychiatry (*Full disclosure: A. Garakani is a faculty member of the Faculty of 1000*).

Evaluating the Literature

Instructions on critical appraisal of the scientific literature and teaching statistical analysis are beyond the scope of this short chapter, but suffice it to say, these are skills worth acquiring. The abilities to scrutinize validity and assess statistical methodology are of crucial importance when evaluating conflicting results and applying guidelines to clinical practice. Consider reviewing the JAMA series "Users' Guides to the Medical Literature", as well as "Basic Statistics for Clinicians", published in the Canadian Medical Association Journal. Also see: "How to Read a Journal Article." The Carlat Psychiatry Report, Volume 5, Number 2, February 2007.

Literature Management

Now that you have decided how and where to look efficiently for reading material, as well as how to appraise the relevance and validity of its content, you face the actual task of management. You

should strive to develop a routine of reading peer-reviewed journals for some small bit of time each day or week. Carry a few articles with you so that when you are waiting for a ride, or a patient cancels, you can use the time constructively. Focus on those articles and abstracts that have titles that interest you or seem pertinent to your education. From those, take at least two articles per journal issue to read in depth and practice your skills at critical appraisal. Involve yourself regularly in journal clubs and give presentations when there is the opportunity, as these are excellent incentives for keeping up with the literature.

Conclusion

The task of keeping up with psychiatric literature may appear daunting to the resident juggling service and educational demands with physical and emotional needs. The quantity of available information can be overwhelming, but continual renewal and updating of the knowledge base is essential for professional growth and the sound practice of medicine. By maximizing yield and efficiency in your approach to the processes of access, selection, evaluation, and management of the literature, you can establish a routine that will serve you well throughout your entire professional life.

LIST OF PSYCHIATRIC AND RELATED JOURNALS
Amir Garakani, M.D.

**Note: These journals' titles, publishers and websites are subject to change. The information below is accurate as of April 2007.*

Name	Website Address
Academic Psychiatry	ap.psychiatryonline.org
Acta Psychiatrica Scandinavica	www.blackwellpublishing.com
Addiction	www.addictionjournal.org
Addiction Biology	www.blackwellpublishing.com
Alcohol	www.elsevier.com
Alcohol and Alcoholism	alcalc.oxfordjournals.org
Alcoholism - Clinical and Experimental Research	www.blackwellpublishing.com
Alzheimer Disease & Associated Disorders	www.alzheimerjournal.com
American Journal of Geriatric Psychiatry	ajgponline.org
American Journal of Medical Genetics. Part B, Neuropsychiatric Genetics	www.interscience.wiley.com
American Journal of Psychiatry	ajp.psychiatryonline.org
American Journal of Psychoanalysis	www.springerlink.com
Annals of Clinical Psychiatry	www.tandf.co.uk/journals
Annals of Neurology	www.interscience.wiley.com
Annals of the New York Academy of Sciences	www.annalsnyas.org
Archives of General Psychiatry	archpsyc.ama-assn.org
Autism: The International Journal of Research and Practice	aut.sagepub.com
Behavioral and Brain Sciences	www.bbsonline.org
Behavioral Medicine	www.heldref.org/bmed.php
Behavioral Neuroscience	www.apa.org/journals/bne
Behavioural Brain Research	www.elsevier.com/locate/bbr
Biological Psychiatry	www.elsevier.com/locate/biopsychiat
Bipolar Disorders	www.blackwellpublishing.com
Brain Research	www.elsevier.com/locate/brainres
British Journal of Psychiatry	bjp.rcpsych.org

Name	Website Address
Canadian Journal of Psychiatry	publications.cpa-apc.org
Cerebral Cortex	cercor.oxfordjournals.org
Child and Adolescent Psychiatric Clinics of North America	www.childpsych.theclinics.com
CNS Drug Reviews	www.blackwellpublishing.com
CNS Drugs	pt.wkhealth.com/pt/re/cns/home.htm
CNS Spectrums	www.cnsspectrums.com
Comprehensive Psychiatry	www.elsevier.com
Current Opinion in Psychiatry	www.co-psychiatry.com
Current Psychiatry	www.currentpsychiatry.com
Dementia and Geriatric Cognitive Disorders	www.karger.com/dem
Depression and Anxiety	www.interscience.wiley.com
Developmental Psychobiology	www.interscience.wiley.com
Drug and Alcohol Dependence	www.elsevier.com/locate/drugalcdep
Epilepsy and Behavior	www.elsevier.com
European Archives of Psychiatry and Clinical Neuroscience	www.springerlink.com
European Journal of Neuroscience	www.blackwellpublishing.com
European Neuropsychopharmacology	www.elsevier.com/locate/euroneuro
European Psychiatry	www.elsevier.com
Experimental and Clinical Psychopharmacology	www.apa.org/journals/pha
FOCUS: The Journal of Lifelong Learning in Psychiatry	focus.psychiatryonline.org
General Hospital Psychiatry	www.elsevier.com
Harvard Review of Psychiatry	www.tandf.co.uk/journals
Hormones and Behavior	www.elsevier.com
Human Psychopharmacology	www.interscience.wiley.com
International Journal of Eating Disorders	www.interscience.wiley.com
International Journal of Geriatric Psychiatry	www.interscience.wiley.com
International Journal of Neuropsychopharmacology	journals.cambridge.org/jid_PNP

Name	Website Address
International Journal of Psychoanalysis	www.ijpa.org
International Psychogeriatrics	journals.cambridge.org/jid_IPG
Journal of Affective Disorders	www.elsevier.com/locate/jad
Journal of Anxiety Disorders	www.elsevier.com/locate/janxdis
Journal of Autism and Developmental Disorders	www.springerlink.com
Journal of Child and Adolescent Psychopharmacology	www.liebertpub.com
Journal of Child Psychology and Psychiatry, and Allied Disciplines	www.ingentaconnect.com/content/bpl/icpp
Journal of Clinical Psychiatry	www.psychiatrist.com
Journal of Clinical Psychology	www.interscience.wiley.com
Journal of Clinical Psychopharmacology	www.psychopharmacology.com
Journal of Clinical Sleep Medicine	www.aasmnet.org/JCSM
Journal of Consulting and Clinical Psychology	www.apa.org/journals/ccp
Journal of ECT	www.ectjournal.com
Journal of Geriatric Psychiatry and Neurology	jgp.sagepub.com
Journal of Nervous and Mental Disease	www.jonmd.com
Journal of Neuroimaging	www.blackwellpublishing.com
Journal of Neurology, Neurosurgery, and Psychiatry	jnp.bmj.com
Journal of Neuropsychiatry and Clinical Neurosciences	neuro.psychiatryonline.org
Journal of Neuroscience	www.jneurosci.org
Journal of Neuroscience Research	www.interscience.wiley.com
Journal of Pain	www.ampainsoc.org/pub/journal
Journal of Psychiatric Practice	www.practicalpsychiatry.com
Journal of Psychiatric Research	www.elsevier.com/locate/jpsychires
Journal of Psychiatry & Neuroscience	www.cma.ca/jpn
Journal of Psychosomatic	www.elsevier.com/locate/jpsychores

Name	Website Address
Research	
Journal of Sleep Research	www.blackwellpublishing.com
Journal of the American Academy of Child Psychiatry	www.jaacap.com
Journal of the American Academy of Psychiatry and the Law	www.jaapl.org
Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry	www.guilford.com
Journal of the American Medical Association (JAMA)	jama.ama-assn.org
Journal of the American Psychoanalytic Association	www.apsa.org
Journal of the International Neuropsychological Society	journals.cambridge.org/jid_INS
Journal of Traumatic Stress	www.interscience.wiley.com
Lancet	www.thelancet.com
Mental Retardation and Developmental Disabilities Research Reviews	www.interscience.wiley.com
Molecular Psychiatry	www.nature.com/mp
Nature	www.nature.com
Nature Neuroscience	www.nature.com/neuro
Nature Reviews Neuroscience	www.nature.com/nrn
Neurobiology of Aging	www.elsevier.com/locate/neuaging
Neurobiology of Learning and Memory	www.elsevier.com
Neuroimage	www.elsevier.com/locate/ynimg
Neuropsychobiology	www.karger.com/nps
Neuropsychologia	www.elsevier.com
Neuropsychology	www.apa.org/journals/neu
Neuropsychopharmacology	www.nature.com/npp
Neuroreport	www.neuroreport.com
Neuroscience	www.elsevier.com/locate/neuroscience
Neuroscience and Biobehavioral Reviews	www.elsevier.com/locate/neubiorev
Neuroscience Letters	www.elsevier.com/locate/neulet
New England Journal of Medicine	content.nejm.org
Pain	www.elsevier.com/locate/pain

Name	Website Address
Pharmacopsychiatry	www.thieme-connect.com
Primary Care Companion to The Journal of Clinical Psychiatry	www.psychiatrist.com/pcc
Primary Psychiatry	www.primarypsychiatry.com
Proceedings of the National Academy of Sciences of the United States of America	www.pnas.org
Progress in Neuro-Psychopharmacology & Biological Psychiatry	www.elsevier.com/locate/inca/525488
Psychiatric Annals	www.slackinc.com/general/psyann
Psychiatric Clinics of North America	www.psych.theclinics.com
Psychiatric Genetics	www.psychgenetics.com
Psychiatric Quarterly	www.springerlink.com
Psychiatric Services	ps.psychiatryonline.org
Psychiatry: Interpersonal and Biological Processes	www.guilford.com
Psychiatry Research	www.elsevier.com/locate/psychres
Psychiatry Research: Neuroimaging	www.elsevier.com/locate/psychresns
Psychological Medicine	journals.cambridge.org/jid_PSM
Psychoneuroendocrinology	www.elsevier.com/locate/psyneuen
Psycho-Oncology	www.interscience.wiley.com
Psychopathology	www.karger.com/psp
Psychopharmacology (Berlin)	www.springerlink.com
Psychopharmacology Bulletin	www.medworksmmedia.com/psychopharmbulletin
Psychosomatic Medicine	www.psychosomaticmedicine.org
Psychosomatics	psy.psychiatryonline.org
Psychotherapy and Psychosomatics	www.karger.com/pps
Schizophrenia Bulletin	schizophreniabulletin.oxfordjournals.org
Schizophrenia Research	www.elsevier.com/locate/schres
Science	www.sciencemag.org
Sleep	www.journalsleep.org
Substance Use & Misuse	www.tandf.co.uk/journals
Trends in Cognitive Sciences	www.trends.com/tics
World Journal of Biological Psychiatry	www.wfsbp.org/about_journal.html

A READING LIST AND REFERENCE GUIDE FOR PSYCHIATRIC RESIDENTS

Amir Garakani, M.D.

The task of making a “must-read” list for the field of psychiatry is daunting at best. It would take a person a lifetime to complete the works of even a portion of the great minds that have graced the profession of psychiatry. Therefore, this list is meant only as an introduction to some of the landmark books, reviews, textbooks, teaching guides, memoirs, and even novels. No articles are included.

Books in print can be found at any major bookseller, dealer or medical school bookstore in your area. Books by the American Psychiatric Press of the APA are available on-line (www.appi.org), or at the Annual Meeting (there is a 25% discount for Members-in-Training). Other publishers, such as Guilford Press, also offer discounts to trainees. Finding out-of-print items may be trickier. Some online dealers sell used and out-of-print editions, but you may need to use a search engine to find rare items. Certain sellers specialize in books on psychiatry, psychology, and neuroscience (www.gach.com).

***Disclaimer:** The following is not a comprehensive list and is not meant to replace your own program’s recommendations. It also is not an endorsement of any particular author or publisher, and no author received or will receive any compensation or consideration for including books on this list. It was merely a compilation of texts culled from residency programs’ recommended reading lists and curricula, word of mouth, surveying of faculty and fellow residents, and personal knowledge. Some of the textbooks may have newer editions in press, so be sure to check the publication date before buying.*

Reference Texts

- Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR. American Psychiatric Press; 4th edition (2000)
- American Psychiatric Association Practice Guidelines for the Treatment of Psychiatric Disorders. Compendium 2006

Comprehensive Texts

- Psychiatry. Allan Tasman, Jerald Kay, Jeffrey Lieberman. John Wiley & Sons; 2nd edition (2003)

- Kaplan and Sadock's Comprehensive Textbook of Psychiatry (2 Volumes). Benjamin J Sadock, Virginia A. Sadock. Lippincott Williams & Wilkins; 10th edition (May 2007)
- New Oxford Textbook of Psychiatry (2 Volumes). Michael G. Gelder, Juan J. Lopez-Ibor, Nancy Andreasen. Oxford University Press, USA (2003).
- Treatments of Psychiatric Disorders. Glen O. Gabbard. American Psychiatric Publishing; 4th edition (2007)

Board Preparation/General Study

- Massachusetts General Hospital Psychiatry Update & Board Preparation. Theodore A. Stern, John B. Herman. McGraw-Hill Professional, 2nd Edition (2003).
- Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry. Benjamin J. Sadock, Virginia A. Sadock. Lippincott Williams & Wilkins; 9th edition (2002).
- Clinical Study Guide For The Oral Boards In Psychiatry. Nathan R. Strahl. American Psychiatric Publishing; 2nd edition (2005)
- Boarding Time: The Psychiatry Candidate's New Guide to Part II of the ABPN Examination. James R. Morrison, Rodrigo A. Munoz. American Psychiatric Publishing; 3rd edition (2003)
- The American Psychiatric Publishing Board Prep and Review Guide for Psychiatry. James A. Bourgeois, Robert E. Hales, Stuart C. Yudofsky. 1st edition (2006)
- Psychiatry Test Preparation and Review Manual. John C. Spiegel, John M. Kenny. Mosby (2006)

Review Books

- Mnemonics & More for Psychiatry. David J. Robinson. Rapid Psychler Press; 3rd edition (2001)
- Psychiatry Pearls. Alex Kolevzon, Daniel Stewart. Hanley & Belfus (2004) (*Full disclosure: A. Garakani is an author of this textbook*)

Forensic Psychiatry

- Clinical Handbook of Psychiatry and the Law. Thomas G. Gutheil, Paul S. Appelbaum. Lippincott Williams & Wilkins; 3rd edition (2000)
- Principles and Practice of Forensic Psychiatry. Richard Rosner. Arnold Publication; 2nd edition (2003)
- The American Psychiatric Publishing Textbook of Forensic Psychiatry: The Clinician's Guide. Robert I. Simon, Liza H. Gold. (2004)

Psychopharmacology

- The American Psychiatric Publishing Textbook of Psychopharmacology. Alan F. Schatzberg, Charles B. Nemeroff. 3rd edition (2003)
- Manual of Clinical Psychopharmacology. Alan F. Schatzberg, Jonathan O. Cole, Charles DeBattista. American Psychiatric Publishing; 6th edition (2007)
- Essential Psychopharmacology : Neuroscientific Basis and Practical Applications. Stephen M. Stahl. Cambridge University Press; 2nd edition (2000)
- Clinical Handbook of Psychotropic Drugs (Spiral-bound). K.Z. Bezchlibnyk-Butler, J.J. Jeffries, A.S. Virani. Hogrefe and Huber Publishers, 17th Edition (2007)
- Handbook Of Psychiatric Drug Therapy. Jerrold F. Rosenbaum, George W. Arana, Steven E. Hyman, Lawrence A. Lobbate, Maurizio Fava. Lippincott Williams & Wilkins; 5th edition (2005)
- The Biochemical Basis of Neuropharmacology. Jack R. Cooper, Floyd E. Bloom, Robert H. Roth. Oxford University Press, 8th Edition (2002)
- Concise Guide to Drug Interaction Principles for Medical Practice: Cytochrome P450s, UGTs, P-Glycoproteins. Kelly L. Cozza, Scott C. Armstrong, Jessica R. Oesterheld. American Psychiatric Publishing; 2nd edition (2003)
- Electroconvulsive Therapy: A Programmed Text. John L. Beyer, Richard D. Weiner, Mark D. Glenn. American Psychiatric Publishing; 2nd edition (1998)
- The Practice of Electroconvulsive Therapy: Recommendations for Treatment, Training, and Privileging. American Psychiatric Association Task Force on Electroconvulsive Therapy (1990)

Neuroscience/Neuropsychiatry

- Neurobiology of Mental Illness. Dennis S. Charney, Eric J. Nestler. Oxford University Press; 2nd edition (2004)
- American Psychiatric Publishing Textbook of Neuropsychiatry and Clinical Neurosciences. Stuart C. Yudofsky, Robert E. Hales. 4th edition (2002)
- Brain Circuitry and Signaling in Psychiatry: Basic Science and Clinical Implications. Gary B. Kaplan, Ronald P. Hammer, Jr.. American Psychiatric Association; 1st edition (2002)

- Neuroscience for the Mental Health Clinician. Steven R. Pliszka. The Guilford Press (2004)
- Clinical Neurology for Psychiatrists. David Myland Kaufman. Saunders; 6th edition (2006)

Consultation/Liaison Psychiatry

- Massachusetts General Hospital Handbook of General Hospital Psychiatry. Theodore A. Stern, Gregory Fricchione, Ned H. Cassem, Michael S. Jellinek, Jerrold F. Rosenbaum. C.V. Mosby; 5th edition (2004)
- The American Psychiatric Publishing Textbook of Psychosomatic Medicine. James L. Levenson. (2005)
- Psychosomatic Medicine. Michael Blumenfield, James J. Strain. Lippincott Williams & Wilkins (2006)
- Manual of Psychiatric Care for the Medically Ill. Antoinette Ambrosino Wyszynski, Bernard Wyszynski. American Psychiatric Publishing (2004)

Emergency/On Call Psychiatry

- Emergency Psychiatry. Randy Hillard, Brook Zitek. McGraw-Hill Professional; 1st edition (2003)
- On Call Psychiatry. Carol A. Bernstein, Ze'ev Levin, Molly E. Poag, Mort Rubinstein. Saunders; 3rd edition (2006)
- Handbook of Emergency Psychiatry. Jorge R. Petit. Lippincott Williams & Wilkins (2003)

Child Psychiatry

- The American Psychiatric Publishing Textbook Of Child And Adolescent Psychiatry. Jerry M. Wiener, Mina K. Dulcan. 3rd edition (2003)
- Child and Adolescent Psychiatry: A Comprehensive Textbook. Melvin Lewis. Lippincott Williams & Wilkins; 3rd edition (2002)
- Pediatric Psychopharmacology: Principles and Practice. Andres Martin, Lawrence Scahill, Dennis S. Charney, James F. Leckman. Oxford University Press, USA (2002)
- Child and Adolescent Clinical Psychopharmacology. Wayne Hugo Green. Lippincott Williams & Wilkins; 4th edition (2006)
- Child and Adolescent Psychiatry. Sandra Sexson. Blackwell Publishing Limited; 2nd edition (2005)

Geriatric Psychiatry

- Comprehensive Textbook of Geriatric Psychiatry. Joel Sadavoy, Lissy F. Jarvik, George T. Grossberg, Barnett S. Meyers. W. W. Norton & Company; 3rd edition (2004)
- Clinical Geriatric Psychopharmacology. Carl Salzman. Lippincott Williams & Wilkins; 4th edition (2004)
- The American Psychiatric Publishing Textbook of Geriatric Psychiatry. Dan G. Blazer, David C. Steffens, Ewald W. Busse. 3rd edition (2004)
- Clinical Manual of Geriatric Psychopharmacology. Sandra A. Jacobson, Ronald W. Pies, and Ira R. Katz. American Psychiatric Publishing (2007)

Addiction Psychiatry

- The American Psychiatric Publishing Textbook of Substance Abuse Treatment. Marc Galanter, Herbert D. Kleber. 3rd edition (2004)
- Substance Abuse: A Comprehensive Textbook. Joyce H Lowinson, Pedro Ruiz, Robert B Millman, John G Langrod. Lippincott Williams & Wilkins; 4th edition (2004)
- Principles of Addiction Medicine. Graham, Schultz, Mayo-Smith, Ries, Wilford. American Society of Addiction Medicine (2003)
- Clinical Manual of Addiction Psychopharmacology. Henry R. Kranzler, Domenic A. Ciraulo. American Psychiatric Publishing, Inc. (2005)

General Interest

- Neurotic Styles. David Shapiro. Basic Books (1999)
- The Perspectives of Psychiatry. Paul R. McHugh, Phillip R. Slavney. The Johns Hopkins University Press; 2nd edition (1998)
- Psychiatric Interviewing: The Art of Understanding. Shawn Christopher Shea. W.B. Saunders; 2nd edition (1998)
- The Practical Art of Suicide Assessment: A Guide for Mental Health Professionals & Substance Abuse Counselors. Shawn Christopher Shea. Wiley (2002).
- The Psychiatric Interview in Clinical Practice. Roger A. Mackinnon, Robert Michels, Peter J. Buckley. American Psychiatric Publishing; 2nd edition (2006)
- Night Falls Fast: Understanding Suicide. Kay Redfield Jamison. Vintage; 1st edition (2000)
- Psychiatry and the Cinema. Glen O. Gabbard, Krin Gabbard. American Psychiatric Publishing; 2nd edition (1999)

- Rethinking Psychiatry: From Cultural Category to Personal Experience. Arthur Kleinman. Free Press (2005)
- Brave New Brain: Conquering Mental Illness in the Era of The Genome. Nancy C. Andreasen. Oxford University Press, USA; New edition (2004)

Psychopathology

- Dementia Praecox or the Group of Schizophrenias. Eugen Bleuler. International Universities Press (1950)
- General Psychopathology, Volumes 1 & 2. Karl Jaspers (Author), J. Hoenig, Marian W. Hamilton (Translators). The Johns Hopkins University Press; Reprint edition (1997)
- The Mask of Sanity: An Attempt to Clarify Some Issues About the So Called Psychopathic Personality. Hervey Cleckley. Emily S. Cleckley; 5th edition (1988)
- Symptoms in the Mind: An Introduction to Descriptive Psychopathology. Andrew C. P. Sims. W.B. Saunders Company; 3rd edition (2002)
- Disorders of Simulation: Malingering, Factitious Disorders, and Compensation Neurosis. Grant L. Hutchinson. Psychosocial Press (2001)

Psychological Therapies

- Ego and Mechanisms of Defense. Anna Freud. International Universities Press (1971)
- The Freud Reader. Sigmund Freud (Author), Peter Gay (Editor). W. W. Norton & Company (1995)
- A Primer for Beginning Psychotherapy. William N. Goldstein. Brunner-Routledge (2001)
- Psychodynamic Psychiatry in Clinical Practice. Glen O. Gabbard. American Psychiatric Publishing; 4th edition (2005)
- Supportive Therapy: A Psychodynamic Approach. Lawrence H. Rockland. Basic Books (2003)
- A Primer of Supportive Psychotherapy. Henry Pinsker. The Analytic Press; 1st edition (2002)
- Theory and Practice of Group Psychotherapy. Irvin D. Yalom. Basic Books; 4th edition (1995)
- Interpersonal Psychotherapy of Depression. Gerald L. Klerman, Eve S. Chevron, Myrna M. Weissman, Bruce Rounsaville. Basic Books (2001)

- Psychoanalytic Diagnosis: Understanding Personality Structure in the Clinical Process. Nancy McWilliams. The Guilford Press (1994)
- Psychoanalytic Psychotherapy: A Practitioner's Guide. Nancy McWilliams. Guilford Press (2004)
- Psychodynamic Diagnostic Manual. Alliance of Psychoanalytic Organizations (2006)
- Dynamic Psychiatry in Theory and Practice. Edwin R. Wallace. Lea & Febiger (1983)
- Cognitive Therapy: Basics and Beyond. Judith S. Beck. The Guilford Press; 1st edition (1995)
- Cognitive Therapy of Depression. Aaron T. Beck, A. John Rush, Brian F. Shaw, Gary Emery. The Guilford Press; New Edition (1987)
- Cognitive-Behavioral Treatment of Borderline Personality Disorder. Marsha Linehan. The Guilford Press (1993).
- Existential Psychotherapy. Irvin D. Yalom. Basic Books (1980)

Memoirs/Personal Accounts

- Darkness Visible: A Memoir of Madness. William Styron. Vintage Books, 1st edition (1992)
- An Unquiet Mind : A Memoir of Moods and Madness. Kay Redfield Jamison. Vintage (1997)
- A Beautiful Mind: The Life of Mathematical Genius and Nobel Laureate John Nash. Sylvia Nasar. Simon & Schuster (2001)
- Girl, Interrupted. Susanna Kaysen. Vintage; Reprint ed (1994)
- I Never Promised You a Rose Garden. Joanne Greenberg. Signet (1989)
- The Quiet Room: A Journey Out of the Torment of Madness. Lori Schiller, Amanda Bennett. Warner Books; Warner Books (1996)
- Love's Executioner: & Other Tales of Psychotherapy. Irvin D. Yalom. Harper Perennial (2000)

Novels

- When Nietzsche Wept : A Novel of Obsession. Irvin D. Yalom. Harper Perennial (2005)
- Lying on the Couch: A Novel. Irvin D. Yalom. Harper Perennial (1997)
- Mount Misery. Samuel Shem. Ballantine Books (2003)
- One Flew over the Cuckoo's Nest. Ken Kesey. Penguin Books (2003)
- The Bell Jar. Sylvia Plath. Perennial (1999)

SLEEPLESS IN PSYCHIATRY: HOW TO SURVIVE ON CALL

**Laura Davies, M.D.
E. David Hjellen, D.O.**

Although we've all taken call as students, for most of us, call nights assume more gravity when we become not only "the doctor", but perhaps the only psychiatrist on site. It can be quite daunting, but it is manageable, especially if you are prepared with an understanding of your role and if you can be clear about your limits and marshal available resources.

Understand Your Role

Know what you're in for. Talk to other residents. Some institutions have "learning the ropes" call or tandem call. These may seem like a pointless drain on your already tight schedule, but time with a senior resident in the actual location where you will be taking call can ease the pain of the first nights on call.

Make sure you ask the following questions:

1. Where are the keys and the pager kept? If they aren't where they're supposed to be, what is the backup system?
2. When and where is sign-out? Do you have to call the day consult service or inpatient service to update them?
3. Is there a logbook?
4. Is there a central referral book that has key phone numbers?
5. Where is the call room? Where are blankets and towels? Are personal belongings safe there?
6. When is the cafeteria open? Are there meal tickets?
7. Which nurses are especially helpful?
8. Does it help to do mini-rounds before going to bed, or does that stir up a lot of extra business?
9. Which faculty members are more likely to be helpful? Who will tell you they "haven't done clinical work in years, just use your best judgement"?
10. Exactly what are the seclusion and restraint regulations? How often does a M.D. need to do a face to face evaluation? Where is the written policy on this, and who should you call for clarification?
11. What are the hidden perks – parking passes in nearby lots, etc.
12. Get some sense of what you may be called for: Are you part of the code team? Who is the leader? Does your institution have a "code green," or psychiatric emergency? What is the procedure for those?

The 80-Hour Work Week

In 2001, the ACGME began requiring all residency and fellowship programs to limit the number of weekly duty hours a resident and fellow can work. Duty hours are defined as all clinical and academic activities related to the program; i.e., patient care (both inpatient and outpatient), administrative duties relative to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled activities, such as conferences. Duty hours do *not* include reading and preparation time spent away from the duty site. Here is a summary of the working limitations:

1. Duty hours must be limited to 80 hours per week, averaged over a 4-week period, inclusive of all in-house call activities.
2. Residents must be provided with one day in seven free from all educational and clinical responsibilities, averaged over a 4-week period, inclusive of call. *One day* is defined as one continuous 24-hour period free from all clinical, educational, and administrative duties.
3. Adequate time for rest and personal activities must be provided. This should consist of a 10-hour time period provided between all daily duty periods and after in-house call.
4. The objective of on-call activities is to provide residents with continuity of patient care experiences throughout a 24-hour period. *In-house call* is defined as those duty hours beyond the normal work day, when residents are required to be immediately available in the assigned institution (does not apply to at home/pager call).
 - a. In-house call must occur no more frequently than every third night, averaged over a 4-week period.
 - b. Continuous on-site duty, including in-house call, must not exceed twenty-four consecutive hours. Residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics, and maintain continuity of medical and surgical care (total thirty hours).
 - c. No new patients may be accepted after twenty-four hours of continuous duty.

You can contact the ACGME for more information or to report noncompliance with these regulations. To contact the ACGME, you

can call 312-755-5000, go to www.acgme.org, or write to the following address:

ACGME
Suite 2000
515 North State Street
Chicago, IL 60610-4322

Set Limits

Setting limits involves understanding yourself and your institution. Take time to process who *you* are on call – are you anxious, frustrated, excited, exhausted? Know how you cope with sleep deprivation. Do you get grumpy and irritable? Does your judgment slip? Of course -- we are only human. It is normal to become physically stressed by difficult work and sleepless nights. One of my colleagues had terrible heartburn, and when he finally sought help, the doctor asked, “How much coffee do you drink?” When he counted the cups before rounds, during breakfast, before seminar, at dinner, and between admissions, he realized he was drinking over 20 cups a day. That may be extreme, but many residents notice that sometimes, we are not quite ourselves as we try to take care of our patients and learn a new body of knowledge. If you go into call knowing what pushes your buttons, you are less likely to become overwrought when, invariably, someone pushes them.

Know what your responsibilities are on call, and stick to them. You only have to get people through to the morning. It took your patients years to get where they are – their situations will not be resolved in a few hours. Your time on call is limited, often circumscribed between 5 p.m. and 8 a.m. on weeknights. Within that time, be sure to take breaks, even if you have five consults and two admissions waiting. Taking breaks is not a sign of weakness but a sign that you are attuned to your own needs. It is also an acknowledgement that in psychiatry we are the “tools”, and if we are frazzled, we will not be able to help anybody else. Five minutes rest can mean a much smoother interview and a better ability to interact with others.

It can also be helpful to remember that your knowledge and abilities are limited by definition – you are in training. Don’t be afraid to ask for help.

Marshal Resources

There are always people available to help. First and foremost is the faculty backup. Some programs have senior residents available for consultation as well. They can discuss a case with you, and

sometimes the process of presenting the case will help you realize areas you missed, or give you a better sense of what is truly going on with a patient. It can be difficult to think in the middle of a crowded emergency room, but taking time to reflect can make a big difference for you and the patient. Faculty members and senior residents may ask questions that can help you consider other possibilities in terms of diagnosis and disposition. They can also be helpful in thinking about community resources, legal issues, and turf issues.

If you are a consultant, the primary team can speak with family members or address disposition issues. For psychiatric patients, nurses familiar with the case may be able to give you an idea of the patient's baseline. They can also advise you about effective management techniques for particular patients.

There may be social workers to help with insurance issues. The clerks in the emergency room can copy paperwork or call ambulances to transport patients. There may be a list of referral numbers for you, from drop-in clinics to evaluation appointments. Make sure you know where the numbers are.

Not to be forgotten are textbooks of psychiatry and general medicine. Many emergency rooms have a mini library, and often the texts are kept on medicine wards, as well. The internet also has a surprising amount of information available.

The take home message is that you will survive on call, over and over again. And if you take time to understand your role, set limits, and marshal resources, you might even enjoy it.

HOW TO GET THE MOST OUT OF YOUR PSYCHOTHERAPY SUPERVISION

Beth Boyarsky, M.D.

You probably picked the program you're in because of the quality of, and amount of, supervision provided. Your supervisors heavily influence your therapy style, your attitudes towards your patients, and even your abilities as a psychiatrist. Early in the residency, who your supervisors are may be a function of the rotations you're on. During the last few years, you'll have more say in choosing your supervisors, as well as the amount of time you see them, and for what purpose. Take advantage of the gift of supervision – this is the only time in your career that supervision will be free. Following are suggestions that may be helpful in providing you with a good basis for practice. Review this list periodically throughout residency for new ideas, especially if you feel “stuck” in your relationship with a supervisor.

1. If you have a choice of supervisors, choose a physician competent in modern psychopharmacology.
2. Pair one supervisor with one patient and let your supervisor know *everything*, including your fantasies and fears, about this patient. Think of your most difficult patients, the ones you really don't want to see and especially, those you don't *like* very much. Your supervisor can tune you in to self-observation. Your actions, lack of action, and feelings about each patient are all grist for understanding therapy, countertransference, and how you function as a tool in the therapeutic relationship. Understand that good use of supervision will be hard at times – you will be showing your supervisor your weaknesses, as well as your strengths, as a psychiatrist. You will have to juggle your desire to impress your supervisor with an honest disclosure of your mistakes.
3. Try to choose supervisors who can show you theory as they supervise you. Learn the similarities and differences among the psychoanalytic, dialectical, cognitive behavioral, supportive, group, family, couples and addiction therapies. Ask each supervisor for his or her opinions about each method of therapy and when another approach might be more appropriate.
4. Many supervisors use helpful techniques to recapture the therapy time. Although these techniques can be time-consuming for the resident, they are an extremely helpful

addition to a neophyte therapist's selective memory of the session. These techniques may include process notes or audio or videotaping the session. Some therapy groups employ a co-therapy model where one co-therapist records while the other leads the sessions.

5. Many supervisors will bring in journal articles or book chapters or even books for you. Read them – this information probably influenced *them*. Have information that has influenced *you* handy for them to see. They might be interested in it, as well. In the not-too-distant future you'll be peers, you know.
6. Consider your supervisor's advice and *choose what is best for you as the patient's therapist*. Above all, use your good sense. If there is a conflict that you and your supervisor cannot resolve, you may want to get additional advice from your residency director.

You will be pleasantly surprised how small the world of psychiatry really is. The relationships you cultivate in residency will often be revisited in your professional future at national meetings, job interviews, peer review boards, and a host of other places. When it comes to saying goodbye to a great supervisor, keep this in mind and it won't be so painful.

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FINDING AND DEVELOPING A RELATIONSHIP WITH A MENTOR

Beth K. Boyarsky, M.D.

Many of us chose psychiatry because we wanted to be like one of our role models. Now that you're in training, how do you choose a new mentor? More importantly, how do you cultivate a relationship of trust and mutual respect? Working with a mentor can give you ideas on 1) how to balance family, patient and professional relationships; 2) leadership issues; 3) the acquisition, accumulation and use of power; and 4) responsibilities to patients, trainees, your institution, and national leadership organizations.

Finding a Mentor

1. Decide which professionals you most want to be like and why. Do you like them as people? Are their general interests similar to yours? Can you envision yourself in their roles? If you were their peer, would like to serve with them on committees or see them regularly at meetings?
2. Spend time watching how they behave. Are they good teachers, or do they give the same canned lecture years in a row? Are they good leaders? How do they react in difficult situations? Do they appear to enjoy what they are doing? Many good mentors say they love what they do so much they'd continue doing it if they suddenly became independently wealthy.
3. Talk with others who have worked with this particular mentor. Have their careers flourished? Look at the mentor's recommendations of these people. Do they say positive things about the people they've taken on? Have they given them opportunities? Have they taken an active interest in promoting the interests and careers of others they've mentored? Where are these protégés now? What are their relationships with this mentor like *now*? Are they peers or competitors?
4. Check out the mentor's publications. If they have established careers, look to see who is the first author – the protégé or the mentor? (If the mentor is always first author, expect that you won't be first if you work with them.)
5. Are there enough people working with the mentor for you to learn from even when your mentor is busy? Do they work cordially with each other? Do they believe the mentor is helping them attain their goals?
6. Is the mentor a team player? Do they review for peer-reviewed publications? Are they leaders in professional organizations or editors of journals?

7. Don't be afraid to ask simply because they look like they're too busy. They will make time for a protégé if (and because) they are a good mentor.

Developing a Mutually Respectful Relationship with a Mentor

1. Be industrious and pro-active. Make suggestions about how you can help. Get involved in the research or other activities they're doing so you learn their style. Make yourself an expert in your mentor's area by reading their publications as well as the generally important publications in the area. Initially (and rightly so), the mentor should give you simple, easy to do tasks. Do them completely and in good time, and you should be rewarded with trust and increasing inclusion into what your mentor is doing and thinking.
2. Expect the relationship to change as you mature professionally, and try to keep a healthy balance of mutual respect and dedication. Both of you should be clear on what each expects from the other. You oblige yourself to work hard and consider, not necessarily act on, all advice your mentor gives you. Your mentor in turn, must understand that his or her commitment to you includes teaching you a certain set of skills, whether for therapy, research, academia, managed care, or whatever the two of you both decide.
3. Take professional risks as guided by your mentor. If he or she has faith in you to research/publish/present something, do it. If you're making a major contribution to a paper or presentation, discuss authorship with your mentor.
4. Watch and learn, especially during your mentor's stressful times. You think a night on call is stressful? Watch them give Grand Rounds after they've stayed up all night with a sick child, and after that, teach the resident's psychopharmacology class and make rounds on the inpatient unit. Then watch them take home work for the grant that's due soon. Learn how they prioritize and how they delegate responsibility.
5. The mentor-protégé relationship may promote transference and/or countertransference. Examine these issues and deal with them maturely and honestly before they interfere with your goals for the partnership. Making it a friendship, business partnership, or allying against another person or group may cause you to lose sight of the original purpose of the relationship. Attraction is common in intense relationships – be aware of this in the partnership. Also be aware that each of you brings experiences, positive and negative, from other partnerships. Overcompen-

sation, stereotyping, and self-deprecation may be attempts to work through a previously unhappy relationship. Keeping the relationship honest and open is a good way to work through this. Maintain a healthy balance between your personal and private life to avoid depending on one to satisfy the other, and to avoid blurred boundaries.

6. Take inventory occasionally on the progress you've made toward your short and long-range goals. How long can you expect to work with this person? What percentage of time do you spend with them? How does this compare with what you've been able to accomplish and what you'd still like to learn from this person?
7. Make a commitment to someday pass on the important things you've learned to someone who has been watching *you*.

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DOING RESEARCH AS A RESIDENT

Lisa Kotler, M.D.

Residency training is a time when most of us are learning the clinical skills that we will use in our careers as psychiatrists. It is a busy time, filled with challenges and opportunities. Few residents are exposed to research during their residency training, as they may not have the interest, opportunity, or time to do so. However, involvement in research can be a rewarding experience and can complement your residency training. This chapter will discuss the reasons to become involved in research as a resident, review the types of psychiatric research, and give suggestions on how to participate in research as a trainee in psychiatry.

Why Do Research?

Research can be simply defined as coming up with a question and systematically attempting to answer it. Research in psychiatry is within the reach of any good clinician, and ideas can arise from clinical work in the form of everyday experiences such as a treatment response, an unexpected side effect, or a particularly interesting patient. Research requires personal effort and enthusiasm since scientifically pursuing the answers to questions is a slow and methodical process. Why take the time or effort to do research when you are already involved in residency training, a stressful and time-intensive endeavor in its own right? The answer is because conducting psychiatric research can enhance you on both a professional and personal level. The care we give to patients should be based on proven, effective interventions and not solely on tradition or anecdote. Doing research can further your career, gain recognition from colleagues, advance the field, and contribute to improved care of patients. Personal rewards include the satisfaction of curiosity, interactions with other researchers in the field, and the experience of seeing an idea through from its conception to its execution and completion.

There is Research and There is Research

There are a variety of different areas of research in psychiatry. Basic neuroscience research includes laboratory or bench research and the newer area of neuroimaging. Clinical treatment trials establish the effectiveness and safety of psychiatric treatments. Health services research is a newer area of research that applies structured instruments to large populations to detect psychiatric disorders and follows outcomes of current treatments. Lastly, clinical

phenomenology studies characterize specific diagnostic groups of patients.

As researchers begin to answer the questions they pose, the type of study necessary starts to take shape. The most basic study is a descriptive study, in which one simply describes a particular finding such as clinical case, or a side effect of a treatment. This form of research usually leads to publications such as letters to the editor, case reports, and systematic case series. A more complicated study is an analytic study. These studies look at cause and effect relationships. These studies are found in the literature as retrospective and prospective chart reviews and reports of questionnaire findings. The most complex studies are experimental studies where one aims to ascertain the effect of an intervention. These studies are published as clinical trials, the most rigorous being the randomized, double-blind controlled trial.

Where to Start

It is easy to become overwhelmed by the idea of doing research and fear that it will require much time and grant money. In reality, many projects start small and progress through stages from a single experience to a more complex project. Many medical centers offer small grants to resident investigators. You can contribute to the field of psychiatric research by participating in several different ways. The following are some ideas of how a resident in training can gain experience in psychiatric research.

1. Obtain a list of faculty members and their current research interests from your department. Speak with faculty members who are doing research in an area that interests you. Most faculty members welcome interest and enthusiasm from residents and are glad to discuss a potential research project with them. It is often good to do a literature search on the topic to familiarize yourself with the area prior to your meeting with the faculty members.
2. When considering the type of project to do, be realistic about the time you have to spend doing the research and what you want to get out of it. Research tends to move slowly, and projects take place over months to years. It may be better to join an existing project as a resident rather than start something completely new.
3. Negotiate whether your name will be on any publications. If you do a significant amount of work on a project, make sure that you get the proper academic credit for doing so.

4. Get involved in research-related activities in your department, such as journal clubs and grand rounds presentations.
5. Find out if your institution offers post-residency research fellowships.
6. Attend professional meetings such as the American Psychiatric Association Annual Meeting or sub-specialty organization meetings.
7. Look for opportunities to present at scientific meetings. This can be accomplished through young investigator sessions or poster presentations. These presentation experiences will allow you to fine tune your scientific ideas and start to put you on the map with colleagues working in your area of interest.
8. Be aware that your research efforts will likely require extra time outside of your residency training requirements. However, many programs will allow you to use elective time for research.
9. The National Institute of Mental Health (NIMH) has PGY-4 research electives as well as post-residency fellowships available. For more information, visit their web site at www.nimh.nih.gov.

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GETTING PUBLISHED DURING RESIDENCY

Joshua Roffman, M.D.

Residency training is a fertile intellectual environment in many ways. Psychiatric residents often encounter a more diverse array of patients than at any other point in their careers. They are often on the front line as new treatments are deployed, and are among the first to see whether clinical trial efficacy translates into real-world effectiveness. Trainees' clinical skills are sharp, and their ties to other medical disciplines are fresh. During residency, there are often opportunities to perform research, or to interface with those who do. Later in training, residents sometimes are involved in teaching or in modifying and updating the curriculum for junior residents. For all of these reasons, residents are uniquely well positioned to contribute to the psychiatric literature.

Why do residents publish?

Publication during residency can accomplish several things. It provides the opportunity to collect and organize one's thoughts around a topic that is interesting or important. Writing can be a tremendous learning experience in itself and can literally turn the author (even if he or she is a trainee) into a respected expert in the field. For those who are interested in academic careers, publications are considered a primary currency, and are an absolute prerequisite for obtaining grants, receiving promotions, and developing a scientific or clinical niche following training.

What do residents publish?

Publications by residents fall into several categories. **Original research articles** and **brief reports** describe experiments that have been conducted to answer clinical, translational, or basic science questions. **Review articles** describe, critique, and synthesize existing studies that relate to a common clinical or scientific theme, while **book chapters** can serve a similar purpose. **Meta analyses** combine several primary studies that have examined similar questions within a single statistical analysis that usually has greater power to derive a more definitive and reliable answer. **Case reports** document one (or several related) scenarios of rare or instructive clinical phenomena and are also sometimes accompanied by a brief literature review and a summary of management points. Residents sometimes write **commentaries** or other opinion pieces that reflect their personal or unique experiences with patients, families, other trainees and medical

professionals, and even industry, advocacy groups, and other elements related to their training experience.

When do residents find time to write?

As a general rule, it is difficult to get much writing done early in residency, during the more demanding inpatient rotations. However, this time can be used to plan ahead, by identifying topics about which to write, finding others to collaborate on projects, and gathering background articles, clinical records, or other relevant information. Many residents do not have the time (or the funding) during residency training to design, implement, analyze, and write up their own research; however, it is often the case that senior investigators already have raw data that can be rapidly analyzed by residents to generate their own publications. Review articles and chapters, while time-consuming, need not be written all at once. Sections can also be split among several authors, as long as the first (or senior) author keeps the process organized and timely. Case reports, though, are best put together soon after the clinical encounters that inspire them; motivation to write, encouragement by supervisors, and familiarity with the material all tend to wane once the resident has moved on to subsequent rotations. Fortunately, though, case reports tend to be less time-consuming to write.

Where can residents send their work for publication?

While residents are usually able to submit their work to the same venues available to more senior authors, there are several that have been especially receptive to trainees' manuscripts. Residents frequently publish work about the training process in the journal *Academic Psychiatry*. For residents and fellows who have completed research related to the delivery of psychiatric care, or to the milieu in which psychiatric care occurs, there is a special series in *Psychiatric Services* called *TRAININGGrounds* designed specifically for trainees' work. Several widely-read journals, including *Psychosomatics*, *The Primary Care Companion to the Journal of Clinical Psychiatry*, *CNS Spectrums*, and others, have published case reports by residents. *The American Journal of Psychiatry* runs a section called *Introspections* which features brief personal vignettes, some of which have been written by trainees.

How can residents who want to publish get started?

Writing can be an intimidating process, especially for those who are early in their career. It is always a good idea to enlist the support of a supervisor with publication experience in the relevant field. These individuals can impart their familiarity with the existing

literature, help develop and focus new ideas, and provide feedback on drafts. In addition, if they appear on the manuscript as a senior author, it lends instant credibility to the work, a significant advantage during the peer review process. Before tailoring review articles to specific journals, it is always a good idea to contact the journal editor first to ensure that the manuscript fits within the journal's scope and might be of interest to the editorial board. (Of course this usually does not guarantee acceptance, but sometimes it is useful to gauge the interest of multiple journals and to weigh their relative levels of enthusiasm for the idea.) Finally, it is often not difficult to reconfigure presentations from residency seminars, abstracts or panel discussions from conferences, or other pre-existing material into a format suitable for publication. With this bit of extra effort, the time and energy already invested into these projects can result in substantially greater dividends.

RESIDENTS AND THE PHARMACEUTICAL INDUSTRY

Ashley Wazana, M.D.

Interactions between physicians and the pharmaceutical industry start as early as medical school and continue well into practice (Wazana 2000, Lexchin 1993). These encounters can take the form of industry sponsored meals, formal presentations sponsored by pharmaceutical companies, and informal discussions with pharmaceutical representatives. In addition, pharmaceutical companies frequently supply residents with reprints of journal articles, books, and travel funding. But when does taking a free lunch, a book, or a pen cross the line and become evidence of undue influence by the pharmaceutical industry? Historically, little guidance has been available to assist residents with these questions.

Residents are targeted by pharmaceutical companies eager to influence a new prescriber's practice patterns. There have been some attempts to teach residents about industry marketing techniques, critical appraisal of industry product claims, and the interaction with the pharmaceutical representative, (Mahood 1997, Lichstein 1992) yet these attempts have left most residents' wanting (Hodges 1995, Keim 1993, McKinney 1990). Guidelines exist (Canadian Medical Association 1994, Royal College of Physicians and Surgeons of Canada, Council on Ethical and Judicial Affairs 1991, and American College of Physicians 1990), but again there is general lack of awareness among residents of their content (Sergeant 1996, Reeder 1993). Even when residents are aware of these guidelines, their interactions with industry are not very different than those of residents who were unaware of their guidelines (Sergeant 1996). In the end, most residents, especially those enrolled in a program without any explicit guidelines, are left to their own devices to figure out their own fine lines about these personal and delicate decisions that often lead to heated discussion among colleagues.

A few suggestions are elaborated below, but first, some common beliefs have to be addressed:

1. **“These interactions with the industry are innocuous, be it conversations with pharmaceutical representatives (PRs), free meals, lunch rounds or receiving gifts.”** A recent systematic review of the literature finds evidence for the impact of these interactions on the knowledge (inability to identify wrong claims about medication), attitude (positive attitude toward pharmaceutical representatives, awareness, preference, and rapid prescription of a new drug), and behavior (making formulary requests for medications that rarely held important

advantages over existing ones, non-rational prescribing behavior, increasing prescription rate, prescribing fewer generic but more expensive newer medications at no demonstrated advantage) of physicians (Wazana 2000).

Specifically, four interactions were identified as more influential. Meetings with pharmaceutical representatives were associated with requests by physicians for adding the drugs to the hospital formulary and changes in prescribing practice. Attending sponsored CME events (which were found to highlight the sponsor's drug) and accepting funding for travel or lodging for educational symposia were associated with increased prescription rates of the sponsor's medication. Attending presentations given by pharmaceutical representative speakers was also associated with non-rational prescribing.

2. **“All interactions are harmful.”** Physicians believe PRs provide accurate information about their medications. They are equivocal about their beliefs that PRs provide accurate information on established or alternate drugs (Hodges 1995). Most believe that lunch rounds and conference attendance would decrease without free meals (Lichstein 1992, Ziegler 1995). Interacting with PRs also allows physicians to receive medication samples for patients. Only one study quantitatively examined the outcome of these interactions and found attendance at rounds given by a PR-speaker improved ability to identify the treatment for complicated illnesses (Spingarn 1996).
3. **“I will not be affected by this interaction.”** One study shows that a dramatic increase in post-conference prescribing rate of the sponsor's drug occurred in the home institution of the participants to an all expenses paid conference although all but one beneficiary denied the possible impact of such an interaction (Orlowski 1992).
4. **“I can tell if the information presented is useful.”** Residents appropriately question comprehensiveness of the material presented by the industry (Hodges 1995, McKinney 1990, and Ziegler 1995), but the best critical appraisal skill does not allow them to discern inaccurate statements (Ziegler 1995).
5. **“I rarely remember the name of the sponsor, so I can't be affected.”** Attendance at presentations given by pharmaceutical representatives is associated with learning of appropriate and inappropriate treatment rationales, irrespective of the resident's memory of the presenter's affiliation (Spingarn 1996 and Sandberg 1997).

So What Can You Do?

1. In your practice, varied sources of information need to be used. Using journals to keep up to date is associated with more rational prescribing.
2. Read the guidelines. The American Medical Association, Canadian Medical Association, American Psychiatric Association, and most specialties have guidelines on physicians' interaction with the pharmaceutical industry. Few residency training programs have their own guidelines, let alone distribute them or give formal teaching on them. Consider setting up a committee in your resident's association jointly with some faculty members to assess common interactions in the program and see how they compliment (or hinder) the educational and training needs of the residents.
3. Ask for guidelines to be developed and distributed as part of orientation package for residents. In addition, ask to receive teaching early in residency on the following issues: an approach to bioethical issues; industry-physician interactions; industry-patient interactions and how to help patients understand the barrage of marketing by the industry; and evidence-based medicine and appraisal of treatment claims.
4. Be careful about those interactions that are not endorsed by the guidelines or are found to be more influential.
5. There is a dose-response associated with these interactions. Less is best.
6. Suggest that your institution organize a workshop to practice effective interactions with the pharmaceutical representative. Residents in all specialties do not believe they receive enough training on this issue.
7. Mould your interaction with the industry representative to fit your own educational needs. Two papers (Shaughnessy 1996, Shear 1996), as well as a video (Shear), can assist residents with these matters. Shaughnessy and Lawson suggest being guided by STEP (an acronym for Safety, Tolerability, Effectiveness and Price) in evaluating information from drug representatives. They also recommend asking the PR to provide "patient-oriented evidence that matters" (Shaughnessy 1996) and retaining the responsibility of synthesizing that information for yourself. Shear et al, with the use of a video, describe the typical dynamic of an interaction with the physician and offer an alternative model of interaction where the PR is directed to offer information on efficacy, safety, cost, compliance, and availability,

as well as the sources of information checked to verify that information. Ad hoc meetings between residents and PR should be discouraged, especially prior to educational sessions such as grand rounds. Consider meetings arranged in advance and made with other residents and staff to encourage open and critical discussion of treatment issues.

8. If your institution accepts educational industry gifts and travel funding, consider redirecting industry representatives to donate to a pooled fund that the program can use to purchase books or fund residents for selected conferences. This would have the goal of diluting branding.

Other issues not addressed here but that are also important include the ethics of accepting gifts, the psychology of gift giving, the impact on medication cost of physician promotion to the tune of \$8,000 - \$13,000 per year per physician, and how each physician's behavior shapes the expectations the industry has about physicians. Use your residency as an opportunity to formulate your own opinions and practices related to pharmaceutical industry interactions.

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PART II:

STANDING OUT IN THE CROWD: HOW TO BECOME A PSYCHIATRIC LEADER

- Your Role as a Team Leader
- See One, Do One, Teach One: Your Role as a Teacher
- How to be a Chief Resident
- Getting Involved: Participating in Professional Organizations
- Directory of Organizations
- Being Assertive in Your Professional Roles
- Awards and Fellowships for Psychiatric Residents

YOUR ROLE AS A TEAM LEADER

Ashley Wazana, M.D.

One of the important roles the psychiatrist will develop is as a team leader. This is a role you will find yourself filling in psychiatric settings and in medical emergency settings as a consultation psychiatrist.

Your first day in a psychiatric setting can be quite difficult, and you might feel overwhelmed by your new responsibilities in an unfamiliar clinic site. Mental health is multidisciplinary. The psychiatrist, whether a novice or an experienced clinician, is usually expected to take the role of leader in a team of health professionals. Often these colleagues entered practice while you were still in elementary school, so becoming able to assume a leadership position takes learning, trial, and error. It is difficult to overstate the anxiety of your first experience when a patient is escalating, the ward is reacting nervously, and a nurse asks you, "So what are you going to do, doctor?" This is only one of the instances where the benefits of working with a team are apparent because you can look to more experienced team members for suggestions.

It is tempting to try to establish your authority at the expense of the team. For example, when you write an order, and someone innocently says, "Doctor, don't you think that Drug X is a better choice for this patient?", you may be tempted to resent the intrusion or question your knowledge base. You might ask yourself, "What was the purpose of spending all those years in school, reading countless articles, and sweating through tedious lectures on pharmacokinetics?" How easy to feel frustrated! Your goal should be to develop your efficacy and autonomy while maximizing the functioning of the team and respecting each member's contributions. Your supervisor or other role models can help you accomplish this lofty goal.

Keep these points in mind. Everyone has a role and expertise in the team. Each member might have fears and insecurities about his or her position and wants to feel like part of a team. Giving feedback to team members is essential. The time spent understanding the strengths of your team members will be returned to you in dividends in terms of your own clinical effectiveness. Also, never ask for advice if you're not going to follow through or at least acknowledge and explain why you will or will not select that option. Making that mistake will rapidly and understandably alienate your colleagues. If your suggestion to a team involves more work, you should explain

why and listen for feedback. Following basic rules of courtesy will go a long way toward earning your team's respect.

Some of the more crucial moments for a team will occur in relation to a crisis. Suicide attempts or completion, code responses for agitated patients, and violent outbursts will shake up all caregivers. Taking the necessary time to debrief not only keeps the team healthy but also trusting and cohesive. It also highlights how the psychiatrist's hat often is one of a caregiver to the treatment team itself.

Teamwork as a Consultant

As a consultation psychiatrist, you will be called to assist another team, that of the medical or surgical ward. The call to the psychiatrist usually has to do with mental health issues related to medical conditions. At times, medical teams will call you because they are simply uncertain how to address a problem with a patient or the family. For example, you might be asked to assist with hostile families, agitated patients, and suicide attempts. While these issues are bread and butter for psychiatrists, they can be anxiogenic for medical professionals in non-psychiatric fields.

The medical ward can also become the perfect setting for difficult patients with personality pathology to cause difficulty among a team of caregivers. The patient might "split" the members into "good" and "bad" caregivers or project emotions, thereby challenging the cohesiveness of a team. Such divided teams sometimes call for assistance in stabilizing the team. It will rapidly become clear to you that your role in such settings is to provide care to patients *and* the medical caregivers. As you formulate an impression and plan, your task will involve not only gathering a thorough history from the chart, caregivers, patient, and families, but meeting with the team to understand the nature of their difficulties. It cannot be overstated how much listening, offering basic reassurance, and education will attenuate many crises both in caregivers and their patients' concerned families. It may require several meetings to show the team that they are not being forgotten or left alone in dealing with troubling issues. At other times, it means meeting with the patient and their families and even acting as a bridge in a meeting that gathers patient, family, and caregivers. Your role as a psychiatric "ambassador" to other specialties can go a long way toward improving the functioning of the entire health care team.

Conclusion

In summary, psychiatric residency will provide you with many opportunities to function as a team member, and frequently, as a leader. Cultivating your skills as a team player will help you work effectively as a clinician, a teacher, an administrator, or a myriad of other professional roles.

SEE ONE, DO ONE, TEACH ONE: YOUR ROLE AS A TEACHER

Jason Wuttke M.D., M.P.H.

Most residents are expected to teach and supervise medical students, yet few post-graduate programs offer specific training, guidelines, or even feedback for the resident wishing to develop in this role. Becoming a competent teacher is a difficult process, complicated further by the rigorous time demands of residency. Given these encumbrances and the paucity of support and recognition, you might wonder why you should strive to become a good teacher. In his cynical bible of internship, House of God, Samuel Shem cynically requests, “Give me a medical student who only triples my work and I will kiss their feet.” Medical student teaching is time-consuming and may even appear thankless. Yet despite these obstacles, it is a worthwhile endeavor. Teaching is a central part of our identity as professionals and healers. Mentoring is emphasized in the Hippocratic Oath, and it was through the attention and guidance of respected teachers that many of us chose our career paths.

Supervising medical students provides residents with an excellent opportunity to organize and consolidate their burgeoning knowledge and skills while fostering their professional development. Psychiatric residents, with their proximity to the medical school experiences, their training in empathy and self-awareness, and their close interaction with rotating students, have a unique opportunity to influence future physicians. By demonstrating competence and compassion in all interactions with psychiatric patients, and emphasizing the prevalence of psychological factors in medical illness and the applicability of psychiatric principles in all areas of medicine, the psychiatric resident can reduce the stigmatization of both the patient and the entire specialty. To do this requires confidence, commitment, and preparation on the resident’s part. However, to ignore the importance of effective teaching and to fall short as a role model will further marginalize psychiatry and the mentally ill in the medical community.

Teaching psychiatry to medical students is in some respects easy and in others almost impossible. Factual information, DSM IV criteria, and basic psychopharmacology are all reasonably straightforward and often well enough covered by didactic lectures to be regurgitated at the end of a medical student’s rotation. More nuanced skills, however, such as intuition, active listening, empathy, and tolerance of affect in oneself, are qualities critical to psychiatry and all fields of medicine. These skills are not obtained simply

through reading, role memorization, or lectures, but require repeated live patient interactions with direct supervision and opportunities for constructive examination and discussion. The psychiatric resident as teacher can facilitate the medical student's fledgling efforts at diagnostic and therapeutic interviewing by serving as a role model and constructive critic. Regardless of future career choice, students should be encouraged to participate in patient interactions and discuss their observations as well as their own experience in treating mentally ill patients. Early in the rotation you should meet with the medical student to delineate expectations and goals. Thereafter, meetings to give and receive feedback on how the rotation is proceeding should be held regularly. A final closing session is critical to summarize the student's strengths and areas for future development, as well as to provide a forum for feedback on your own teaching style and its effectiveness.

Serving as a mentor and supervisor is an integral part of what is means to be a doctor. Developing and practicing these skills early helps solidify your resident's knowledge base and improves future work performance and satisfaction. For the psychiatric resident in particular, working with medical students provides a critical forum for addressing misconceptions and issues of stigma towards mental illness. Hopefully, your attention to the education and growth of the rotating medical student, both by example and by direct supervision, will contribute to the development of a more sophisticated and humane future physician.

Although all residency programs should offer formal didactics on how to teach medical students, some do not. The following, a must-read for all residents, is a comprehensive, step-by-step guide on how to be a more effective teacher:

Psychiatric Residents as Teachers: A Practical Guide Committee on Graduate Education 2001-2002. American Psychiatric Association.

www.psych.org/edu/res_fellows/psychresidentguide.pdf

HOW TO BE A CHIEF RESIDENT

John Barker, M.D.

Most chief residents begin their work with only the example of their predecessors to guide them. Very few have any formal training in organization, teaching, or leadership, and many have no preparation at all for their new responsibilities. This predicament can produce frustration and disappointment for both the chiefs, as well as the residents. This chapter will address this situation with some suggestions on how to approach the job of being a chief.

Role Definition

Chiefs have different roles in different programs – from administration to clinical care to research – yet all sit in a “boundary position,” midway between residents and faculty (Lowy 1980). In administrative functions, their role is akin to faculty. In their everyday work, they still act as residents. This boundary position isolates chiefs, but it also provides them with both an understanding of how to manage complex systems in conflict and a better appreciation of the social context of practice.

Residents and faculty may view chiefs in simplistic ways – either as ally or opponent – although residents, with their more limited experience with chiefs, are more apt to split in this way. As a result, you may feel unsupported in your work as chief. However, this is not a reflection of your job performance or your abilities. Their job of being a chief can't be a popularity contest. There will be situations, such as dealing with non-performing residents or taking a stand for residents' rights that will require you to be decisive and confrontational, sometimes in a very public way, in order to maintain the morale of the residents as a whole. And the fact that you are in a boundary position can actually make your actions more meaningful and effective.

It is important to define your own role as a chief, even before your tenure begins. This means starting your regular meetings with the department chair or his/her designee in the month before you begin your term, and selecting for yourself those parts of the job on which you would like to concentrate. It is also important in this preparation period to consult with the outgoing chief, to get his or her advice on how to handle important ongoing conflicts in the residency, and to get a sense of the progress made under his or her leadership.

Clarification of your role will be a continuing process. Some residents will need to be reminded of your authority, and you will

need to remind yourself when you are needlessly over-reaching. A useful approach to beginning this process is to organize and facilitate a residents' retreat. This retreat is a day or weekend to elicit residents' opinions and concerns, while also building a sense of community. This should be done early, as it will significantly help establish your role and differentiate you from the outgoing chief.

Details of the Job

After establishing your role, it is important to complete your own administrative and organizational duties (scheduling call, assigning cases, organizing and teaching classes, etc.) in a timely way. It is helpful to schedule yourself an hour of time each day to do these tasks, as it will take at least that long. Nothing erodes morale or exacerbates resident stress more than a perception that you are not organized enough to provide them with structure.

Most important to the job of chief is the need to communicate constantly to convey information among the residents, from the residents to the faculty, and vice-versa. This is a necessary precursor to building consensus among the residents, and is essential to your role as a mediator within the program. This is a part of the job that takes an inordinate amount of time, often because it happens in hallways or after meetings. Periodic memoranda can help facilitate this communication. In addition, some chiefs will schedule brief drop-in office hours for residents, as a way to minimize the disruption of being collared in the hall. In reality, however, the job requires many reminders, explanations, and coordination that have to be done on an ongoing basis. You need to be available and approachable. If your program doesn't take this time into account in budgeting your hours, insist that they do so.

An especially valuable communication function is that of informal teaching: how to manage one's caseload, how to arrange one's schedule, how to teach medical students, how to operate in the clinic and in the hospital...how to be a resident. Residents will rely heavily on a good chief for help. It is useful to produce written guidelines and reminders for residents on hospital and clinic policies and procedures, both at the beginning of the year and on an ongoing basis. It is also helpful to share with junior residents your experience as a beginning therapist or resident. Again, make time to be available.

Rather than being a therapist to the residents, lead by example. Be straightforward, compassionate, respectful of confidences, as patient as possible, and honest about your own feelings. Have a sense of humor, take care of yourself, and never fail to address important problems rather than just hope they will resolve

themselves. Be fair and consistent in the application of rules. Clarify the matters at issue in conflicts. With problem residents, focus on the tasks they need to complete, rather than on their psychopathology. Protect your residents as much as you can from overwork and abuse, and support them as much as you can in their personal and professional needs. There will be many occasions when neither junior resident nor faculty will be able to understand everything involved in the care of patients as well as you do, having just been through the experience, and your judgment can be invaluable in difficult situations.

The American Psychiatric Association offers an annual seminar entitled the APA/Lilly Chief Residents Executive Leadership Program, at the Institute of Psychiatric Services. One chief or senior resident from each accredited program is invited to attend and learn how to be an effective leader. Go to the APA Website (www.psych.org) for more information.

Conclusion

Being a chief resident is a demanding job that will take your time away from patient care, research, or other interests. In an era of shrinking budgets and support staff and rapidly evolving clinical and training organizations, the job of chief is more important and demanding than ever ...and potentially more rewarding.

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GETTING INVOLVED: PARTICIPATING IN PROFESSIONAL ORGANIZATIONS

Daniel B. Martinez, M.D.

Only a fraction of doctors in most fields of medicine become involved with local or national professional organizations. Those who do tend to find the experience rewarding. It takes effort, energy, and time to participate in organizations. Not everyone sees this kind of involvement as worth their while. However, for those who choose to become involved, the payoff certainly surpasses all the inconveniences and sacrifices. In this chapter, we will consider the implications of participating in professional medical organizations and how this may relate to three areas of professional life: (1) gaining a broader perspective of the residency training experience, (2) supplementing residency education, and (3) establishing a network of colleagues with similar interests.

The Resident as Advocate

Residency training is often a heavy burden, and it is easy to lose sight of the “big picture” in the midst of clinical demands. Periodically meeting with residents from across the country and comparing training programs and clinical experiences provides encouragement and enlightenment. Open discussions about rotations, didactics, supervision, call, and other issues important to our daily lives help us realize that all programs have strengths and weaknesses. We become informed about common challenges in residency training. We learn how other programs may do certain things better, and we can become catalysts for improving our own programs.

Whether it is through a local or national medical society, learning about the climate of psychiatry in a region of the country is of profound importance. Professional organizations exist for both patient advocacy and professional development. Joining professional organizations allows the resident to learn from peers about available resources in the community and expands his or her scope on patient care. Collaborating in organizations allows you to learn about political trends that directly affect the way mental health care is delivered and provides avenues to advocate for change that is beneficial to our patients and our profession.

Enriching the Educational Experience

Every subspecialty has at least one professional organization. Whether your interest is government policy, child and adolescent psychiatry, forensics, substance abuse, or psychopharmacology, there is an organization for you. Participating in one of these organizations can enhance your knowledge base. Presenting workshops, lectures, or other projects makes training in psychiatry a richer experience. It can also prepare you for active participation throughout your career.

Networking

A rewarding aspect of participation in professional organizations is the opportunity to network with others in the field. Residency can be an isolating experience, and involvement in organizations can open the door to countless resources. For example, you can make contacts that might facilitate employment opportunities during or after training. From meeting and interacting with leaders in the field, to obtaining mentorship from more senior psychiatrists, to meeting residents from neighboring programs, expanding your network of contacts offers life-long benefits to your career. Organizations such as the American Medical Women's Association provide much needed support to unique populations of trainees.

In summary, participation is more than simply having a membership and receiving a monthly journal. After all, part of our job as physicians is to advocate for our patients, our profession, our community, and ourselves. Becoming involved will result in a broader educational experience. Keep in mind that professional organizations always welcome enthusiastic young participants. Volunteering for seemingly small or insignificant jobs in organizations will get you noticed. This, in turn, can lead to additional responsibilities and integration into an organization. Over time, this will develop and enhance your professional identity in the field of psychiatry.

Please see the next chapter for a comprehensive list of psychiatric and non-psychiatric organizations.

DIRECTORY OF ORGANIZATIONS

Amir Garakani, M.D.

The following is a list of psychiatric organizations, followed by a list of non-psychiatric organizations that may be relevant to your training. Included are general professional groups, specialty groups, research societies, advocacy groups, and by-invitation-only colleges. Although fairly comprehensive, there may be omissions, including regional psychiatric organizations and certain advocacy group. In addition, the names and website are subject to change. Please contact the APA or your training director or faculty if you want additional information.

Name	Website Address
Academy for Eating Disorders	www.aedweb.org
Academy of Organizational & Occupational Psychiatry	www.aoop.org
Academy of Psychosomatic Medicine	www.apm.org
Administrators in Academic Psychiatry	www.adminpsych.org
Alzheimer's Association	www.alz.org
American Academy of Addiction Psychiatry	www.aaap.org
American Academy of Child and Adolescent Psychiatry	www.aacap.org
American Academy of Clinical Psychiatrists	www.aacp.com
American Academy of Hospice and Palliative Medicine	www.aahpm.org
American Academy of Psychiatry and the Law	www.aapl.org
American Academy of Psychoanalysis and Dynamic Psychiatry	aapsa.org
American Association for Emergency Psychiatry	www.emergencypsychiatry.org
American Association for Geriatric Psychiatry	www.aagpgpa.org
American Association for Technology in Psychiatry	www.techpsych.org
American Association of Chairs of Departments of Psychiatry	www.aacd.org
American Association of Community Psychiatrists	www.comm.psych.pitt.edu
American Association of Directors of Psychiatric Residency Training	www.aadprt.org

Name	Website Address
American Association of Suicidology	www.suicidology.org
American Board of Pain Medicine	www.abpm.org
American Board of Psychiatry and Neurology	www.abpn.com
American Board of Sleep Medicine	www.absm.org
American Brain Coalition	www.americanbraincoalition.org
American College of Neuropsychopharmacology	www.acnp.org
American College of Psychiatrists	www.acpsych.org
American Foundation for Suicide Prevention	www.afsp.org
American Group Psychotherapy Association	www.groupsinc.org
American Neuropsychiatric Association	www.anpaonline.org
American Orthopsychiatric Association	www.amerortho.org
American Pain Society	www.ampainsoc.org
American Psychiatric Association (APA)	www.psych.org
American Psychiatric Association Alliance	www.apaalliance.org
American Psychiatric Foundation	www.psychfoundation.org
American Psychoanalytical Association	www.apsa.org
American Psychological Association	www.apa.org
American Psychopathological Association	www.appassn.org
American Psychosomatic Society	www.psychosomatic.org
American Psychotherapy Association	www.americanpsychotherapy.com
American Society for Adolescent Psychiatry	www.adolpsych.org
American Society for Adolescent Psychiatry	www.adolpsych.org
American Society of Addiction Medicine	www.asam.org
American Society of Clinical Psychopharmacology	www.ascpp.org
Association for Academic Psychiatry	www.hsc.wvu.edu/aap
Association for Behavioral and Cognitive Therapies	www.aabt.org
Association for Medical Education and Research in Substance Abuse	www.amersa.org
Association for Psychoanalytic Medicine	theapm.org
Association for the Advancement of Philosophy and Psychiatry	www3.utsouthwestern.edu/aapp
Association for Women Psychiatrists	www.womenpsych.org
Association of Directors of Medical Student Education in Psychiatry	www.admsep.org
Association of Gay and Lesbian Psychiatrists	www.aglp.org
Association of Medicine and Psychiatry	www.amedpsych.com
Autism Society of America	www.autism-society.org

Name	Website Address
Canadian College of Neuropsychopharmacology	www.ccnp.ca
Canadian Psychiatric Association	www.cpa-apc.org
Center for the Study of Traumatic Stress	www.centerforthestudyoftraumaticstress.org/
Children and Adults With Attention-Deficit/Hyperactivity Disorder	www.chadd.org
Collegium Internationale Neuro-Psychopharmacologicum (CINP) (English: International College of Neuropsychopharmacology)	www.cinp2008.com
Depression and Bipolar Support Alliance	www.dbsalliance.org
Disaster Psychiatry Outreach	www.disasterpsych.org
European College of Neuropsychopharmacology	www.ecnp.eu/emc.asp
Families for Depression Awareness	www.familyaware.org
Freedom from Fear	www.freedomfromfear.org
Group for the Advancement of Psychiatry	www.groupadpsych.org
International College of Psychosomatic Medicine	www.icpm.org
International Psychogeriatric Association	www.ipa-online.org
International Society for Affective Disorders	www.isad.org.uk
International Society for Bipolar Disorders	www.isbd.org
International Society for Neuroimaging in Psychiatry	www.klinik.uni-frankfurt.de/isnip
International Society for the Study of Personality Disorders	www.isspd.com
International Society for the Study of Trauma & Dissociation	www.isstd.org
International Society for Traumatic Stress Studies	www.istss.org
International Society of Psychoneuroendocrinology	www.ispne.org
Mental Health America	www.nmha.org
National Alliance for Research on Schizophrenia and Depression (NARSAD)	www.narsad.org
National Alliance for the Mentally Ill (NAMI)	www.nami.org
National Center for PTSD	www.ncptsd.org
National Institute of Mental Health (NIMH)	www.nimh.nih.gov
National Institute on Alcohol Abuse and	www.niaaa.nih.gov

Name	Website Address
Alcoholism	
National Institute on Drug Abuse	www.nida.nih.gov
National Sleep Foundation	www.sleepfoundation.org
Obsessive-Compulsive Foundation	www.ocfoundation.org
ParentsMedGuide	www.parentsmedguide.org
Royal College of Psychiatrists	www.rcpsych.ac.uk
Schizophrenia International Research Society	www.schizophreniasirs.org
Society for Neuroscience	www.sfn.org
Society of Biological Psychiatry	www.sobp.org
Substance Abuse and Mental Health Services Administration (SAMHSA)	www.samhsa.gov
The Neuroscience Education Institute	www.neiglobal.com
The Stanley Medical Research Institute	www.stanleyresearch.org
US Psychiatric Rehabilitation Association	www.uspra.org
World Psychiatric Association	www.wpanet.org

Relevant Non-Psychiatric Organizations

Name	Website Address
Accreditation Council for Graduate Medical Education	www.acgme.org
American Academy of Neurology	www.aan.com
American Association for the Advancement of Science	www.aaas.org
American Board of Medical Specialties	www.abms.org
American Medical Association (AMA)	www.ama-assn.org
American Neurological Association	www.aneuroa.org
Association of American Medical Colleges	www.aamc.org
Centers for Disease Control and Prevention	www.cdc.gov
Drug Enforcement Administration (DEA)	www.usdoj.gov/dea
Educational Commission for Foreign Medical Graduates	www.ecfmg.org
Electronic Residency Application Service (ERAS)	www.aamc.org/eras
Federation of State Medical Boards	www.fsmb.org
Fellowship and Residency Electronic Interactive Database (FREIDA)	www.ama-assn.org
Food & Drug Administration (FDA)	www.fda.gov
Institute of Medicine	www.iom.edu
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)	www.jcaho.org

Name	Website Address
National Institutes of Health (NIH)	www.nih.gov
National Library of Medicine	www.nlm.nih.gov
National Resident Matching Program	www.nrmp.org
New York Academy of Medicine	www.nyam.org
New York Academy of Sciences	www.nyas.org
Physicians for Human Rights	physiciansforhumanrights.org
Sigma Xi, The Scientific Research Society	www.sigmaksi.org
United States Medical Licensing Examination	www.usmle.org
World Health Organization	www.who.int
National Institute on Aging	www.nih.gov/nia

BEING ASSERTIVE IN YOUR PROFESSIONAL ROLES

Leah J. Dickstein, M.D., M.A.

Becoming and being assertive in your professional roles is an important transition in residency. Medical students are expected to be compliant learners, but residents are expected to perform more leadership duties. It is important to distinguish assertiveness from aggressiveness. Being assertive is healthy and usually appropriate, while being aggressive implies confrontational actions that are generally not helpful.

Psychiatry residency will provide you with several opportunities to develop effective assertiveness skills.

1. **In your residency.** As an intern, try to learn from the more senior residents and faculty as they assign call schedules, handle difficult patients, and interact with other members of the treatment team. Good leadership skills include being fair to everyone, asking the group for suggestions and feedback, and making appropriate decisions. Use your time as a resident to observe leaders in action, and decide for yourself what leadership strategies are effective.

When leadership opportunities arise in your training program, volunteer to participate in these special roles. You should be prepared to define why you should be selected by identifying your interests, strengths, and competencies. Being a leader in your residency can help open doors to special opportunities beyond your program.

For some women and minorities, being assertive may not be part of your earlier life messages from home and society. Use your time in training to seek more challenges. Trust yourself to try new things. We can all learn from firsthand experiences and from observing others demonstrating assertiveness, self-advocacy, and leadership.

2. **With patients.** Being professionally assertive with patients is often part of good medical treatment. Offering suggestions to patients concerning their personal lifestyles, emotional behaviors, and attitudes is part of being a competent psychiatrist. Recommending additional treatments and goals for patients is also appropriate. It is particularly important to learn to set limits with patients if they begin to cross appropriate boundaries with you, other patients, or staff. Often it is your job to tell people things they do not want to hear!

3. **With attending physicians and supervisors.** Sometimes asking for more teaching and/or supervision is appropriate and helps maximize your education. If you believe you are not receiving enough supervision or guidance, you should request more, or ask other residents, particularly the chief resident, what to expect and how to advocate successfully for what is lacking in your training program without antagonizing faculty.
4. **In local, national, and international professional organizations.** If you become involved in organizations, whether by being appointed to a committee or task force, running for office, or submitting a poster or presentation, consider this as an opportunity to meet leaders in the field, future colleagues, and friends. Furthermore, such involvement can offer healthy, creative opportunities to balance the stresses and strains of residency responsibilities for patient care. Participating in professional organizations also allows you to practice being assertive. For example, you may have to muster your courage the first time you introduce yourself to a psychiatric “celebrity.” With practice, however, you will find that people are generally happy to meet residents and provide them with encouragement. Be assertive about introducing yourself to potential mentors, and keep a list of their contact information, including how they prefer to communicate (i.e. via email, telephone, etc.).
5. **Getting credit.** One final aspect of developing assertiveness has to do with receiving proper acknowledgement for your work. For example, if you publish a paper, make sure you are listed as an author. You should establish order of authorship before you write a paper or do a project. Although conversations about authorship can create a few minutes of discomfort, it is better than the lasting bitterness you will feel if you do not receive credit for your work in the end.

Learning to advocate – for yourself, your ideas, and your patients – is an important skill to acquire during residency. Learn from the behavior (both good and bad) of leaders, and apply the best of what you observe to your own practice. Don’t forget that you are your own number one senior advisor and coach.

AWARDS AND FELLOWSHIPS FOR PSYCHIATRIC RESIDENTS

**Nancy Delanoche
Amir Garakani, M.D.**

This is fairly comprehensive list of awards, fellowships, and grants available to psychiatry residents and fellows. In spite of our best efforts, it is possible that some awards have been missed. This list also does not include awards given by regional, state, or local psychiatric organizations. Contact your District Branch for more information.

Here are some factors to bear in mind:

1. Awards are constantly being renamed and retooled, based on funding sources. The information below can become outdated quickly. In certain cases, some awards are discontinued. The most reliable way to find out if the award or fellowship is still available is to contact the organization directly. The website links are provided alongside the award.
2. Some of the awards require membership in the sponsoring professional organization. They may allow you to apply for membership at the time of application, but some may not. Check the site for further information.
3. Most awards only allow one application per training program per year. Therefore, the trainee who will be nominated is often selected by his/her Training Director. Since not all programs are aware of all award opportunities, it is best to express your interest to the program director in a timely manner to ensure that if you are chosen, you will have time to gather all necessary paperwork and recommendations.
4. Be sure to tailor your application, CV, and essays to the specific award, instead of using a generic statement for all awards. Also ask that the faculty members make your letters of recommendation as specific as possible.
5. Try to talk to previous awardees or residents/fellows who are currently in the fellowship. They will be able to give you an insider's perspective.
6. Be sure to check the dates of any meetings or conferences connected to the fellowships or awards, and make sure to obtain approval from the training director prior to applying. Most of them require attendance at their meeting in order to accept the award. If you do not think you can honor the commitment for any reason (such as prior work or personal obligations), it is best not to apply.

List of Available Awards (As of Spring 2007)

WHAT	INFORMATION	DEADLINE/ LINK
Academy of Psychosomatic Medicine (APM) William Webb Fellowship Program	Advanced psychiatry residents and fellows with a subspecialty in consultation-liaison psychiatry. Demonstrate excellent potential for the specific goals and aims of the Fellowship. Provides mentorships and costs of travel to Annual Meeting.	March www.apm.org
American Association for Directors of Psychiatric Residency Training (AADPRT) Ginsberg Fellowship	Residents with academic leadership potential and interest in teaching. Provides funding for AADPRT meeting. Programs with residents winning the award within the last three competitions cannot nominate a candidate.	November-December www.aadprt.org
AADPRT IMG Mentorship	Outstanding IMG who is either PGY 2 or PGY 3 at the time of nomination. Provides travel costs to AADPRT meeting, and mentorship.	November-December www.aadprt.org
AADPRT Fromm-Reichmann Fellowship	Awarded for the best unpublished work in the general area of psychotherapy. Provides monetary prize and travel costs for attending the AADPRT meeting.	November-December www.aadprt.org
AADPRT Henderson Paper Award	Awarded to the best unpublished paper in the general area of child psychiatry. Open to general and child psychiatry residents, or graduates 2 years out of training. Monetary prize plus travel costs for the AADPRT meeting	November-December www.aadprt.org
American Association for Emergency Psychiatry (AAEP)/Janssen	For residents demonstrating excellence in emergency psychiatry. Monetary award plus paid expenses to attend their	March www.emergencypsychiatry.org/

WHAT	INFORMATION	DEADLINE/ LINK
Residents Award	annual meeting.	
American College of Psychiatrists/ Laughlin Fellowship Program	PGY 3 or 4 residents or child psychiatry fellow likely to make a significant future contribution to psychiatry. Funding to attend College's annual meeting.	September www.acpsych.org
American College of Psychiatrists PRITE-Child PRITE Fellowship	Current PGY 2 or 3 general residents or first year Child fellows who are interested in psychiatric education and have a strong fund of knowledge in the field. Attend PRITE meeting and write questions for the exam.	October www.acpsych.org
American Neuropsychiatric Association (ANPA) Young Investigator Award	Selection based on merit of applicant's abstract that is submitted to the ANPA annual meeting. Provides travel costs to the meeting.	October www.anpaonline.org
American Psychoanalytic Association Fellowship Program	Psychiatry applicants must at the time of application be full-time general or child psychiatry residents PGY-2 or higher. Two year fellowship with funding for two of Association's annual meetings.	February www.apsa.org
Association for Academic Psychiatry (AAP) Fellowship	PGY-3, PGY-4, PGY-5 resident/fellow with a demonstrated interest in an academic career and ability as a teacher. (note: only AAP institutional members may nominate fellows). Attend two annual meetings, receive mentorship, and present scholarly work.	March www.hsc.wvu.edu/aap
American Medical Association (AMA) Foundation Leadership Award Program	Open to residents and fellows interested in leadership opportunities in organized medicine. Funding to attend the AMA National Advocacy	December-January www.ama-assn.org

WHAT	INFORMATION	DEADLINE/ LINK
American Psychiatric Association (APA)/ GlaxoSmithKline Fellowship Program	<p>Conference.</p> <p>PGY-2 and 3 residents with demonstrated leadership abilities and potential for contributing to the APA and for becoming future leaders in psychiatry. Provides funding for the APA Fall Component Meeting and Annual Meeting. Membership on APA committee.</p>	<p>March</p> <p>www.psych.org</p>
APA/SAMSA and APA/Astra Zeneca Fellowships	<p>Part of the APA's Minority fellowship program. SAMSA is one year, Astra Zeneca is two years. Fellows are assigned to work with an APA component Provides funding for the Annual meeting and Fall Component meeting.</p>	<p>January</p> <p>www.psych.org</p>
APA/Bristol Meyers Squibb Fellowship in Public Psychiatry	<p>PGY-3 or higher with substantial interest and significant potential for leadership in any area of public sector psychiatry. Provides funding to attend two Institute of Psychiatric Service and Fall Component Meetings.</p>	<p>April</p> <p>www.psych.org</p>
American Psychiatric Institute for Research and Education (APIRE)/Janssen Scholars in Research on Severe Mental Illness	<p>PGY-1, PGY-2, and PGY-3 psychiatric residents with the potential to become leaders in clinical and health services research into severe mental illness. Funding for two years of APA Annual meetings, including mentoring and career enrichment programs. Monetary award in second year of fellowship to assist research career development.</p>	<p>January</p> <p>www.psych.org</p>
APA/APIRE Lilly Psychiatric Research Fellowship	<p>Designed for residents who demonstrate significant research potential and are not already established investigators. For</p>	<p>October</p> <p>www.psych.org</p>

WHAT	INFORMATION	DEADLINE/ LINK
	individuals in last year of residency or child fellowship. Should be members of an underrepresented minority group, including African Americans, Asian Americans, Hispanics/Latinos, Native Americans, Native Alaskans, Native Hawaiians or Pacific-Islanders. Provides salary for research fellowship.	
APA/APIRE Pfizer Minority Psychiatric Research Fellowship	Same as APIRE/Lilly Fellowship. Should be members of an underrepresented minority group, including African Americans, Asian Americans, Hispanics/Latinos, Native Americans, Native Alaskans, Native Hawaiians or Pacific-Islanders.	October www.psych.org
APA/APIRE Wyeth Pharmaceuticals M.D./Ph.D. Psychiatric Research Fellowship	Residents with a MD/PhD in their last year of residency are eligible. Provides funding for a year of research fellowship.	October www.psych.org
APA Research Colloquium for Junior Investigators	Designed to provide guidance and mentorship to young investigators. Awardees expected to give an oral presentation and present a poster at the APA annual meeting. Travel stipend provided.	November www.psych.org
APA/Lilly Resident Research Award	Given to the 5 best unpublished manuscripts on which the resident/fellow is the primary author. Provides a monetary award to the resident and the program.	December www.psych.org
APA/Member-in-Training (MIT) Trustee Elect	Elected position on the APA Board of Trustees. Serve one year without voting privileges as	August www.psych.org

WHAT	INFORMATION	DEADLINE/ LINK
	Trustee Elect, then one year with a vote as the MIT Trustee	
APA/Committee on Residents and Fellows	Elected position on a standing committee of the APA. Seven total members, one from each geographically defined Area.	January www.psych.org
APA/AACAP Jeanne Spurlock Congressional Fellowship	For trainees interested in health policy and legislation. PGY-II and III general psychiatry residents, child psychiatry residents, or child psychiatrists who will be out of training for less than one year at the time of the fellowship. Ten-month fellowship working in DC.	March www.psych.org www.aacap.org
APA/Shire Child and Adolescent Psychiatry Fellowships	PGY-1 to 3 interested in child/adolescent psychiatry are eligible to apply. Provides travel costs to attend APA annual meeting for two years.	December www.psych.org
American Academy of Child and Adolescent Psychiatry (AACAP)/Lilly Pilot Research Award	Available to Child Fellows and junior faculty. Provides awards of \$9000 in pilot research funding, and funding to attend the annual meeting.	April www.aacap.org
AACAP Educational Outreach Program for General Psychiatry Residents	Available to residents interested in child & adolescent psychiatry. Provides travel stipend to attend the annual meeting. Must be member of AACAP.	July www.aacap.org
AACAP Educational Outreach Program for Child and Adolescent Psychiatry Residents	Available to child & adolescent psychiatry fellows. Provides travel stipend to attend the annual meeting. Must be member of AACAP.	July www.aacap.org
AACAP Pilot Research Award for Attention Disorders, supported by the Elaine Schlosser	Large monetary award available to child fellows and junior faculty no more than 2 years out of training. Must not have any significant sources of funding at	May www.aacap.org

WHAT	INFORMATION	DEADLINE/ LINK
Lewis Fund	time of application.	
AACAP Robinson-Cunningham Award	Awarded to the best manuscript by a child & adolescent psychiatrist. Must be started in residency, completed within three years of finishing training.	May www.aacap.org
AACAP/Beatrix A. Hamburg Award for the Best New Research Poster by a Child and Adolescent Psychiatry Resident	Awarded for best new research poster presented at the AACAP Annual Meeting. No application process: the Program Committee reviews all submissions to determine a winner. Provides honorarium to attend the meeting.	June www.aacap.org
American Academy of Psychiatry and the Law Rapoport Fellowship	PGY 3 residents or PGY-4 Child with demonstrated interest in psychiatry and the law. Funding for the annual meeting and forensic review course.	April www.aapl.org
American Association for Geriatric Psychiatry (AAGP) Fellowship in Geriatric Psychiatry	PGY 3 residents. A 2-year fellowship that funds society membership and costs to attend the annual meeting.	November www.aagponline.org
AAGP/Stepping Stones Program	PGY1-4 residents with an interest in geriatric psychiatry. Funding for AAGP annual meeting and one-year society membership	October www.aagponline.org
American College of Neuropsychopharmacology (ACNP) Sanofi-Aventis Travel Award & ACNP NIMH Travel Award	Awards given annually to eligible <u>minority</u> candidates. Available to residents, fellows, graduate students, and junior faculty. Provides travel costs to the December ACNP meeting	April www.acnp.org
Anxiety Disorder Association of America (ADAA) Career Development Travel Awards	Intended to stimulate young investigators to pursue their work in the field of anxiety disorders. Provides travel stipend to attend the ADAA Annual Conference. Includes a	November www.adaa.org

WHAT	INFORMATION	DEADLINE/ LINK
	one-year ADAA membership.	
Association of Women Psychiatrists (AWP) Alexandra and Martin Symonds Foundation Fellowship and AWP Wyeth Pharmaceuticals Fellowship	For outstanding female psychiatry residents with leadership potential and commitment to women's health issues. Provides stipend for travel to AWP/APA meeting.	February www.womenpsych.org
Group for the Advancement of Psychiatry (GAP) Fellowship	PGY 2 or 3 residents or 1 st year child fellows with demonstrated leadership abilities, commitment to social issues, willingness to participate in collective process. Fifteen fellows chosen every other year for a 2-year fellowship. Attend the fall and spring meetings.	September www.groupadpsych.org
<i>Journal of Psychiatric Practice</i> Resident Paper Award	Awarded annually to best unpublished original or review paper on which the resident is a primary author. Monetary prize plus consideration for publication in <i>Journal of Psychiatric Practice</i> .	March www.practicalpsychiatry.com
National Alliance for Research on Schizophrenia & Depression (NARSAD) Young Investigator Award	Applicant must have a doctoral level degree (e.g., M.D. [minimum PGY-IV], Ph.D., Psy.D., etc.) and already be employed in research training, or be in a faculty or independent research position. Funding is for one or two years and is up to \$30,000 per year.	July 1 www.narsad.org
National Institute of Health (NIH) Loan Repayment Program	Must be able to guarantee 50% time for research. In exchange, the NIH pays up to \$35,000 per year for two years toward your medical school loans	December www.lrp.nih.gov
National Institute of	Nomination of one PGY-2	May

WHAT	INFORMATION	DEADLINE/ LINK
Mental Health (NIMH) Outstanding Resident Award	resident by the training program. Support to attend NIMH intramural research program to describe ongoing research.	intramural.nimh.nih.gov/orap/home.do
Robert Wood Johnson Clinical Scholars Program	A 2-year graduate-level post-residency research training program, emphasizing community-based research. Augment clinical skills and provide leadership opportunities.	February www.rwjf.org/cfp/clinicalscholars
Society of Biological Psychiatry (SOBP) Travel Fellowship Award	PGY3 and higher or in a research or subspecialty training. Provides stipend to cover travel costs of attending the SOBP Annual Meeting.	January www.sobp.org
Society for the Study of Psychiatry and Culture - John P. Spiegel Memorial Fellowship	A resident or fellow who has an interest in and commitment to cultural psychiatry	Contact SSPC www.psychiatryandculture.org
World Psychiatric Association (WPA) International Congress Travel Fellowship	Provides travel funds to a psychiatric trainee to attend the WPA meeting	Contact WPA www.wpanet.org

PART III:

TAKING CARE OF YOURSELF DURING PSYCHIATRIC RESIDENCY

- **Charting Your Course: Balance in Your Personal and Professional Life**
- **Benefits (and Pitfalls) of Getting Your own Psychotherapy**
- **Parenthood and Residency: Negotiating Parental Leave**
- **Spirituality and the Psychiatric Resident**
- **Coming to America: International Physicians as Psychiatric Residents**
- **Romance, Relationships, and Residency**
- **Opening the Closet Door: Residency and Sexual Preference**
- **Your Personal Mental Health: The Foundation of Your Career**

CHARTING YOUR COURSE: BALANCE IN YOUR PERSONAL AND PROFESSIONAL LIFE

Brian Kubacak, M.D.

“How many people on their deathbed wish they had spent more time at the office?” asks author Stephen Covey (Covey 1994). This rhetorical question encourages us to evaluate the balance between our personal and professional lives. As residents, it is especially easy for us to become absorbed in our work. However, defining your happiness and success based on professional or financial achievement can lead to the disturbing realization that it was accomplished at the expense of relationships and opportunities for personal and spiritual growth.

Finding the proper balance is a challenge that takes a concerted effort and constant reevaluation. Days spent as a psychiatry resident can be hectic: teaching medical students, attending lectures, seeing patients, returning phone calls, seeking managed care approvals, charting notes, formulating treatment plans, and moonlighting to pay back the cost of medical school, while supporting yourself and significant others. Knowing this, we must begin to establish priorities, set goals, and manage our time effectively so that we can achieve social, spiritual, and professional fulfillment.

Knowing what gives your life meaning is the foundation on which all other decisions, goals, and scheduling of time should be centered. The establishment of priorities becomes essential for future growth and development. Writing these priorities down and reviewing them on regular basis helps to reinforce them and makes it easier to organize your time.

Once you have determined what brings meaning to your life, you can begin setting goals related to these specific desires and ambitions. Many people regularly set goals in their professional lives, yet most fail to establish goals in their personal lives. Without specific goals in both areas, you might begin to focus strictly on professional achievement, diminishing the rejuvenation you gain from outside activities. Personal goals may include such things as making time for hobbies, exercise and fitness activities, or quiet time to relax. If you are married or have a significant other, it may be to have frequent dates, annual vacations, dinner together on a regular basis, or simply to improve listening and communication skills. If you have children, you may consider spending more time with each child, or plan monthly family outings. If spiritual practices are a priority, you might find it helpful to meditate or pray, read inspirational material, or

attend worship services. Professional goals may include reading various texts or journals, preparing for the PRITE or National Boards Exams, giving lectures for medical students, preparing grand rounds, pursuing research interests, becoming involved in professional organizations, or addressing weaknesses that would enhance clinical skills or efficiency. The goals should be realistic and achievable, but avoid setting too many in the beginning to prevent feeling overwhelmed. As you succeed in accomplishing your established goals, you might want to add others. Enthusiastically commit yourself to these objectives, and you are likely to feel fulfilled, both personally and professionally.

Obtaining goals will require you to manage your schedule carefully. Instead of simply planning for the day, plan for the week, month or even year. A more long-term approach allows you to balance work, family, friends, leisure, and spiritual endeavors. Remember your goals as you make appointments, and schedule specific time for yourself and significant others. There will be times when changes must be made to accommodate urgent needs, so remain flexible in adjusting your daily schedule, without losing sight of your long term perspective.

Regardless of how effective you are at managing your time, there will be occasions when obstacles will impede your vision for the future. Some self-imposed errors to avoid include: poor planning, procrastination, striving for perfection rather than excellence, failure to delegate certain tasks, excessive socializing, and taking on more work than you can handle (Culp 1994). It is vital that you learn to say “no” when asked to do more than you believe you can successfully handle. This may be difficult at first because of your innate desire to please others and be successful. However, after examining your conscience and connecting with your heart’s desire, you will realize that you must choose how best to invest your time. Above all, use a “win-win” rather than a “win-lose” approach to time management. A “win-win” mentally encourages you to find ample time for everything of importance, while a “win-lose” mentality forces you to make sacrifices in order to meet urgent demands.

Finally, you are probably incredibly busy, and working on establishing priorities, setting goals and employing time management strategies may initially require you to step out of your comfort zone. While this may not be easy, remember that most good things in life require some devotion. Think of your life as being governed by a compass and a clock (Covey 1994). As you chart your course, choose the direction that helps you make the most of every moment to find the peace and quality of life you are seeking.

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BENEFITS (AND PITFALLS) OF GETTING YOUR OWN PSYCHOTHERAPY

John Barker, M.D.

“But where and how is the poor wretch to acquire the ideal qualifications which he will need in his profession? The answer is in an analysis of himself.” (S. Freud 1937)

Freud’s remark regarding personal analysis – a standard of training a generation ago – is cited less often today. According to studies, a majority of current residents do not get personal psychotherapy. One recent survey (Weintraub 1999) of three residency programs found that an average of only twenty percent of current residents had used personal psychotherapy during their training, whereas an average of seventy percent of residents from the years 1970-94 had done so. Reasons for this decline are several, and probably include less insurance reimbursement for psychotherapy, an increased training focus on psychopharmacology at the expense of psychotherapy, more frequent use of medications to help with mood, and questions about the effect of personal therapy on future insurability. The lack of clear-cut evidence that personal therapy can quickly improve one’s own psychotherapeutic skills could also contribute to this decline (Greenberg and Staller 1981, Dubovsky and Scully 1990).

Personal psychotherapy can be rewarding both in terms of personal growth and in your ability to understand and empathize with patients. This chapter will examine the pros and cons of getting therapy during residency training.

Indications and Needs

Obviously the most important consideration regarding psychotherapy is personal need. Estimates of psychiatric disabilities in residents have ranged from four to eight percent (Russell 1975). In these circumstances, there is little question about the importance of therapy. Lacking such disability, residents may seek therapy for acute problems, including those created by the stress of the residency. It is important, however, not to confuse difficulties particular to the processes of beginning a residency and acquiring a professional identity – role confusion, frustration and irritability, social isolation, even depression – with psychopathology that would require longer-term therapy (Dubovsky and Scully 1990). In other words, brief or supportive therapy might be what is indicated for routine job stress

or for a relatively normal transition through age-appropriate developmental stages.

Understanding the Process

Lacking any crisis, there remains the question, “Why do it?” If you are coping well and therapy is begun for professional reasons only, the experience may be distorted by a lack of motivation for personal change and even risks becoming a hazing ritual for new members of the profession. In 1974, Yager commented, “An analogy in surgery would have all the surgery residents compelled to undergo ritual circumcision (p.497).” On the other hand, psychiatrists have been using their own therapy for training purposes for years, seemingly without being damaged by the process. This is because the motivation to understand therapy springs not from an impersonal professional imperative, but rather from the very personal experience of reacting to your own patients. Not to examine those reactions risks seriously compromising your development as a therapist.

A resident may inject his or her own unconscious needs into the practice of therapy if he or she avoids patients’ issues because they bring up personal conflict, or if he or she mistakes the office as a place for personal support (giving new meaning to the term “supportive” therapy). This situation must be examined in order to practice effectively. Fortunately, examining such phenomena in your own therapy can yield great personal rewards, as well as (eventually) make you a better therapist. Such personal rewards are unavoidable for a good therapist and are nothing to feel sheepish about. Or, as a supervisor once remarked in response to criticisms of physicians who go into psychiatry to understand themselves better, “What other reason is there?” But do not mistake supervision for personal therapy – it is not confidential and has another purpose entirely. Get your own therapist.

Does the experience of getting personal therapy help a *training* therapist with his or her therapeutic skills? The answer is complicated. In a review of the literature on the effect of longer-term, insight-oriented therapy on psychotherapists, Greenberg and Staller (1981) drew several conclusions. Personal therapy seems to improve therapists’ ability to respond actively to seriously disturbed patients and to deal constructively with transference phenomena in less-disturbed patients. It increases the empathic ability and therapeutic alliances of *experienced* therapists, but may *decrease* the empathic ability of inexperienced therapists, probably due to an increase in emotional turmoil as newer therapists deal with their own

personal problems. The clinical utility of personal therapy depends both on how well you were coping without it, and on when you begin it. If you wait until you begin to practice therapy yourself, the initial shock of residency may already have resolved.

Practicalities and Decisions

There are also practical issues to consider. Residents have little time for psychotherapy, and little money to pay for it. The real, but indeterminate, possibility that psychotherapy will later increase the cost of disability or life insurance premiums can be an additional deterrent to treatment. And, while it is not usually an obstacle to licensure, state medical boards may ask about one's experience in therapy.

Lacking any compelling need, the decision to get psychotherapy involves weighing many factors, including the possibility that it may initially make life more difficult. The fact that most current resident supervisors have probably undergone long-term therapy may make it more difficult to evaluate this decision independently. The current trend toward not getting therapy while in residency may, in part, reflect a decreasing resident interest in understanding the process, as well as a caution about the "external costs" of therapy in terms of time, money, and insurability. The evidence that it can improve specific therapy skills balances these externalities for some, and the decision may become simply one of when to do it. If undertaken during residency, psychotherapy can help you cope with and understand countertransference and transference reactions. It provides a separate, confidential environment in which to observe these phenomena and the curiously common parallel processes between your own therapy and that of your patients. This, in and of itself, may make the decision to get therapy during residency training worthwhile.

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PARENTHOOD AND RESIDENCY: NEGOTIATING PARENTAL LEAVE

**Laura Davies, M.D.
E. David Hjellen, D.O.**

There are no randomized controlled trials about the right time to have children. Starting a family during residency is certainly a challenge, but also rewarding. If you and your partner are ready for children, residency, in and of itself, should not be the stumbling block. While many of us are experts at deferring our “real lives,” enabling us to get through college and medical school, at some point, we want to get to the “generativity” developmental stage. If that is where you are, residency is not a contraindication for having a child.

The more flexibility you and your training director have, the better. Life loses much predictability once a baby comes into your life. However, there are ways to make the experience simpler for you and your program throughout the planning process, the realization of your goal (a.k.a. birth!), and while raising your family.

Planning

You might have time to plan for a child during your pregnancy, or you might adopt on quick notice. Whatever time you have in the planning stage, it is important to focus on your needs, now and after the baby comes. You might want to arrange your schedule to do the more difficult rotations now to get them out of the way, or you might need to have a more relaxed schedule if you or your partner’s pregnancy is difficult. Many women find themselves exhausted during the first trimester, dragging through workdays then napping as soon as they get home. Some are virtually bedbound with nausea. Other women do not notice much change at all and describe pregnancy as a time of unexpected well-being.

When thinking about having a child, it is important to take a look at how much energy you have right now. If you are already stretched, something will have to go once the baby comes. So think about your priorities—sleep, exercise, nutrition, relationships, work, studying, travel, hobbies, etc.

Before talking with your program director, you need to clarify your own needs and wishes. You also need to look at the program regulations/information booklet that outlines leave policies. Talk with other residents who have had children. They are your best resource for advising you about your particular program and recommending what approach to use. When you tell your director is

an individual decision. Although more notice is helpful for planning coverage, there may be other reasons to delay discussing your plans.

Considerations When Planning for Parenthood

1. What order to do rotations? Outpatient vs. inpatient? Consult? Can neurology or medicine be deferred until a later year, if necessary?
2. What is the safety net? What happens if you require bed rest? What if you need additional time off once the baby comes home? Is there a backup for taking call?
3. What are the program's expectations of residents? Call responsibilities? Didactics? Teaching students? Can these be rearranged to suit your needs?
4. What is the culture of your residency program? How are other parents doing? Would you be seen as a "slacker" or would your peers support you? If you are thinking of going part-time, is there someone who would share your slot with you?
5. How long *exactly* is parental leave? Is it automatic, or do you only get sick leave for certain conditions? Do adoptive parents and fathers have the same leave benefits as biological parents? Leave can range from one week to four months at different institutions. Can your vacation be taken all at one time? At what point will a longer absence mean a delay in graduation? Check the ACGME and ABPN standards if you are not sure.
6. What portion of the leave will be paid? Will your insurance benefits continue unchanged, or at a lower level? (Also make sure that your insurance covers healthy newborns, who are sometimes excluded). The Family Medical Leave Act stipulates that you may take twelve weeks, but this may or may not be paid.

Your Right to Request Leave

1. ACGME: The ACGME does not require residency programs to provide a specific amount of annual paid or unpaid leave time for paternal, maternal, family, or sick leave. However, the ACGME does state that the program director must provide written information to applicants and residents regarding financial compensation, liability coverage, and the policies regarding vacations, sick leave, parental leave, and other special leaves. This information should be available through the program coordinator or the program director. Do not be afraid to request this information prior to planning a pregnancy.

2. FMLA (Family Medical Leave Act): The FMLA is a federal regulation that states that any employer who employs more than fifty people must offer any employee who has worked more than twelve months at least twelve weeks of paternal, maternal, family, or sick leave. This rule applies to most (if not all) residencies because when you include ancillary staff (administrators, secretaries, etc.), most residencies employ more than fifty people. There is no requirement that the leave be paid, and it is likely that a resident will have to make up any missed rotations, but you will still be entitled to the time off work for a qualifying event.

Baby Arrives

Initially, parenthood is all consuming. Then you begin to shift your focus a little wider and start to contemplate integrating the baby into the rest of your life. Work-wise, this means deciding when to go back, whether to return full-time or part-time, and how to arrange for childcare. Pay attention to your own feelings and energy level. If you decide that what you arranged before you became a parent will not work for you, remember that you have options. As my mentor says, “This is not the ICU.” There is time to think of alternative arrangements. Speak with other parents, new and experienced. It helps to normalize your own feelings.

Networking is the key to negotiating the transitions involved in starting a family. Prior residents are often happy to share their experiences and how they might have done things differently. It is also important to connect with supportive supervisors who can address issues of pregnancy in therapy or countertransference sparked by newly developed parental instincts. Throughout the process of starting a family while in residency, stay as clear as possible about your needs and preferences in order to get the best fit possible for you and your work situation. Enjoy the process and the wonderful end result!

SPIRITUALITY AND THE PSYCHIATRIC RESIDENT

Daniel B. Martinez, M.D.

Daniel O. Rippetoe, D.O.

In the past, writing on the topic of spirituality among psychiatrists might have been discouraged. Today, the examination of one's own spirituality is encouraged and necessary to provide optimal healthcare to our patients. It may also be of benefit to our own health. The purpose of this chapter is to consider the idea that a psychiatric resident brings his or her own spiritual beliefs to the psychiatric session. This chapter will consider the following three topics: (1) changes in psychiatry regarding its view on spirituality and religious practices, (2) the spirituality of the resident, (3) psychiatric training and the issue of spirituality.

Religion and Psychiatry

The once held view of religion/spirituality as neurotic by the field of psychiatry has taken a sharp turn in recent years (Freud 1966). Contrary to the portrayal of religion as pathological in the DSM-IIIR, in 1994 the DSM-IV acknowledged for the first time a non-psycho pathological category entitled "Religious or Spiritual Problem" under the section "Other Conditions That May Be a Focus of Clinical Attention" (Larson 2000). The field is not simply more tolerant, it now encourages trainees to learn about the religious/spiritual practices of patients and to view them as possible resources for improved physical and mental health (Sloan 1999). This is in tune with the recent attention to training in cultural sensitivity since religious beliefs and practices are often intertwined with cultural identity.

Our individual beliefs as psychiatric residents become relevant as we consider the beliefs of our patients. Thus, taking the time to discuss the spiritual life of the psychiatric resident may be essential to well-rounded training. Eighty percent of psychiatrists believe in God, compared to ninety-six percent of the general population (Gallup 1996). Although this number is high, in order to include as many residents as possible, we will discuss a resident's spirituality in the broadest way possible, rather than refer to "God." We will focus on personal views and behaviors that express a sense of relatedness to the transcendental dimension or to something greater than the "self" (Mathews et al 1998). From this point of reference, we will consider the individual "spiritual life" of a resident as it relates to his or her personal and professional life.

The Psychiatric Resident as a Spiritual Being

Since 1977, Engel has encouraged the medical illness model to be understood from a biopsychosocial perspective (Engel 1977). Over the last twenty-five years, there has been an increasing emphasis on the ethnocultural aspects of mental health. For some, including residents, spirituality is an integral part of their cultural roots. For others, it has been a discovery through the journey of life, including the journey toward becoming a physician/psychiatrist. In whatever way we have attained our belief system about the meaning of life, a personal inventory may be important. Who am I? Why am I here? What is the meaning of my existence? What do I value and why? Understanding our own personal belief system will help us work with our patients, for it will undoubtedly come through in our countertransference.

Spirituality can take many forms. For some people, organized religion offers comfort through ritual and membership in a community of faith. Service to patients as a psychiatrist can become a way of serving God and fulfilling an obligation to help those who suffer. However, organized religion is only one avenue through which people express their spirituality.

Mindfulness is a term that encompasses a variety of practices intended to heighten spiritual awareness. Mindfulness is a simple process that has been defined and utilized in the research setting for attaining a mentally-oriented balance that could be a scientific model for spirituality or transcendence. Researchers with the Consortium of Academic Health Centers for Integrative Medicine have found that regulated daily routine that includes mindfulness can increase immune function, increase resilience to deal with stress, and increase rates of recovery in physical illness. (Gazella 2005) Symptoms of anxiety are associated with and can exacerbate common medical conditions. Dr. Jon Kabat-Zinn describes mindfulness as “the effort to intentionally pay attention, nonjudgmentally, to present-moment experience and sustain this attention over time. The aim is to cultivate stable and nonreactive present moment awareness. This is usually accomplished through a regular daily discipline involving both formal and informal practices including: body scan, sitting meditation, mindful hatha-style yoga, mindful eating, routine activities, stress reactivity and difficult communication.” People with anxiety comorbid to other medical problems, such as hypertension, chronic pain, heart disease or cancer, showed decreased anxiety

sustained after three years of practicing mindfulness, regardless of whether or not anxiolytic medication was used (Miller 1995)

Residency can be the most stressful period of one's career. The benefits of finding a spiritual practice that feels appropriate for an individual resident's philosophy should not be overlooked.

Religion and Spirituality in Psychiatric Training

In 1996, the National Institute for Healthcare Research produced the Model Curriculum for Psychiatric Residency Training Programs: Religion and Spirituality in Clinical Practice (Larson et al 1997). Programs are now beginning to train residents to consider the impact of patient's religious and spiritual practices. If the resident views the patient's spiritual practices as valuable resources, they can be used to promote and maintain mental health.

In conclusion, this new era of psychiatry contends "that a value-free scientific method that is bereft of reflection on ethical philosophical and spiritual values" is not possible (Mathews et al 1998). A ten-year retrospective analysis of two leading journals showed a positive correlation between "religious commitment and mental health" in eighty-four percent of the studies (Larson 1992). Thus, given that all physicians are likely to someday become patients themselves, there is personal and professional value in looking at their own spiritual lives.

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**COMING TO AMERICA: INTERNATIONAL PHYSICIANS AS
PSYCHIATRIC RESIDENTS**
Tonya Foreman, M.D.

As if residency training is not stressful enough, residency often coincides with other major life events including marriage, the birth of children, purchase of a house, and relocation to a new city. Although these changes are positive, they can contribute to a resident's stress. Imagine going through this process in a foreign country!

International medical graduates comprise a substantial portion of residents in psychiatry and other medical specialties. These individuals face the typical personal and professional challenges of residency while they must adapt to a new country. Acculturation requires a stable sense of self and an ability to incorporate elements of the culture of origin with the new culture. Obstacles for international medical graduates can include:

1. **Language barriers.** The USMLE, PRITE, and ABPN exams are not easy for individuals for whom English is their first language. Many international medical graduates have to take these exams in a language that is not their mother tongue. In addition, psychiatry is perhaps more language-dependent than any other medical specialty. Subtle nuances of language and inflection can convey information that is crucial to diagnosis and treatment. A heart murmur sounds the same whether your first language is English, French, or Arabic, but detecting delusions requires a sophisticated familiarity with the patient's language. International physicians for whom English is a second language face a unique challenge and should be commended for their willingness to take on this task.
2. **Cultural adaptation.** Although exciting, going to a foreign country is also stressful. Leaving behind familiar foods, holidays, clothing, music, and social customs can leave immigrants feeling lost in their new country. Adapting to a new role as a physician is made even more difficult when it must be done in a foreign country.
3. **Separation from family.** Most international medical graduates must endure separation from at least some, if not all, members of their family of origin. This separation can take a toll on relationships with spouses, children, and other relatives and friends. If an international resident needs to return to his or her country of origin, it may require a lengthy absence from his or her training program. International travel is also expensive and

takes preparation and planning. Separation from family of origin constitutes one of the major challenges faced by immigrant physicians.

4. **Legal issues associated with immigration.** International residents must navigate the complex, time-consuming bureaucratic tangle of the Department of Immigration and Naturalization Services. The tragic acts of 9/11 resulted in the creation of the Office of Homeland Security and the implementation of many new procedures meant to keep the United States safe from terrorism. However, these procedures can cause innocent residents to experience a nightmare of delays, red tape, and threatened ability to remain in the United States.
5. **Discrimination.** Unfortunately, international medical graduates sometimes experience discrimination from patients, colleagues, and society at large. Ignorance can cause people to behave in ways that make acculturation even more difficult for international residents.

Despite the unique challenges faced by international residents, their presence enriches the landscape of medical practice. The United States is a melting pot, and immigrant physicians are a welcome ingredient in our cultural soup. International residents have as much to teach as they have to learn, and a rich exchange of ideas and culture can result. Please consult the following resources for additional information about international physicians:

American Psychiatric Association:

https://www.psych.org/edu/res_fellows/info_intern.cfm

American Medical Association Department of IMG Services:

www.ama-assn.org/go/imgs

Educational Commission for Foreign Medical Graduates (ECFMG):

www.ecfm.org

Information about Test of English as a Foreign Language (TOEFL):

www.toefl.org

Information on Health Professional Shortage Areas (HPSA):

www.bphc.hrsa.dhhs.gov

Information on the J-1 Exchange Program:

exchanges.state.gov/education/jexchanges/

U.S. Citizenship and Immigration Services:

(800) 375-5283 outside of the United States (785) 330-1048

(automated information only)

uscis.gov

ROMANCE, RELATIONSHIPS, AND RESIDENCY

Beth K. Boyarsky, M.D.

Romantic relationships during residency are healthy and diverting, nurturing our bodies, minds, and souls. They are difficult to begin and even more difficult to sustain during this time. My partner and I went through medical school and psychiatric residency at different times, giving us each the titles of both Resident and Resident's Partner, and with some measure of pride, *Survivor* of Residency and *Survivor* of Partner's Residency. The partnership concerns that arise during residency are sometimes based in reality, sometimes based in fear, and often based on combination of both.

Reality Testing

Reality #1: The resident has intense clinical experiences: success, failure, inadequacy, competence, sometimes birth and death, and no matter how busy, a sense of loneliness at times. The resident's partner has intense personal experiences: success, failure, inadequacy, competence, sometimes death and birth, and no matter how busy, a sense of loneliness. (Do you sense a pattern here?)

Fear: That your partner will not understand or be interested in your work because he or she didn't experience it.

Thoughts: Your partner may or may not completely understand the technical details of your medical and psychiatric experiences, but he or she probably wants to hear about the insights that you develop based on these experiences. Your partner will probably want to share with you the ideas that are stimulated by what you are telling him or her. Share with each other, and listen. Sometimes so much can happen in one day that you may be too mentally exhausted to go over everything at the end of the day. Beep him or her, or use the phone or email to make contact during breaks.

Reality #2: Both the resident and his or her partner are working very, very hard.

Fear: Both of you think, "No one knows how hard I'm working, and what I give is never enough. My partner does not understand how difficult this is."

Thoughts: Keep talking with each other. Each of you is working hard, mostly alone and without each other. Do not be afraid to tell your partner how frustrated you are, and also trust that if they could help you out they would, just as you would do for them. The PGY-1 year is time-consuming, but your personal time becomes more

flexible as you go through residency. Make an effort to leave work at work so the little time you have together is quality time. Relax together. Watch a good movie together. Revisit your favorite restaurant to help remind you why you got together in the first place. Laugh together. If you find that this is not good enough for you to be satisfied with your life as a resident, consider moving into a half-time position. Most residencies have this option, and increasing numbers of residents are taking advantage of this opportunity.

Reality #3: You do not see each other as much as you used to. Everything feels more rushed – because it is.

Fear: Intimacy will be lost because there is not enough time for closeness.

Thoughts: A good psychiatrist understands the value of relationships, and there is nothing more important than your relationship with your partner. Take time as you can. Do what you can together. Go grocery shopping, or do the laundry together. Touch each other. Hold hands. Massage each other's feet. Cuddle when you sleep. Savor the moment, because that may be all you have for now. Moonlighting may be financially necessary, but spending more time at home might be well worth economic sacrifices.

Reality #4: Being away from the kid(s).

Fear: They can't live without you.

Thoughts: If you do not find a way to somehow put yourself in their lives, they will learn to live without you, which is not what you want. Call them on the phone when you are working late or on call. Try to have them take a dinner break with you in the cafeteria. "Accidentally" wake them up occasionally when you get home and check on them. Make it a priority to schedule family outings.

Reality #5: You do not have the kind of life you once had.

Fear: That if you do not have the kind of life you once had, your relationship will die.

Thoughts: Have confidence in the strength of your relationship. Help your partner keep this faith. Keep a list in your mind of all the things you are going to do as soon as you are able. Share this wish list with your partner. Incorporate his or her wish list into a dream you both share, and make as many plans together as you have the imagination to create. Romance can take different forms at different stages in your life.

Reality #6: Many psychiatry residents and faculty work closely together, sharing emotionally-charged times. We have a lot in common with each other. At times, we may feel guilty that we are sharing intimate pieces of ourselves that we may not have shared with our partners.

Fear: Our romantic relationship is in trouble, or that we are in love with another resident or faculty member. Our partner may become jealous of the information we share with colleagues.

Thoughts: Be honest with your partner about the emotional intensity of some collegial relationships, but set appropriate boundaries with colleagues so that you do not share information that would make your partner uncomfortable.

Reality #7: You do not have a partner, and it seems impossible to find one now.

Fear: You are unlovable because you are (choose the best answer): a) a psychiatrist, b) never home, c) getting too old, d) boring because all you do is work or study, or f) so adept at psychiatric assessment that you rule out most of your dates within the first fifteen minutes of conversation.

Thoughts: Most of the people we see at work are “off limits” for romantic relationships because they are our patients. When you think about it, we see relatively few people we might actually consider dating during our working hours, and for an intern, that may be sixteen hours a day. Sometimes we can get so wrapped up in identifying pathology that we forget that most people (including ourselves) also have pathology, just not in pathological amounts. Where can we meet normal people who are willing to tolerate spending a lot of time without us? This is the hard part. Try your church/synagogue/mosque. Look to your neighborhood or your nuclear family’s neighborhood. Go to your friends’ and family’s weddings. If you do not find a mate, it is not because you are unlovable. It is because you need more time with normal people. Get a hobby. Cultivate friendships. Develop a life and fill it with good things. If you build it, a mate will come.

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OPENING THE CLOSET DOOR: RESIDENCY AND SEXUAL PREFERENCE

Leah J. Dickstein, M.D., M.A.

Although the American Psychiatric Association voted in 1973 to amend its diagnostic code to state that “homosexuality per se is a variation of normal and consequently no longer considered a mental illness,” cultural stereotypes persist (APA 1973). By the time you reach residency, you will almost certainly know someone—a colleague, classmate, neighbor, relative, or friend—who is gay or lesbian. You may be homosexual or bisexual yourself. If you have not done so already, psychiatric residency can provide you with an opportunity to explore your feelings about the sexuality of others, as well as yourself.

Clearly, no resident applicant should be asked about his or her sexual preference, nor feel obligated to inform training directors or others with whom they interview. Nevertheless, stigma and discrimination still persist. Assumptions and questions may startle, shock, or pain the gay or lesbian applicant or resident.

A larger-than-expected percentage of gay/lesbian/bisexual residents seek training in larger metropolitan areas where they believe they will find more supportive social communities. However, all residents and faculty members must be sensitive and respectful to all residents. This respect extends to departmental social functions to which a resident brings a same gender partner, thus identifying himself or herself for the first time as homosexual. Having reached psychiatric training, all residents should take time to reflect, understand, and re-evaluate the personal values, and perhaps biases, with which they grew up. As psychiatrists, we must be sensitive and empathic to the question we ask all patients in the first psychiatric contact, “What is your sexual orientation?”

The Association of Gay and Lesbian Psychiatrists (AGLP) publishes a newsletter and directory and invites all psychiatrists to join if they wish to be part of a national referral system. If you are working through your own feelings regarding sexual identity, attending a national meeting and/or contacting a member can be helpful. This can also be a way to meet gay-friendly psychiatrists in your geographic area.

If you are a gay, lesbian, or bisexual resident and you feel a need to seek mental health consultation, please do so. Sometimes seeking treatment can be a sign of maturity and mental health!

Two excellent texts you will find useful, regardless of your sexual orientation are:

1. Cabaj R, and Stein T: Textbook of Homosexuality and Mental Health. Washington, DC: American Psychiatric Press, 1996
2. Guss J, and Drescher J: Addictions in the Gay and Lesbian Community. New York: Haworth Press, 2000

Another helpful resource is:

Association of Gay and Lesbian Psychiatrists (AGLP)

4514 Chester Avenue

Philadelphia PA 19143-3707

(215) 222-2800

www.aglp.org

Reference:

American Psychiatric Association Board of Trustees minutes of the meeting, December 14-15, 1973

YOUR PERSONAL MENTAL HEALTH: THE FOUNDATION OF YOUR CAREER

Leah J. Dickstein, M.D., M.A.

The issue of whether or not to obtain psychotherapy as part of your residency training has been addressed in another chapter in this book. The goal of this chapter is to remind you that nobody, not even a physician, is immune to serious mental illness. As a psychiatrist for nearly three decades, I have been honored to spend most of my clinical career, by choice, treating more than a thousand medical students and residents as patients.

You may have sought consultation for a personal life issue or been treated for a psychiatric disorder before entering residency. You are well aware that receiving timely professional care enables one to feel better emotionally and physically and to succeed with studies and enjoy life. As a resident, you must be wise and courageous to recognize sooner, rather than later, if you need mental health treatment. You will be unable to function well in any of your roles—physician, spouse, parent, friend—if you are suffering from an untreated mental illness.

If you have symptoms of a mental disorder, do not try to treat yourself. The old adage “someone who has himself for a physician is a fool” is true. Ask your primary care physician or someone in your department for a referral. You do not have to tell anyone who the referral is for if you are uncomfortable saying it is for you. The state and county medical societies are other potential sources of referrals or information.

You have worked long and hard to reach your goals. If you think you need professional help, get it immediately. In this situation, you come first.

PART IV:

AND JUSTICE FOR ALL: LEGAL ISSUES IN PSYCHIATRIC TRAINING

- Sexual Harassment: You Don't Have to be a Victim!
- Gender Bias Issues
- When Attending Physicians Appear Impaired

SEXUAL HARASSMENT: YOU DON'T HAVE TO BE A VICTIM!

Cathy K. Bell, M.D.

Sexual harassment is unpleasant and frightening. It is not an uncommon occurrence in the residency workplace, but often remains unrecognized and underreported. No one should have to endure sexual harassment. This chapter will briefly cover three areas: (1) definition of sexual harassment; (2) steps to take if you are a victim of sexual harassment; and (3) common emotional reactions to sexual harassment.

What is Sexual Harassment?

All residency programs should have a policy on sexual harassment since both state and federal laws prohibit it. Sexual harassment is defined as unwelcome sexual advances, requests for sexual favors, or other physical or expressive behavior of a sexual nature when:

- submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment, educational benefits, or services;
- submission to or rejection of such conduct is used as a basis for employment or academic decisions affecting the individual;
- the conduct has the purpose or effect of unreasonably interfering with an individual's professional or academic performance or creating an intimidating, hostile, or offensive working or educational environment; or
- such conduct is sufficiently severe or pervasive as to alter the conditions of an individual's employment and create an abusive working environment. (AMA 1997)

As you can see, the definition includes phrases that are not entirely clear. For example, phrases such as "unreasonably interfering," "intimidating, hostile or offensive environment," "sufficiently severe or pervasive," and "abusive working environment" are open to interpretation. The important point is that if someone's statements or behaviors make you feel uncomfortable, you should discuss it with a trusted supervisor or mentor so that the situation can be resolved.

Listed below are scenarios that may constitute sexual harassment and should be reported to the residency training director.

1. A faculty member with whom you work persistently comments on your attire and/or attractiveness, making you uncomfortable.
2. A fellow resident continues to ask you out despite multiple refusals on your part. As a result, you find yourself avoiding him or her in the halls. You adjust your routine so that you don't have to interact with the resident.
3. You suspect that an upper level resident gives you a poor evaluation because you refused to go out with him or her.
4. A faculty member uses sexual jokes while teaching residents and medical students. You feel obligated to endure the constant jokes and laugh at them because you are afraid of receiving a poor evaluation.

Sexual harassment often involves a power differential that makes it difficult for you as a victim to assert that the sexual advances are unwelcome. The behavior makes you feel uncomfortable or makes the work environment unpleasant. It persists despite repeated attempts to discourage the unsolicited behavior. In some situations, sexual harassment can be subtle, but can have a tremendous impact on an individual. Therefore, it is important for you to understand what constitutes sexual harassment so that you can take action if it happens to you or a colleague.

Steps to Take if You Experience Sexual Harassment

Under most circumstances, the best first step is to ask the individual to stop the offensive behavior. This is not always possible, however, due to power differentials and fear of retaliation. All programs should have a sexual harassment policy that indicates to whom you should submit a detailed written report of what has transpired. Your employer is legally required to investigate the incident(s), protect your confidentiality as much as possible, and determine the best course of action to remediate the situation quickly. It is illegal for an employer or employee to impose any punitive action against you for reporting a possible case of sexual harassment. There are alternative ways to address the issue if you believe the residency program is not responding in a way that you believe is appropriate. You can file a complaint with the equal employment officer from the affiliated hospital and/or the university with which your residency is affiliated. They are obligated to investigate the

situation or provide guidance about additional actions you should take. If the sexual harassment is severe or you believe that you might be in danger of physical harm, you should file a police report and consider obtaining a temporary restraining order. The goal is to ensure your safety and seek information that will help you decide what action to take. The process can be overwhelming, so it is important to identify individuals who will support you in the process.

What Can I Do to Get Help?

Sexual harassment is traumatic. Common emotional responses include denial, guilt, self-doubt, anger, depression, anxiety, and fear. Common thoughts include the following: “I’ll just ignore it,” “Nothing can be done anyway,” “My program director will think I’m overreacting,” “Other residents will think I’m a prude,” “Maybe I encouraged it,” or “It will be embarrassing”. If you find that your emotions are affecting your well-being or your ability to perform your work competently, it is time to seek help. The experience can make it difficult to sleep, concentrate, listen to patients, and provide care to others with emotional needs. At the very least, you need to find someone who will validate your feelings and support you in not tolerating a hostile work environment. A friend, individual psychotherapy, related reading materials, or some time off from work can be helpful and may be necessary in order to regain optimal functioning. Seeking help early, even if you are functioning adequately, can often ameliorate the situation quickly so that you can focus on your training.

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GENDER BIAS ISSUES

Leslie Hartley Gise M.D.

In her book, Hardball for Women, Pat Heim says, “To change the game we’ve got to get the power first, and that usually requires adhering to the establishment rules...we need to learn how to rely on other women.” (Heim, Intro) Although discrimination against women has generally decreased over recent decades, from time to time there is a backlash, and more subtle forms of bias emerge. In a favorable economic climate, opportunities for women may increase. However, when there are cutbacks in funding for research and clinical services, men may tend to get priority over women for these scarce resources. Following are some issues to consider if you are a female psychiatric resident:

1. **Stand up for yourself.** How many times have you answered the telephone, “This is Dr. So-and-so” and gotten the response, “Put the doctor on the phone!” Women are often introduced differently from men, either by their first name or by their family role. What resident has not completed a history and physical, ordered laboratory tests and medication, and explained a treatment plan to a patient only to hear “Thank you, nurse,” or be called “Miss” or “Mrs.” and not “Doctor”. Since there is still ignorance about women physicians, you must condition yourself to say calmly, “My name is Dr So-and-so.”
2. **Speak up.** What woman has not been in a meeting and made a comment that is ignored? A few minutes later, a man makes the same comment and gets praised. Men tend to talk a lot and may interrupt each other. They are more willing to be confrontational and less likely to become emotional. Watch successful women to see how they make their voices heard amidst a sea of men. Women may need to adopt some of the strategies men use in order to get our points across.
3. **Learn the rules of the game.** Another rule of the game that is difficult for women to understand is how men can be at each other’s throats at work but be drinking buddies at night. Boys grow up playing adversarial games, and “when the game is over, it’s over” (Heim, p 17). Women need to learn how to be team players without becoming overly invested in interpersonal dynamics in the workplace. The successful woman has a job to do – every person may not love her, but she will get the job done.
4. **Keep your emotions in check.** Pick your battles. When situations become tense, you are better off if you behave pleasantly and calmly, without screaming and causing a fuss. Remember that when a man turns red in the face and pounds his fist on the desk, “the boss is

having a bad day,” but when a woman does the same thing, she is called “hysterical” or written off as having PMS. Other labels that are used to discredit women include the following: bossy, obnoxious, overbearing, ambitious, and bitchy (Heim, p 8 and 20). So just acting like a man will not work. Women have to “operate within a narrow band of acceptable behavior” and know “how far to go without overstepping the bounds” (Heim, p 20).

5. **Keep your radar on.** With regard to sexual harassment, your radar must be on. Unsolicited comments about your appearance and sex life are unacceptable. Be aware of gender bias and unequal treatment. If behavior or comments seem out of line to you, speak up. Ignoring such events can be dangerous and lead you down the slippery slope toward sexual harassment. If you are not sure whether a statement or an action was inappropriate, discuss it with a colleague. Think about the situation, and then plan your response. Consider the consequences before you take action. In many cases, a firm statement of your point of view will be sufficient. For example, “Dr. So-and-so, perhaps you meant no harm by your comments about my appearance, but I don’t think such comments are appropriate and I would like you to focus on my work and my education.”
6. **Network and look for mentors.** Networking and mentoring are two related areas where women are often at a disadvantage. Most leadership positions are currently filled by men, who often think of their male junior colleagues when opportunities arise. These male authority figures are accustomed to advising and promoting men. When women are not considered for positions and not helped to get them, they lose out. As a woman, you might have to work harder to connect with people in power who can help guide your career path. Mentors can be women or men, and you are advised to think about having several mentors.
7. **Look to the future.** Women professionals often tend not to look ahead, make choices, or develop strategies to achieve successful careers. They often take a more passive position. Many women get so busy working in the present that they fail to take the long view and focus on what they ultimately desire professionally. Mentors can help you develop goals and chart a roadmap for achieving them.
8. **Stretch yourself.** “Don’t back away from leadership positions” (Heim, p 129). If you are offered an opportunity that seems completely overwhelming, stop, take a deep breath, and consider it carefully. You do not have to say “yes” to every opportunity that comes your way, but do not shortchange yourself and your potential for growth. Be prepared to take calculated risks. Women are not necessarily more reluctant to take risks than are men. Still, if you do

not look ahead, you cannot strategize. You can't be guaranteed a win every time, but if you don't throw your hat in the ring, you will definitely miss out.

9. **Blow your horn.** In many cases, you may have to prove yourself before you are taken seriously. If you have done something well, you must learn to be a public relations department for yourself and make sure your supervisors know about it. Do not be afraid to a self-promoter sometimes.
10. **Be cautious.** Many women are interested in the field of women's health, which is both interesting and provides an opportunity for valuable work. However, some people believe that a professional focus on gender issues is bad for a woman's career. If you choose to study gender issues, be aware of the potential consequences of not being on the main playing field of psychiatry. You may want to supplement your expertise in women's issues with some more mainstream endeavors in order to get the recognition you deserve.
11. **Seek support.** Associations for women can provide networking, troubleshooting, and friendship. Sharing war stories is a way of bonding and connecting. Women tend to have assets men do not have. We tend to be better listeners and to work collaboratively (Heim, p 270). Think about what Kathleen Brown, California State Treasurer, said. "The difference between men and women is that women seek power in order to address issues, while men address issues in order to seek power." (Heim p 272). This may or may not be true, but give some thought to what issues you want to address and how you plan to tackle them?

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WHEN ATTENDING PHYSICIANS APPEAR IMPAIRED

Leah J. Dickstein, M.D., M.A.

When residents' behaviors signal mental illness, attendings and peers should, and do, intervene to insure that the resident gets the psychiatric evaluation and treatment needed. However, when behaviors of an attending physician suggest mental illness, intervention may not take place for a variety of reasons.

Physicians as Patients

Physicians often have difficulty accepting the patient role whether they have medical, psychiatric, or substance abuse issues. Physicians use their intelligence and knowledge to deny symptoms, signs, and needs for medical intervention and care. Below are some reasons that physicians deny or minimize their symptoms:

1. Fear of what their symptoms mean
2. Fear of medical care mishaps
3. An overvalued ability to self-diagnose
4. Concerns over the impact of illness of practice
5. Difficulty entrusting care to colleagues
6. Concerns over the reaction of patients, colleagues, family
7. Worries about confidentiality
8. Avoidance of discomfort or indignities of a diagnostic work-up or treatment (Goldman 2000)

What Can I Do?

As a resident, you might ask yourself: who should I tell when my attending arrives late, smells of alcohol, is irritable for no apparent reason, seems depressed, and appears unable to concentrate? What do you do if your supervisor tells you about problems with significant others, talks about suicide, or is seen putting medication samples in his or her own pockets? These hypothetical situations present difficult dilemmas for residents. The imbalance of power between the resident and the impaired attending, as well as the transference to this "parental figure," must be acknowledged honestly and immediately so appropriate actions can be taken and tragedy avoided.

If you are concerned about the well-being of an attending, speak immediately to another faculty member. Respectfully and confidentially report what you have seen and heard. Your expectation should be that this faculty member will take action to insure that the attending in question is contacted, confronted

carefully, and evaluated or treated as indicated. If, as a lone resident, you are hesitant to make the report, ask your chief resident for assistance in reporting your concerns. After you have notified the faculty leadership in your department, they will decide whether referral to the employee assistance program or the medical licensure agency is necessary. You should familiarize yourself with regulations in your state regarding reporting impaired providers.

Hopefully, you will never face the situation of having a potentially impaired supervisor, but if you do, act quickly and appropriately. It is better to take a risk and intervene than to attend a memorial service because people were too frightened to speak out.

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PART II:

ENTRUSTED TO YOUR CARE: SPECIAL ISSUES IN CARING FOR PATIENTS

- Understanding the Diverse Cultures of All Patients
- Boundary Issues in Psychiatry
- Looking the Part: Professional Attire
- When it's Time to Say Goodbye: Terminating With Patients When You Leave
- When Disaster Strikes
- Advocating for Psychiatric Patients

UNDERSTANDING THE DIVERSE CULTURES OF ALL PATIENTS

Cathy K. Bell, M.D.

Every individual is part of his or her own unique culture. The fact that Caucasians have unique cultural heritages and that they cannot be understood as a single group has been overlooked for a long time. Failure to recognize this led to the misconception that Western “scientific” psychiatry was the “truth,” devoid of any cultural biases. Minority populations’ cultural beliefs were thus compared to the Western “reality.”

Pitfalls of Cultural Assumptions

The dangers of understanding different ethnic groups from a Western perspective are becoming more evident as the cross-cultural literature expands. For example, a review of the literature reveals that African-Americans are more likely to be diagnosed with schizophrenia, involuntarily committed, placed in seclusion and restraints, and receive PRN medication at higher doses, and may be perceived to be more dangerous and violent than patients from other ethnic groups (Lawson 1996). African-Americans have also been shown to have more adverse effects to psychotropic medications (Lawson 1996). Culture-bound syndromes, such as *ataque de nervios*, previously seen as psychiatric illnesses, are now understood as cultural phenomena.

Traditionally, culture has been defined as the beliefs, values, customs, and behaviors belonging to a particular ethnic group. However, the understanding of culture became more complex when intra-ethnic differences were considered. Newly derived definitions have to account for intra-ethnic differences such as degree of cultural identification, mixed ethnicities, socioeconomic factors, immigration status, sexual orientation, religious affiliation, acculturation, geography, and politics. This recognition of the complexity of culture highlights the importance of gaining a complete understanding of all aspects of a patient’s cultural background.

The pervasive impact of culture requires us to expand our biopsychosocial formulation to a biopsychosociocultural formulation. Understanding the cultural aspects of the patient’s life will provide a fuller appreciation of his or her psychopathology and help create an effective and culturally appropriate treatment plan.

Cultural Implications in Illness, Diagnosis, and Treatment

Each cultural group may experience illness differently and may have a unique explanatory model of illness. For example, a Christian woman may believe that her recurrent nightmares are a result of past sins in her life, rather than a neurochemical imbalance. Her solution may be prayer and repentance, rather than psychotropic medication. Thus, it is important to inquire about the patient's understanding of his or her illness and what he or she believes would alleviate suffering. The physician also needs to recognize how Western medicine's explanatory model and his or her own cultural background may bias diagnosis and treatment. For example, if a psychiatrist grew up with an alcoholic father who was away from home frequently, he or she may feel the need to protect patients who grew up in a similar environment. He or she may overstep professional boundaries that could have disastrous consequences for both patient and physician. As psychiatrists, we must recognize our own cultural biases in order to avoid imposing our own values on patients.

Culture may also affect presenting symptoms of illnesses and interfere with making an accurate diagnosis. For example, Vietnamese immigrants in the United States might present with somatic complaints, but might not be able to acknowledge or express sad feelings. Research has also shown that some psychiatric diagnoses are more common in certain cultures. For example, anorexia nervosa is more common in Western cultures. "Culture-bound syndromes," such as *amok*, *mal de ojo*, or *susto*, occur exclusively in particular cultures. Knowing the epidemiology of psychiatric illnesses and culture-bound syndromes increases the likelihood of an accurate diagnosis.

Finally, consider culture when formulating a case and devising a treatment plan. Cultural factors influence presenting symptoms and affect treatment success or failure. Inaccurate formulations, impractical treatment recommendations, poor compliance, and patient dissatisfaction may result if all aspects of the patient's life, including cultural ones, are not considered. Addressing culture will enhance the healing process and improve outcome.

Training Issues

This was a brief overview of some of the important cultural issues to consider when diagnosing and treating patients. Obviously, no one is able to learn everything there is to know about all cultures, including one's own. Culture is complex, dynamic, and ever

changing. The point is not to know everything about culture. Rather, as residents, we should attempt to achieve the following goals:

1. Appreciate the impact of culture on psychiatric illnesses, diagnosis, and treatment.
2. Be familiar with the many different aspects of culture, including, but not limited to, ethnicity, religion, age, gender, sexual orientation, socioeconomic status, profession, and worldview. Elicit information about these areas during patient interviews and inquire how these cultural aspects affect patients and their illness.
3. Understand your own cultural background and biases and how they may affect assessment and treatment. Individual therapy, clinical supervision, and discussions with colleagues can be helpful tools to gain this type of understanding and insight. Always ask yourself, "Do I understand the patient's needs, values and concerns, or am I imposing my own views onto the situation?"
4. Become adept at using a biopsychosociocultural formulation in understanding psychopathology and devising an appropriate treatment plan. If a particular treatment is not effective, reexamine the patient's situation from all perspectives, including a cultural one, and revise your formulation and treatment plan accordingly.

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BOUNDARY ISSUES IN PSYCHIATRY

Susan Watrous, M.D.

What Are Boundary Issues?

The relationship between a psychiatrist and a patient is unique in that intimate topics are discussed within the context of a working relationship. The rules governing proper behavior in this setting are often unclear. As a general guideline, the therapist should conduct therapy with the understanding that the only personal gratification gained should be that of helping that patient to overcome problems, and the only monetary gain should be that of a monetary fee. Boundary violations occur when the therapist obtains gratification from the patient and not from the therapeutic process itself. The following chapter will address examples of boundary violations and may serve as a guide toward defining, recognizing, and preventing potential boundary violations.

What are Boundary Violations, and How Do They Arise?

Boundary violations are difficult to define and perhaps best shown through the use of examples. The concept of the “slippery slope” (Gutheil 1993) refers to a progressive series of behaviors or actions that increase the risk that boundary violations will occur. Often, these develop from strong feelings for (or from) the patient, leading to extended and/or frequent sessions, after-hours appointments, and off-hours telephone calls. Other clues to potential boundary problems are gift-giving (especially if the gift is expensive or of personal relevance), and “overdoing” for the patient (e.g. helping when the patient should help him or herself, as in finding a job). Bartering for services is also considered risky, although this may be the norm in rural areas. Dual relationships with patients (as in obtaining goods or services through their business) may be difficult to maintain, and can lead to unspoken expectations or dissatisfaction with the goods/services. The intensity of inappropriate behaviors increases when the therapist discloses details about him or herself. Self disclosure has a high correlation with therapist-patient sexual encounters (Borys 1989). The period of time “between the chair and the door” (Simon 1999) invites socialization beyond the therapeutic encounter. And finally, any physical contact between therapist and patient, even if innocent at first, can greatly increase the likelihood of subsequent boundary lapses (with the possible exception of nurturing contact with young children).

Are Boundary Transgressions Ever Acceptable?

There is a not-so-clear distinction between boundary crossings, in which only potential harm to the patient is possible, and boundary violations, which are clearly destructive to the patient's well-being. Sometimes, boundary crossings are appropriate within the setting in which they occur. For example, returning a hug from a patient who has just lost a child might not be considered inappropriate. Shaking an offered hand is generally acceptable behavior. Visiting a patient in the ICU (e.g. after an overdose) or at home (e.g. is seriously ill) can be necessary at times. It is advisable in certain circumstances to have a chaperone present if there are doubts about the patient's perception of such actions. Even such simple actions as providing samples of medication, or medication pamphlets, may be misperceived by certain patients. The context of the situation, and the nature of the relationship with the patient, should be taken into account when faced with situations similar to those described above.

Who Is At Risk?

Psychiatric patients can be at risk for potential exploitation due to low self-esteem, poor judgment, and prior familiarity with boundary transgressions within their own families. They may identify the therapist as an ideal parent who can gratify their wishes, or rescue them from their pain. Patients with a history of sexual abuse appear to be particularly at risk. Any perceived wrongdoing by the therapist, whether accurate or not, may lead patients to allege improper behavior on the part of the therapist. Unfortunately, there are therapists who do engage in predatory behavior towards their patients, and who may even suggest that sexual activity is part of the therapeutic process. Or, therapists may find themselves at risk due to impairment (substance abuse, life stressors, and poor training). Finally, the possibility exists that therapist and patient find what they believe to be a genuine love relationship. This is perhaps the most difficult situation and will be addressed further in the following section.

Legal Implications

The APA holds that "sexual activity with a current or former patient's unethical" (see *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*, 1995; updated in 1998). This means that sexual activity with a patient is unethical

forever, even if the therapeutic relationship has long since ended. Furthermore, sexual transgressions are never considered the patient's fault, even if the patient was the aggressor. Simple boundary crossings may be viewed legally as a presumption of sexual misconduct. For example, a question may be raised as to why the patient consistently had the last appointment of the day. Or why didn't this patient have to pay for services? Was payment being extracted in a different kind of currency?

Three kinds of punitive measures exist for boundary transgressions: state licensing reporting, civil sanctions, and criminal charges. The consequences of boundary violations can be severe, and may include license revocation, dismissal from professional organizations, civil lawsuit, and criminal prosecution (Simon 1999). Malpractice insurance typically does not cover sexual misconduct (although transference-countertransference issues may be covered) (Gutheil 1998). See Gutheil (2005) for case examples.

Prevalence

The prevalence of boundary transgressions is difficult to estimate. Most studies on sexual transgressions rely on surveys, which pose the problem of biased return or frank dishonesty. Estimates of sexual involvement between therapist and patient range from 7-10%, and in light of the previous statement, are probably higher (Simon 1999). Male therapist-to-female-patient transgressions account for the highest percentage (80%), with female-to-female interactions being the least common. One study shows that 87% of therapists do experience sexual attraction to a patient at some time during their careers, but relatively few (9.4%) act upon it (Simon 1999).

Prevention

If a patient behaves inappropriately in the office setting, the best action on the part of the therapist is to identify the inappropriate behavior and process it with the patient. Gift-giving can be addressed by thanking the patient, but advising them that you are unable to accept gifts. Maintenance of professional conduct should include regular scheduling during office hours only, maintaining standard duration of sessions, and practicing within the office setting only. Fees should be set, even if for a token amount. After-hours calls should be taken (or made) in emergencies only. Avoidance of personal disclosure, dual relationships (as defined previously), and

physical contact is also critical. Additional preventive measures such as education (during medical school, residency, and afterward), consultation with a colleague, and personal therapy may be helpful. If necessary, a patient may be referred elsewhere. These recommendations may seem stringent, but the possibility of losing everything, including occupation, reputation, and family, cannot be discounted. Always use your best judgment!

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LOOKING THE PART: PROFESSIONAL ATTIRE

Melva Green, M.D.

Thoughtful attention to dress is a crucial consideration in maintaining both professional and safety standards in any professional environment. This is especially important as it pertains to psychiatry. Following are a few suggestions:

Do's

Although one might think that “dressing down” makes for a more comfortable patient-doctor interaction, most patients prefer traditional professional attire.

1. White coats should generally be worn when caring for patients. Some psychiatrists prefer not to wear a white coat when seeing outpatients, but white coats are expected on inpatient services and in the emergency department and consultation-liaison service.
2. Photographic identification badges indicating name, position, and department should be clear and visible at all times.
3. Although scrubs may be worn while on call or on duty in the emergency department, they should be replaced for standard professional clothing prior to the start of the workday.
4. Be aware that religious jewelry or head coverings may prompt questions from patients. Spend some time deciding how you want to address these questions when they arise.

Don'ts

1. Casual clothing such as T-shirts, tank tops, jeans, mini-skirts, athletic apparel, shorts, sneakers and hiking boots should be avoided. Athletic shoes may be acceptable when worn with scrubs, but they should be clean and well-maintained.
2. Loose jewelry and other accessories that could potentially be used violently against the wearer should be avoided.
3. In some clinical situations, men may want to avoid neckties. For example, you might want to remove your necktie if you are assessing a highly agitated, psychotic patient.
4. Clogs, sandals, and high-heeled shoes are often in residents' shoe repertoire but clearly pose a safety risk. Agility is the key, especially in the emergency department, and any footwear that would encumber should be avoided.

5. Long hair should be tied out of your face if you are dealing with a potentially dangerous patient.
6. Avoid clothing that could be construed as sexually provocative, and err on the side of conservatism. The workplace is not the place to wear your black leather pants or to show off your tan!

Giving some consideration to your outward appearance can help people see you as the competent professional that you are.

WHEN IT'S TIME TO SAY GOODBYE: TERMINATING WITH PATIENTS WHEN YOU LEAVE

Tonya Foreman, M.D.

Terminating with patients, particularly long-term psychotherapy patients, is an inevitable part of residency training. Some patients will leave your care when they move and seek treatment with another provider or when they “graduate” from therapy. The subject of this chapter, however, is when you have to leave because of rotation to another site or completion of your training. Learning to terminate in a timely fashion, gracefully, and therapeutically, are crucial skills to develop during residency. At least three individuals will be affected by the termination process: the outgoing clinician, the patient, and the new clinician.

You and Your Patient

Sometimes you may breathe a sigh of relief as you refer a particularly difficult patient to a new resident. With other patients, saying goodbye may feel like a loss. Terminating with all your patients at once can be overwhelming. Some residents report feeling as if they are in “goodbye overload” and becoming numb to their feelings of sadness about leaving individuals they have known well. This situation may be compounded if you are not only leaving your patients, but your colleagues, office staff, and familiar surroundings, as well. You are likely to have to terminate with your patients at the same time that you prepare to move to another city and leave your residency friends and teachers. These stressors may compound to make you personally (and professionally) vulnerable to some of the pitfalls of termination. The following suggestions can help you make the most of the termination process:

1. Tell your patients early that you will be leaving. You may be surprised by which patients have the most difficulty with termination. Some seem to sail through it easily, while other will struggle with the loss. It is not easy to predict which patients will be the most affected by your absence, so announce your departure far enough in advance to provide time to process it in therapy and for them to work through the issue outside of the therapy session.
2. Remember that the experience of termination can provide grist for the therapeutic mill. Consult your favorite psychotherapy

text to brush up on psychodynamic issues associated with termination (Weinberg 1996).

3. Use your departure to assess whether or not a given patient needs to continue in therapy. You and the patient may decide that most of the goals have been met and that your leaving provides a logical time to conclude therapy, rather than continue in treatment with a new clinician.
4. Do not take it personally if some patients are not as heartbroken by your leaving as you expect them to be. Remember that many patients are used to having their therapists leave – you may have been one in a succession of caregivers involved with a particular patient. The goal of therapy is to have a productive working relationship, not an enduring friendship!
5. Try not to fall into the trap of believing that no other clinician will be able to care for your patients as skillfully as you have. If you develop this attitude, you may convey your feelings to the patient and sabotage his or her ability to form an alliance with the new physician. Remind the patient (and yourself) that although the new physician may have a style that is different from yours, he or she will share your goal of providing quality care for the patient.
6. Be particularly vigilant for boundary violations around the time of termination. You may be tempted to loosen your boundaries as you prepare to leave. While some expression of your sadness about leaving may be appropriate, be careful not to burden the patient with your own issues of loss. Supervisors can be especially helpful by offering suggestions about how to share your feelings with the patient without overwhelming him or her with your own issues. Supervisors can also assist you in deciding how much information to share with your patients about where you will be going, whether or not to provide your new office address to patients, and whether or not to accept gifts.
7. Termination can provide an opportunity for you to assess your development as a clinician. Make use of the chance to summarize your progress with individual patients and your personal progress as a therapist. Your supervisor can be helpful in giving you feedback about your work and identifying areas that you need to improve.
8. Termination is a time during which many patients praise you for your work. Positive feedback from patients can be hard to come by, so savor any kudos that you receive. You may be surprised when some patients tell you how much difference you have

made in their lives. Cherish their kind words and use them to replenish your supply of professional self-esteem.

The New Clinician

As you pack your belongings and look forward to the next assignment, you may be tempted to skimp on completing chart work for the patients you are leaving. Don't do it! If you have ever come onto a service and been the beneficiary of shoddy (or even absent) off-service notes from the previous physician, you know how demoralizing it can be for you and how disruptive it is for the care of the patient. Writing a mountain of off-service notes is not fun, but it is a way of showing respect for the next clinician and for your patients. Several steps can make the process easier:

1. Be organized. Keep a list of all your patients and mark the list each time you complete an off-service note.
2. Start early. Do not wait until your last week to try to write all the notes. After your last appointment with a patient, write the off-service note. Since you only see some patients infrequently, you may be able to sign off on their charts months before you leave the service.
3. Keep complete chart notes throughout the course of treatment. If you are vigilant about documenting changes in the treatment plan along the way, your task of summarizing the treatment will be easier.
4. Take care of little details before you leave. Make sure your patients have sufficient medication for the transition period and that letters or forms are completed before you ride off into the sunset. The new physician will not appreciate receiving frantic messages from patients they have never met who are out of medication because you failed to provide them with refills for the transition period. Similarly, if managed care forms or letters to social agencies need to be handled, do it yourself. The incoming clinician will be overwhelmed and will not be equipped to complete paperwork on unfamiliar patients.
5. For especially complicated patients, you may find it helpful to talk to their new clinician before you leave, or even to arrange a three-way meeting for you, the patient, and the new physician. These meetings can allay some of the patient's anxiety over having a new physician, as well as make the new clinician feel invested in the care of the patient. Do not use a face-to-face meeting as an excuse not to write an off-service note, though. The new physician will still need a written a summary of the treatment course.

6. Use resources such as dictation services, voice-activated computer transcription programs, or word processing programs to compose your off-service notes. You will be able to produce more complete (and legible) notes in less time.
7. Avoid the temptation to do a disappearing act and leave the new physician with a “trainwreck.” If you have a particularly difficult patient, let the new clinician know where you can be reached if questions arise during the transition. Also, make sure the new physician knows your supervisor’s name so that they can contact him or her if needed.
8. Termination is a transition in which fragile patients may fall through the cracks. Consider calling the clinic a few weeks after you leave, just to make sure that the sickest patients have made contact with their new clinicians.

Clearly, termination is a stressful experience. The best way to take good care of your patients and yourself is to prepare in advance, be organized, and seek supervision when needed. Remember that termination can provide a rich opportunity to reflect on our privilege of working intimately with individuals in need.

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WHEN DISASTER STRIKES

Margaret Fang, M.D.

Everyone has been affected by the events of September 11, 2001. Americans have realized that we are not immune to catastrophe. Hopefully, you will never have to participate in disaster management, but disaster management skills are like insurance – you hope you will never have to use it, but you would not want to be caught without it. Following are some insights I gleaned by working as psychiatry resident in New York City on September 11, 2001. I am grateful to the staff at NYU/Bellevue, Dr. Carol Bernstein, and Dr. Zev Levin.

1. Turn off the television. Many adults and children were traumatized by watching the events on TV over and over again. Although being informed is important, re-experiencing visual trauma is not helpful. Recommend that patients and staff limit their and their children's television time.
2. Take care of yourself and conserve your energy. Many residents were so busy volunteering on September 11 that they forgot to take care of themselves. Do not forget to eat, drink, and get enough sleep. (Carry food and bottles of water with you.)
3. Find out if your family and friends are okay. Residents who were able to contact family and friends had peace of mind to help others who were distressed. Return phone calls of your family and friends.
4. Carry your hospital photo ID with you at all times.
5. After taking care of yourself, do not forget to call your patients to let them know whether the hospital system is up and running, or whether routine appointments will be rescheduled.
6. Follow your leaders, and do not reinvent the wheel. Most residents realized after the first few days that they were more effective working through organizations and hospital establishments rather than trying to do things on their own. Scattered individuals make less impact than organizations that can tap directly into already established relationships. (For example, it was easier to volunteer through Bellevue Hospital and Disaster Psychiatry than to walk up to Chelsea Piers as an unknown individual.)
7. When talking to witnesses of disaster, be cognitively concrete. Traumatized witnesses are so emotionally overwhelmed that short and simple statements or questions are most helpful.

8. When seeing traumatized people, first introduce yourself and ask if they want to talk to you. People's space and privacy should be respected. Some people are not ready to talk right away. Make sure traumatized individuals are not hungry or thirsty and that their medical needs have been addressed. (I met a diabetic woman who did not eat and drink for two days because she was so intent on finding her missing fiancé.)
9. Reassure people. Tell people that the government, the hospital, the police, and the establishment will protect them. (I had to reassure a firefighter that no one was going to blow up Bellevue Hospital after he was brought up from Ground Zero.)
10. Ask patients to tell you what had happened and what they were feeling when the disaster occurred. Then normalize what they are feeling. (Do not unload your own emotional burden on patients. Utilize your own supports. Most patients are already overwhelmed.)
11. Educate, educate, educate. Most experiences such as nightmares and trouble sleeping are normal one month after a large disaster. Do not pathologize. Educate people about the risk of substance abuse and alcohol and let people know there are services available to help them.
12. Give people a referral number just in case they need to talk in the future. Ask people if they need anything such as water, food, or access to a telephone. Mobilize people's family and friends around them. Make sure people have a way to get home. (People can be so overwhelmed that they forget this.)
13. Use medications sparingly. Do not give more than one-week supply without following up with patients.
14. Consult colleagues in psychiatry, social work, psychology, medicine, and critical care. Most trauma patients will see primary care doctors first and be referred to psychiatry. Make yourself known to primary care doctors.
15. Remember that trauma does not just affect people at the disaster site.
16. Remember to take care of the staff.
17. Get help when you need it. You are not alone.
18. Beware of your own prejudices and feelings when helping diverse populations. People revert back to old prejudices and ways of coping when there is a disaster. Remember nothing is black and white. (One of the doctors stated that when he saw a Muslim doctor helping a patient, he had to overcome his own initial rage at the physician.)

19. Remember that in times of crisis, psychiatrists are privileged to have services to offer those in need. Be grateful that you can intervene in ways that are enormously meaningful to people who are suffering.

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James.rundell@ramstein.af.mil

ADVOCATING FOR PSYCHIATRIC PATIENTS

Leslie Hulvershorn, M.D., M.Sc.

Organizations such as the National Alliance for the Mentally Ill (NAMI; www.nami.org), The Treatment Advocacy Center (TAC; www.psychlaws.org), and the American Psychiatric Association (APA; www.psych.org) provide various resources to help patients and psychiatrists advocate for those with mental illness. For an excellent list of disorder specific advocacy organizations, visit: www.bazelon.org/links/nat_advocates.htm.

Provide Your Patients with Educational Resources

- Encourage your patients to attend a Peer-to-Peer Program. This is a course provided by NAMI for people with serious mental illnesses who are “interested in establishing and maintaining their wellness and recovery.” It is taught in nine two-hour units and is taught by a team of three trained “mentors” who are personally experienced at living well with mental illness.
- Briefing Papers: Print out these patient-friendly explanations of various mental illnesses, treatments, and recovery from the TAC and educate your patients so that they can advocate for themselves.
- Provide your patients with a smoking cessation kit and online program at www.philipmorrisusa.com/en/quitassist/index.asp. Call or request as many kits as you need, and they will mail them to you for free. Some cities, including the City of New York, offer free smoking cessation kits and nicotine patch.
- Refer patients to Consumers Advocating Recovery through Empowerment (C.A.R.E.) groups, NAMI’s peer-based groups designed to support and empower members recovering from serious mental illnesses.

Provide Your Patients with Financial Resources

- Visit www.nrchmi.samhsa.gov/lists/default.asp to download an extensive list of resources for your homeless or impoverished patients. When appropriate, encourage your patients to seek financial resources such as Social Security Disability, VA service connected disability pension, and food assistance programs.
- Planned Lifetime Assistance Network (PLAN): Visit www.nationalplanalliance.org to help families of adult children

with a disability (including mental illness) develop a funded future-care plan to ensure their loved one's best interests and quality of life.

- Start at www.needymeds.com to help low-income patients connect with low-cost and free medication provision programs.

Become a Resident Activist

- Become a member of the APA and NAMI as well as your local psychiatric and medical associations!
- Listservs: Sign up for e-mails alerting you to pressing legislation, news, and mental illness advocacy information at the APAs' Government Relations Grassroots Network and NAMI's various member listservs. They also provide convenient links to write and call your lawmakers.
- Legal Resources: Know your state's mental health laws. Visit www.psychlaws.org/LegalResources/Index.htm for up to date summaries and detailed information about mental health laws. Go to www.youthlaw.org for information specific to children and the law.
- Take the NAMI Provider Course and encourage your co-workers to do the same. The NAMI Provider Education Program is a 10-week course that presents "a penetrating, subjective view of family and consumer experiences with serious mental illness." The course "helps providers realize the hardships that families and consumers face and appreciate the courage and persistence it takes to live with and recover from mental illness."
- Support the APA's political voice, the Political Action Committee. Make a nominal donation yourself and encourage family members, employers, and friends to contribute.
- Dedicate some journal club time in your program to reading *Blueprint for Change: Ending Chronic Homelessness for Persons With Serious Mental Illness and/or Co-Occurring Substance Use Disorders* (download free from www.nrchmi.samhsa.gov)

PART VI:

PERSONAL FINANCES DURING AND AFTER RESIDENCY TRAINING

- Moonlighting for Residents
- Debt Management: Avoidance Equals Interest Accrual
- How to Make Your University Work for You
- Coping with the Changes in Medicine That Affect Residency Training
- Dealing with Managed Care in the Outpatient Setting

MOONLIGHTING FOR RESIDENTS

Maria Leonido-Yee, M.D.

Despite the demands of residency, some residents choose to moonlight in order to broaden their clinical experiences and, of course, make some extra money! Deciding whether or not to moonlight is a personal issue that should address your individual and family needs, as well as your financial obligations. Moonlighting is not for everyone. However, if you decide to moonlight, check your training program's policies to find out whether or not moonlighting is even allowed. If it is permitted, arm yourself with the information contained in this chapter.

ACGME Guidelines for Moonlighting

1. The moonlighting workload must not interfere with your ability to achieve the goals and objectives of your training program.
2. Your program director will monitor the number of hours you spend moonlighting and the nature of the moonlighting.
3. Your program director will also evaluate your performance to insure that factors such as resident fatigue are not contributing to diminished learning or performance, or detracting from patient safety.
4. You cannot be required to engage in moonlighting.
5. All residents who moonlight must be licensed for unsupervised medical practice in the state where the moonlighting occurs.
6. When it comes to moonlighting, it is not the responsibility of your training program to determine whether your medical licensure is in place, adequate liability coverage is provided, or whether you have the appropriate training and skills to carry out assigned duties.
7. Your program director should acknowledge in writing that he or she is aware that you are moonlighting, and this information should be part of your personnel records.

Caveats about Moonlighting

1. It is imperative that you have malpractice insurance. Depending on the type of moonlighting job you take, you may or may not be provided liability coverage. If not, you will need to purchase your own malpractice insurance. You will need to factor the cost of malpractice insurance into the equation when you decide whether or not to moonlight. In addition to your malpractice

premiums, you will probably need to purchase “tail coverage” when you terminate the policy. “Buying your tail” when you close a policy covers you in the event that a suit is filed for services you provided while your policy was active.

2. Talk to other residents about their moonlighting experiences. They can give you advice about moonlighting opportunities, malpractice insurance, working conditions, etc. In short, your co-residents can give you the scoop on selecting a plum moonlighting job and avoiding the lemons.
3. Some moonlighting opportunities are highly desirable, and your co-residents may be unwilling to share their resources. Therefore, you will have to be resourceful. Check out the advertisements in your district APA newsletter, monthly psychiatric periodicals, and the local newspaper. Surf the internet. Network at local professional functions. Make it known to your faculty members who have private practices that you are interested in moonlighting after your regular residency training hours.
4. Find out whether your training institution allows its own residents to moonlight in the facility after hours. Although some medical centers consider this “double dipping,” if it is allowed in your facility, you would have the advantage of already being familiar with the procedures and expectations.
5. Be informed. Generally, you will go through an interview process to secure a moonlighting job. Ask specific questions! For example, inquire about your duties, credentialing requirements, work hours, hourly wage, and payment schedule. Ask for a tour so that you can decide whether or not you would feel competent and comfortable in that environment.
6. Know your limits. You are likely to find people who are willing to hire you to do things you are not really competent to do. For example, if you were the only physician on duty at a hospital with a crash cart, would you be expected to run the code in the event of a cardiac arrest? Would you feel comfortable doing that? Do not accept more responsibility than you can handle – no amount of money can erase the damage you could cause if you make a mistake out of inexperience.
7. Consider your future. If you have already developed a vision of “what you want to be when you grow up,” try to tailor your moonlighting to your future plans, and make it a learning experience.
8. Take care of yourself! Remind yourself why there are weekends and why there are work-time cutoffs. It is easy to get carried

away once you start getting those extra paychecks. If you moonlight, do it in moderation. You need to allow yourself sufficient time for rest and relaxation to prevent burnout. Remember that you still have to get to that long-awaited Graduation Day!

DEBT MANAGEMENT: AVOIDANCE EQUALS INTEREST ACCRUAL

Brian Kubacak, M.D.

The cost of graduate medical education is soaring, with the average student owing between 70 to 110K. The average public school tuition continues to remain lower than the average private school education. The ability to borrow money for higher education is the only means for many individuals to pursue and obtain a career in medicine. The demand for people in health professions has become a moneymaking venture for many lenders. It is essential that health professions students and graduates remain informed and organized about their loan portfolios. Avoidance behavior in regard to keeping accurate records and managing student loans can have damaging consequences.

Organize

It is important to keep good records of the original loans obtained, lenders, institutions servicing loans interest rates, and options of repayment. Familiarize yourself with your rights and responsibilities as a borrower. Subsidized and unsubsidized government loans and institutional loans may differ in length of grace periods, deferment, and forbearance terms. Once postgraduate residency begins, it is wise to develop a calendar of important dates regarding your loans. This will help prevent delinquent or late payments. If you fail to contact the loan servicing institution, you will be placed in default status 180 days after the payment due date. Defaulting on your student loans can adversely affect your ability to obtain credit and may result in legal action against you.

Repayment

Once you enter repayment status, there are several plans to consider. It is possible to vary the amount of your monthly payment and terms of repayment to meet your budgetary constraints. Most loans have a ten-year repayment plan, but there are options to extend the life of certain loans to twenty to thirty years, if necessary. However, you should remember: the higher the monthly payment, the lower the total repayment, and the shorter the duration of payment, the lower the total repayment. You may also choose to have level, graduated, or income-sensitive monthly payments. It is

helpful to calculate the monthly payment amounts and length of repayment to figure the total cost of your loans. For each loan, check with your lender to inquire about repayment incentives. By paying electronically, some lenders will discount the interest rate. Other lenders offer interest discounts or deductions from loan amounts for origination fees that were incurred if you make several consecutive payments on time. Finally, inquire about the terms of paying off loan amounts early and any associated fees.

Deferment and Forbearance

If your current budget does not allow you to enter into repayment status, you may want to consider deferment or forbearance. Stipulations determine whether you qualify for deferment or forbearance, depending on the type of loan and the year it was obtained. Deferment allows you to delay repayment without the accrual of interest on various subsidized loans. If you have this as an option, consider yourself lucky. Most post-graduate interns and residents who do not have the resources to begin repayment will apply for forbearance. The disadvantage of this is that the interest continues to accrue and is compounded to the original loan amount at varying lengths of time, which can be very costly in the long run. For many loan types, you must reapply annually or semiannually for deferment or forbearance. This makes it essential for you to keep up with important dates to insure that you will not be delinquent or default on your loan repayment. Finally, you might be able to claim financial hardship and defer repayment if the monthly amount of repayment excess 20% of your monthly gross income.

Consolidation

If you have several different loan types and lenders, consider consolidating your loans. This can simplify the information you need to keep track of and make repayment more convenient by requiring only one monthly payment. This might also allow you to renew deferment or forbearance options if you were under prior limitations. You will need to inquire about which loans you can consolidate, what the new interest rate will be, and if there are any grace periods or options for deferment/forbearance.

Resources

If you have questions or need information regarding your student loans, you should contact the financial aid office at your post-graduate institution. You can also seek a qualified financial advisor if you have difficulty organizing your loans or have trouble with budgetary planning. There are also repayment programs that will assist in loan repayment in exchange for work commitments after residency training (i.e. state programs, Public Health Services, Armed Forces, and National Institutes of Health). There are also debt management workshops, books, videos, and internet sites provided by the Association of American Medical Colleges' MEDLOANS program to offer a variety of services for managing student loans (www.aamc.org): student and applicant information, section on financial aid).

Suggested Reference

AAMC (1999) The Layman's Guide to Educational Debt Management for Residents and Graduate Medical Education Staff. AAMC website at www.aamc.org

HOW TO MAKE YOUR UNIVERSITY WORK FOR YOU

Gregory M. Singleton, M.D.

Psychiatric residency is rewarding in and of itself; however, this does not mean that you shouldn't take advantage of the benefits and perks that are available. After all, knowing that you and your family are well taken care of will allow you to focus on your studies and keep stress to a minimum. Residency programs will vary in the benefits that they offer, so the following might not be available at all programs, nor should it be considered an exhaustive list of the options you might have at your program. Your local graduate medical education (GME) office is a good place to get information pertinent to your program.

Health Insurance

All programs require that residents have health insurance to participate in training, but the specifics differ from one program to the next. Some programs will pay all of your premiums; others will offer cost-sharing programs. The same applies to spouses and children. Depending on your institution, insurance benefits might be available to significant others or same-sex partners. Be aware of open-enrollment deadlines. These are the times of the year when you can add coverage to your medical insurance policy for spouses, significant others, and children. In the case of new babies, there is usually a set period of time after birth in which to add coverage for them. If they are not added within this timeframe, you will have to wait for the next open enrollment. The amount of time you will have will vary among insurance companies, so check your policy packet or contact your GME office for details.

Dental Insurance

As with medical insurance, some residency programs will provide dental insurance at no cost to you and others will offer it as a cost-sharing option. Some might make it available if you want it but will expect you to pay the premiums. Again, check your policy or with your GME office regarding coverage for spouses, significant others and children.

Disability, Life, Accidental Death and Dismemberment Insurances

Disability insurance and dismemberment insurances protect you in the event that you sustain some injury or illness that renders you unable to perform your duties as a physician. If your program

covers these for you, it will most likely be a group policy for all of the residents. Usually these types of insurance provide some percentage of your monthly salary until you are able to return to employment.

Food

With those student loans collecting interest and with all of the other expenses residents have, there's nothing to be ashamed of in taking free food when it is offered. Most programs have some sort of meal compensation for when you are on call. If you look hard enough, there are usually lunch meetings, lectures, conferences or journal clubs with food available.

Counseling Services

Psychiatry residency training is stressful. You will spend your days treating others for their anxiety and depression, and thinking about your own feelings may be the last thing on your mind. However, successful transition from student to resident to graduated expert in psychiatry can take a toll on your mental well-being. Most residency programs offer counseling services for their residents. Don't neglect your own mental health!

Malpractice Insurance

Your malpractice insurance is covered by your training institution while you are a resident. However, if your residency program allows moonlighting, particularly off-campus, you may be required to obtain a separate malpractice insurance policy to participate.

Fitness Facilities

When residency gets so busy that you can't make it to the gym, and the only exercise you get is taking the stairs to the cafeteria, there may be a solution to your fitness woes! Many medical center campuses have fitness facilities on site that you can use during your lunch break or after work. In addition, check with your GME office to see if they have partnered with any local facilities to get discounted memberships for residents.

Maternity/Paternity and Other Unpaid Leave

All residency programs are required to comply with the Family Medical Leave Act, which provides for up to 12 weeks of unpaid leave for the birth or adoption of a child, illness of self or family members, and other emergency situations. Be aware that most programs will require the use of paid time off and sick days prior to

starting unpaid leave. In addition, many universities offer daycare for a reduced fee for the children of residents and fellows.

Vacation/Paid Time Off

While you will undoubtedly enjoy your time as a resident and derive a sense of satisfaction from your experience, you might, on occasion, feel the desire to take a break from it. All residency programs offer paid vacation time for residents, usually 2-3 weeks/year for first- and second-years and 3-4 weeks for upper-level residents and fellows. This time may include sick days, or they may be separate. Many programs also offer time off for educational pursuits such as conferences or test-taking and preparation.

College Fee Courtesy

Want to improve your Spanish skills? Thinking about guitar lessons? How about that exciting analytical chemistry course you always thought sounded fun but didn't have the time for? If your residency program is affiliated with a university or college, you may be able to take free classes or pay minimal tuition for college credits. Whether you are seeking that third (or fourth or fifth...) degree, or just for fun, fee courtesy benefits are available at most programs. Check with your GME office for details.

Community Discounts

As a resident, you may have access to discounted tickets for sporting events, performing arts productions, or other cultural experiences through your psychiatry department or the GME office. Additionally, some programs have negotiated discounts on memberships to golf courses, country clubs or other community resources. Some cell phone providers, banks, warehouse shopping clubs, and other businesses have special programs for university employees. It's worth inquiring whether you might be eligible for a discount at a business you would patronize anyway.

Other Benefits

401k Plans: Some programs offer 401k retirement plans in which you can deposit a certain percentage of your stipend and your employer will match it, up to a limited amount.

Flexible Spending Accounts (FSA): A FSA works like a bank account in which pre-tax money is automatically deposited from your stipend that you use to pay for medical expenses not covered by your health insurance. Flexible spending accounts can also be used to pay for childcare expenses. Before signing up for this option, be sure to

understand the specifics of your program's FSA plan, including dates of the enrollment period, how to file claims, and what constitutes a covered expense. Flexible spending accounts are helpful because they allow you to pay for certain expenses with pre-tax dollars. One word of caution, however: if you don't use all the money you put in your FSA during the calendar year, you lose the money.

Conclusion

When you start residency, you will receive a stack of paperwork outlining your benefits. You are likely to be overwhelmed and confused by all the new information. However, it is worth taking some time to familiarize yourself with your universities benefits. Although you will be relieved to be earning money, rather than paying tuition, you will not live like royalty on a resident's stipend. Take advantage of your programs resources to save money and enhance your quality of life.

Suggested References

Northwestern University Feinberg School of Medicine – Office of Graduate Medical Education
https://fsmweb.northwestern.edu/gme_services/benefits_view/Benefits_Menu.cfm

Indiana University School of Medicine – Office of Graduate Medical Education
www.indiana.edu/~resident/

The Ohio State University College of Medicine – Office of Graduate Medical Education
medicine.osu.edu/gme/

COPING WITH THE CHANGES IN MEDICINE THAT AFFECT RESIDENCY TRAINING

Amanda G. Smith, M.D.

Picture this: you arrive at work on Monday morning, only to find that the bustling inpatient unit that you left on Friday is nothing more than a ghost town. Even worse, the sign on the side of the building indicates that the hospital is now affiliated with the “rival” university across town. What happened?

One Word: Money

As hospitals and universities compete for profit in the face of dwindling reimbursement, they are forced to make decisions based on what is best for business, without taking into account who will be affected. Outpatient clinics often terminate unprofitable managed care contracts, suddenly restricting you from seeing patients that you have been treating for months. Inpatient units get “consolidated” or totally shut down with astonishingly little warning, as hospitals and universities shift affiliations. For a resident physician, it can be particularly frustrating as you worry whether or not you are receiving adequate training in such an unstable environment.

Another Word for Money: Funding

Sometimes changes occur within a residency program that are not directly related to the managed care environment. Often, these changes still have to do with financial matters. In most programs, affiliate sites pay the program or university for the services of the resident. These lines of funding dictate how many residents can rotate at a certain site at any given time. If one site provides a significantly higher number of funding lines, a larger proportion of residents will be required to rotate there. This can sometimes make a resident feel that his or her program is skewed. Additionally, affiliates may pull lines of funding if they believe that their needs are not being met, compounding feelings of instability.

What Can I Do as a Resident?

The most important thing to remember is that you need to be flexible and adapt to the changes. Although the names and scenery may shift, there are opportunities to learn in every setting, with every

patient you see. If your outpatient clinic stops accepting patients from one HMO, remember that you will undoubtedly pick up other patients who are equally interesting and challenging. Meanwhile, take the time to help your terminated patients make the transition to a new physician, because they will be as distressed as you are. Helping them cope with the change can be both an educational experience for you and a source of comfort for your patients. If you feel overwhelmed, talk to your supervisors and professors. They can provide support and advice for dealing with these difficult, but increasingly common, obstacles.

It is also important to remember that residency is an educational experience, and you have every right to bring up your questions and concerns with your training director. As a group, residents should be informed about any program changes in a timely manner. Individually, don't be afraid speak up for yourself. If you have specific goals or interests, advocate for an opportunity to rotate at a certain affiliate site that may only provide one or two lines of funding.

By playing an active role in your education, and being tolerant of the transitions that will inevitably take place, you can make the most of your residency, no matter what changes come your way.

DEALING WITH MANAGED CARE IN THE OUTPATIENT SETTING

Amanda G. Smith, M.D.

One of the most frustrating aspects of practicing outpatient psychiatry today is dealing with managed care and insurance companies. It is easy to become overwhelmed by the endless forms and phone calls. At times you might feel more like a secretary than a doctor. In addition, it can be infuriating to try to do what you know is best for a patient, only to be vetoed by someone with little or no medical background. However, there are ways of making the whole process less painful. By being patient, keeping organized, and doing a little homework, you will be prepared to handle almost anything that the insurance companies throw your way.

Before You See the Patient

Make sure you understand the clinic's billing policies before you begin to see patients. One person is usually assigned the daunting task of being "billing integrity officer" or some similarly titled position, and that person often reviews the guidelines and policies for incoming residents. This person is responsible for making sure that the services that are billed match those that are performed so that, for instance, a fifteen-minute medication management visit is not billed as a sixty-minute therapy session. In addition to specifics for billing, Medicare has very strict guidelines about documentation and supervision by the attending physician. You should become familiar with these guidelines as early as possible. A good practice is to make ALL of your notes compliant with these guidelines, Medicare patient or not, so that you never have to worry.

Another helpful thing to know before you begin is whether your clinic has special payment scales to assist patients in obtaining services, such as weekly psychotherapy, that their insurance will not cover, and they could not otherwise afford. In the interest of profit, these services are often not advertised, but are available if you ask for them.

Finally, it may be useful to become familiar with the medication formularies of the one or two insurance plans to which most of your patients belong. Although you should never base treatment decisions on this information alone, it can sometimes prevent headaches.

The Patient Visit

Most patients you see in clinic will be approved only for the beloved “90862,” also known as the fifteen-minute medication management visit, no matter what services you think they need. If you have the luxury of making your own schedule, try to see patients at thirty-minute intervals to help develop a therapeutic relationship and allow yourself time to write your progress notes. If you are in a clinic where the patients are scheduled for you, try to maximize your fifteen minutes with the patient by only jotting down important aspects of the conversation, mental status, and plan, and writing your full progress note during unscheduled time or when you have a cancellation or a “no show.” Adding a few personal details will enhance rapport and jog your memory for the next visit. Asking a patient, “How was your trip to France?” before asking about side effects and refills will certainly make the patient feel more comfortable. It shows patients that you are interested in them as people and makes the managed care environment seem less like a “factory” to both of you.

Between Visits: The Real Fun

You may be required to do several things after your patient leaves, or between scheduled appointments. The most common form you will have to fill out is a treatment plan, the content of which can vary from a simple checklist to a five-page commentary, depending on the insurer. If you believe that a patient requires services above and beyond medication management visits, the treatment plan form is usually the first place to request them. If denied, you can call and speak to someone at the insurance company to plead your case. Persistence usually pays off.

Another form that you will undoubtedly come across is the formulary override or “non-formulary” medication request. Many companies have protocols for prescribing medications, and you will usually find this out by receiving a frantic phone call from your patient saying, “I went to pick up the medicine you prescribed, but my insurance company won’t pay for it, and I can’t afford it!” Some managed care organizations require the failure of adequate trials of one or two specific medications before they will approve certain other ones. Other companies require documentation that a medication is being used for a specific purpose. For example, you might have to document that bupropion is prescribed for depression, rather than smoking cessation. Many times you will need to fax a form; other times you can just call. When you do call, make sure you have the patient’s chart on hand to make the conversation as short as

possible. Make sure you have adequate time to call, as you will be on hold for an eternity and the first number you dial is rarely the one you need to call.

Sometimes, despite your efforts, the insurance carrier will not approve therapy or certain medications. Ask whether or not your clinic will allow you to provide services at a reduced rate, and utilize the time you do have as best you can. If a managed care company denies your patient a medication that you believe would be of benefit, and the patient is unable to buy it, contact the pharmaceutical representative for that drug. He or she may be able to provide samples to your patient. Additionally, many pharmaceutical companies now have patient assistance programs that will provide free medication for several months, sometimes indefinitely. Eligibility and enrollment procedures vary by program.

Remember that however annoying the paperwork and phone calls are, you are trying to provide the best care for your patients. Fill out forms and make calls in a timely manner. As frustrated as you may get, never blame your patients. They are often at the mercy of their employers regarding selection of insurance carriers, and they are frequently more overwhelmed than you are. Most importantly, view all of this work as an educational experience that will prepare you for practice beyond residency.

PART VII:

A LOOK TOWARD YOUR FUTURE AS A PSYCHIATRIST

- Couch Time: Psychoanalytic Training
- Subspecialty Training in Psychiatry
- Roadmaps: Sample Resident Admission Note and Hospital Progress Note

COUCH TIME: PSYCHOANALYTIC TRAINING

Khleber Chapman Attwell, M.D., M.P.H.

“Psychoanalysis is a remarkable combination, for it comprises not only a method of research into the neuroses but also a method of treatment based on the etiology thus discovered. I may begin by saying that psychoanalysis is not a child of speculation, but the outcome of experience; and for that reason, like every new product of science, is unfinished. It is open to anyone to convince himself by his own investigations of the correctness of the theses embodied in it, and to help in the further development of the study.” (S. Freud, 1911)

“I thought psychoanalysis was dead!” “Why would anyone in this day and economic climate sign up for seven years of costly training that will never pay back?” These are common responses among psychiatry residents to the suggestion of pursuing psychoanalytic training. This brief review will shed light on what often seems a mysterious, foreign proposition, by both answering some starter questions and providing resources for further exploration. Probably the best way to learn more about psychoanalytic training is to speak to those doing it. If you have a hard time finding them, we will help you with that (see below). You might also start your own treatment with a psychoanalyst (analysis or otherwise) and go from there (more on that later)!

Analytic training, as discussed here, entails enrollment at one of the Psychoanalytic Institutes accredited by the American Psychoanalytic Association and, therefore, involvement in three major areas of training for certification: a personal analysis conducted by one of your institute’s training analysts; relevant coursework (often four years); and demonstration of clinical proficiency with several control cases (usually of each gender), conducted under supervision.

What compels someone to enter psychoanalytic training? The right combination of misery, tenacity, and desire for understanding – thrown in with a quotient of luck – can lead to the analyst’s couch or to a referral for psychoanalysis four to five times a week. Few experiences in life are as shocking as seeing unconscious forces at work, this time in your own life. As an analysand (def: a person being psychoanalyzed), your identification with your analyst and your desire to help others as you have been helped may inspire you to pursue analytic training. Coursework deepens analytic comprehension – from basic theory of clinical work to genuine struggle with models of human mental functioning. Starting your own cases in analysis strengthens the commitment to this work and

personalizes the process. If you are even vaguely considering analytic training, enter psychotherapy with a training analyst at your local institute so that, should you elect to do training later, you can avoid starting from scratch on the couch (though the latter both happens and works out).

Most of us become analysts because we love it. We all invest too much time, energy, and money for it to be an intellectual sideline or financial investment. We enjoy the pleasure of insight into situations with patients, into our own lives and relationships, and into society as a whole. Analytic work provides the professional gratification of helping someone truly to turn his or her life around when they have exhausted every other consciously available strategy. The analytic community can, in turn, become a professional home – a place to grow and continue to learn.

If you are interested in psychoanalysis, the following pointers may prove helpful:

1. **Start by learning more.** Contact the American Psychoanalytic Association (www.apsa.org), and join as a resident-in-training member. They offer a mentorship program and can put you in touch with the local institutes in your area (most major metropolitan areas have one). Go to one of the semi-annual conferences. The January Winter meeting traditionally takes place in New York City at the Waldorf-Astoria; the June meeting rotates around the country. At these conferences, you can saturate your receptors with reams of exciting clinical material and try the prospect of becoming an analyst on for size. Candidates from all over the country gather at workshops and meals. It is a great way to do the detective work to answer all of your questions and meet skilled, inspirational clinicians.
2. **Do not forget about cyberspace.** Analysts from all over the world increasingly collaborate on-line. Web-sites exist to anchor this work. Contact the American Psychoanalytic Institute for more information.
3. **Keep geography in mind.** When your own seven-year analysis overlaps with taking three control cases into their own X-year analyses, which all in turn overlap with future cases, the likely outcome means living in one place for a long time. The nature of analytic work draws much of its strength from the stability that arises by wandering in the mind rather than on the road. Naturally, some analysts do move successfully after training, but most end up living where they trained.
4. **The money issue is real.** The cost of analysis and tuition at the institute, coupled with the lost income you will incur by

seeing your own training cases at often-reduced fees, naturally spooks a prospective candidate, especially one with the baggage of student loans. The investment first pays dividends more abstractly: a growing sense of trust, a happier marriage, more responsible parenting, or the feeling of being engaged in a human relationship of a wildly new orbit. In the long run, however, analysts learn the skill of continuing to engage patients with curiosity about their lives, hence learning to fill a practice. To pay for these returns, breaks exist. Many training analysts offer reduced fees to candidates. Moonlighting makes the sun shine more brightly. Stipends and grants exist at both the local and national levels. Nothing ventured, nothing gained. Some candidates joke that the better analyzed they are, the more money they make; keep this in mind.

5. **Finally, when to start?** Some institutes do not accept residents; many do. Some residents wish to dive in and get started with what will take years to accomplish. Others wish to have a “real job” before starting, and consolidate one phase of their training before starting another. Either way, it seems to be a question of personal timing.

Best of luck! If you find this type of exploration interesting enough to make a career of it, or a partial career, you will likely not be disappointed.

SUBSPECIALTY TRAINING IN PSYCHIATRY

Caroline Fisher, M.D., Ph.D.

Amir Garakani, M.D.

As you progress through your training, people will undoubtedly ask you whether you plan to pursue fellowship training after residency. Some people know the answer to this question from birth, while others need more time to make the decision.

There are a variety of fellowships available. As of 2007, nine psychiatric subspecialties are recognized by the American Board of Psychiatry and Neurology (www.abpn.com) and its parent organization, the American Board of Medical Specialties (www.abms.org). These are: Child and Adolescent Psychiatry, Geriatric Psychiatry, Forensic Psychiatry, Addiction Psychiatry, Psychosomatic Medicine, Pain Medicine, Sleep Medicine, and Clinical Neurophysiology. Hospital and Palliative Medicine was recently approved as well. Child and Adolescent Psychiatry fellowships are two years long and, depending on when you apply, begin after the third or fourth year of adult psychiatric training has been completed. The others are one-year fellowships that start after the completion of an adult psychiatric residency. A fellowship in any of these areas allows you to sit for the appropriate ABPN subspecialty exam, and if you pass, you can call yourself Board Certified in that area (Note: you must first be Board Certified in General Psychiatry before sitting for the subspecialty exam).

You might decide to do a fellowship for a variety of reasons. In a fellowship, you can study something in greater depth. For example, you might want to increase your skill in cognitive behavioral therapy or neuropsychiatry. Completing a fellowship allows you to focus on a particular patient population, such as children or the elderly. You can also use a fellowship to focus your work on the kind of tasks you enjoy, like consulting to the medicine service or performing forensic evaluations. A fellowship may give you a competitive edge in the job market by making you more qualified than another applicant. You might also want intensive training you did not receive during residency, as you might find in a basic science research fellowship.

There are a few reasons not to do fellowships, as well. The hardest one to figure out is whether the fellowship will do for you what you want it to, whether it's "worth it." Accepting a fellowship position means accepting at least one additional year of training at a training salary rather than an attending salary. That is a tangible and significant cost: if you accept a salary of \$50,000 rather than \$100,000, then your future salary must be increased by \$4,000 to

\$6,000 per year for twenty years to “pay yourself back” the value of the missed earnings. If the additional qualifications get you the exact same starting salary or the same salary in five years, you will have cost yourself financially.

Harder still is the question of whether you can achieve the same goal without doing a formal fellowship. For example, if you want to specialize in child psychiatry and plan to serve as an expert witness for custody cases, a second fellowship in forensics is probably not necessary. You will probably receive some forensic training within the child fellowship, particularly if you let the faculty know about your interest. On the other hand, if you want to perform competence evaluations on incarcerated juveniles, a forensic fellowship might make good sense. If you like emergency psychiatry work, and there is a job available at a local emergency room, you may want to pursue the job rather than an emergency psychiatry fellowship, depending on how much on-the-job training you will receive.

Think of fellowship training as a bus: ask yourself if it is going where you want to go, if the fare is reasonable, and if there are more desirable travel options. Following is information about the main psychiatric subspecialties, what they focus on, and where to get more information.

Addiction Psychiatry

As the name implies, this subspecialty focuses on the treatment of patients with substance use problems. Areas studied during an addiction fellowship might include biopsychosocial assessment of patients with addictions, motivational interviewing, psychopharmacological treatment of withdrawal, detoxification, psychopharmacological treatment to address drug craving, and psychopharmacological treatment for addicted and dually-diagnosed patients. Psychiatrists trained in addiction treatment are in short supply. This is also a rich area for research. The American Association of Addiction Psychiatry web site (www.aaap.org) offers more information on the state of the field.

Forensic Psychiatry

This is the study of psychiatry and the law. Forensic psychiatrists are trained to perform a variety of specialized examinations. For example, forensic psychiatrists can assess a patient’s capacity to make medical decisions. They can evaluate an

accused person's competence to stand trial and his or her ability to understand the legal process and interact with his or her attorney to mount a defense. Forensic psychiatrists serve as expert witnesses regarding a defendant's mental state at the time of crime when the defense of not guilty by reason of insanity is being considered. Forensic psychiatrists can perform third party evaluations of insurance claims for worker's compensation. To apply, contact the programs directly. The American Academy for Psychiatry and the Law (AAPL) lists training sites on its web site (www.aapl.org).

Child and Adolescent Psychiatry

This field focuses on treating families and children. Training might include psychopharmacology for children, behavioral interventions, family therapy, play therapy, learning disabilities and their effect on school performance, consultation-liaison to pediatrics, working with children with attachment disorders, working with the juvenile justice system, adoption issues, infant psychiatry, therapeutic preschools, addictions, and developmental disabilities. But the best part of child psychiatry is the kids! As noted above, this is a two-year fellowship. Fellows apply and are chosen through the ERAS match program. Learn more about it at the American Academy of Child and Adolescent Psychiatry web page (www.aacap.org).

Geriatric Psychiatry

Geriatric psychiatrists focus on treatment of the elderly, and manage the psychiatric symptoms of many medical disorders. Therefore, this is a great specialty for those who want to keep their medical skills sharp. Geriatric psychiatrists must recognize and understand the treatment of comorbid disorders, like Parkinson disease, that can complicate treatment of primary psychiatric disorders. Psychopharmacology training is crucial, as is assessment of dementia and delirium, evaluation of competency and functional skills, and working with families. Geriatric psychiatrists are in particular demand given the aging population. Learn more at the American Association of Geriatric Psychiatry web site (www.aagppa.org).

Clinical Neurophysiology

For those who like neurology, in addition to psychiatry, the American Clinical Neurophysiology Society (www.acns.org), can help

you explore the fellowship opportunities in clinical neurophysiology. Frequently known as sleep specialists, clinical neurophysiologists also specialize in seizures and their effects on psychiatric disorders, electroencephalography, evoked potentials, and quantitative neurophysiologic methods such as electromyography (EMG), and nerve conduction studies (NCS). People who enjoy the interface of neurology and psychiatry might develop a satisfying career as a clinical neurophysiologist.

Psychosomatic Medicine

This subspecialty, formerly known as Consultation/Liaison Psychiatry, deals with the interface between psychiatry and other medical specialties. Fellows work on diagnosis and recommendation of treatment of psychiatric illnesses in complex medically ill patients, in particular chronic medical, obstetric, surgical, and infectious processes that present or are comorbid as psychiatric symptoms, and complicate the patient's course. Specific areas of focus include HIV, organ transplantation, stroke, neurological illnesses such as multiple sclerosis, and traumatic brain injury. Most often, consultation-liaison psychiatrists work within general hospital inpatient units, but in some cases may see patients in other setting such as outpatient clinics. For more information, refer to the Academy of Psychosomatic Medicine (www.apm.org).

Pain Medicine

This is another recently approved subspecialty, open to psychiatrists, neurologists, anesthesiologists, and other qualified specialists. This collaborative field allows the psychiatrist to help diagnose and treat acute and chronic pain syndromes, usually as a consultant in an inpatient or outpatient setting. More information about pain medicine is available on the American Board of Anesthesiology website (www.theaba.org) or the American Board of Pain Medicine website (www.abpm.org).

Sleep Medicine

Sleep medicine is a newly accredited subspecialty, open to psychiatrists, neurologists, and other specialists who have completed the requisite training. Psychiatrists in this field help diagnose and treat sleep-related disorders such as insomnias, hypersomnias, parasomnias, sleep-related breathing disorders, sleep movement

disorders, circadian rhythm disorders, and sleep-related movement disorders. There is a “grandfathering” period until 2011, meaning those that have not completed a fellowship can sit for the exam if they have the required core competencies. For more information, refer to the American Board of Sleep Medicine (www.absm.org).

Hospice and Palliative Medicine

The American Board of Medical Specialties recently approved Hospice and Palliative medicine as a subspecialty, with the first exam to be administered in 2008. See the American Academy of Hospice and Palliative Medicine (www.aahpm.org) for more information.

Non-Accredited Psychiatric Fellowships

There are also fellowships available that are not accredited by the American College of Graduate Medical Education and ABPN. **Emergency Psychiatry** is a one-year program allowing fellows to focus on acute management of mentally ill persons. **Public Psychiatry (Community Psychiatry)** is an area dealing with community-based mental health. Columbia University (ppf.hs.columbia.edu) and the University of Florida (www.psychiatry.ufl.edu/education/fellowships/community) offer 1-year fellowships.

A **Research Fellowship** is an opportunity to build a foundation of scientific study, and work toward becoming an independent investigator and academic faculty member. The National Institute of Mental Health (www.nimh.nih.gov) offers intramural programs in Bethesda, Maryland. Your program may have extramural training opportunities (T32 training grants, for instance), so inquire with your research mentor. The fellowships are usually at least two years, and are meant to transition the trainee to application of “K” career development award. Fellowships are often done in specific subspecialties, such as affective and anxiety disorders, addiction, cognitive disorders, or schizophrenia. The advantage of a research fellowship is that the NIH offers Loan Repayment Awards to certain qualified trainees (see the “Awards and Fellowship” chapter).

Conclusion

The APA web site (www.psych.org) also has useful sections on other psychiatric organizations including subspecialty organizations, as does their weekly newsletter, Psychiatric News. The AMA

publishes a list of basic information about accredited fellowship programs in print and on its web site, under FREIDA online, at www.ama-assn.org. Good luck with your planning. Do not forget to ask yourself – will this bus take me where I want to go?

**SAMPLE RESIDENT ADMISSION NOTE
AND HOSPITAL PROGRESS NOTE
Todd S. Cox, M.D.**

The following is a sample Resident Admission Note and Hospital Progress Note that you might find useful as a guide to your own work during residency. Although the format of admission and progress notes varies tremendously from program to program and hospital to hospital, the content necessary is universal. The admission note is an example of a comprehensive evaluation, as opposed to a less complete “on-call” admit note, which should follow the same format but with significantly less detail. The Hospital Progress Note follows the ubiquitous “SOAP” format and includes the essentials of daily patient assessment, including the psychiatric equivalent of the physical exam, the mental status examination. When reporting a mental status examination, it is important to remember that, like the physical exam, the mental status exam should provide a cross-sectional picture of the patient that describes observations and phenomenology elicited by the interviewer. The mental status examination should not include elements of the history (such as sleep or appetite patterns), nor should it include interpretations of observations, which are to be discussed in the formulation of the case.

Resident Initial Evaluation Note

Patient: John Doe
Date: July 1, 2007

IDENTIFICATION/CHIEF COMPLAINT:

Mr. John Doe is a 35-year-old married white man who presents to the Affective Disorders Unit referred by his outpatient psychiatrist, Dr. Adolf Meyer, due to worsening symptoms of low mood and suicidal ideation. According to the patient, “I’ve been feeling worse for two months – real lousy, just out of it – nothing left in me.”

INFORMANTS:

Informants include the patient, who is considered reliable, his wife, Jill Doe, and recent outpatient notes from Dr. Smith.

HISTORY OF PRESENT ILLNESS:

The patient was in his usual state of mental and physical health until approximately two months ago when he began to experience the

gradual onset of worsening (low) mood. At that time, his employer restructured the bank, placing additional responsibilities on the patient. Additionally, the patient and his wife began to discuss the possibility of having children – discussions that frequently led to arguments, given his desire to begin a family and his wife’s desire to wait. Initially, the patient attributed his low mood to these stresses. However, his mood worsened rather quickly, and he began to experience hopelessness, helplessness, and worsening vital sense. Over the course of the ensuing months, his energy decreased, motivation declined, and he became anhedonic. His sleep became problematic with difficulty falling asleep and early morning awakening at 4 or 5 a.m., with an inability to fall back asleep. His oral intake declined to one small evening meal, and he lost all desire for food. Mr. Doe’s weight has decreased fifteen pounds over the past two months. He reports no interest in sexual activity.

By the second month, the patient became reclusive, spending his days at work and returning home to bed, minimally interacting with his wife. Eventually, his attention and concentration worsened, particularly at work, where he was reprimanded on numerous occasions for errors in processing new accounts. He began to miss work, stating, “I just can’t take it – I’m not smart enough to handle this much new work.” Additionally, his self-esteem declined in relation to his role as a husband, and he reiterated to his wife that she “deserves better.” On five separate occasions, the patient’s wife found him crying inconsolably for no clear reason.

During the month prior to admission, the patient said on numerous occasions, “I wish I could just disappear.” He specifically stated to his wife each evening that he hoped that he “just won’t wake up.” During the two weeks prior to admission, the patient began to perseverate on the notion of taking his own life “by driving off a cliff” or “crashing into the median strip on Charles Street.” Over the past three days, he has not consumed any food (although he claims continued compliance with medication), is drinking only water and coffee, has not cared for his ADL’s, and has remained in his bedroom, leaving only to go to the kitchen and bathroom. He denies attempting to harm himself, but he told his wife about his suicidal thoughts and stated to her this morning that he “cannot go on.” The patient’s wife contacted Dr. Meyer, who saw the patient earlier today and referred the patient for admission to the inpatient Affective Disorders Unit.

PAST PSYCHIATRIC HISTORY

Current Outpatient Psychiatrists:

Dr. Adolf Meyer, The Johns Hopkins Hospital
(410) 555-5555

The patient first experienced symptoms of low mood and hopelessness during his senior year of college. At that time, he sought help at the Student Mental Health Center and was seen by a psychologist for six sessions. The patient states that the psychologist worked with him in “figuring out what I was going to do with my life because that was thought to be at the core of the problem.” The six-week episode of low mood and hopelessness was accompanied by crying spells, low self-esteem, poor sleep, and decreased appetite with a ten-pound weight loss. No medications were utilized or discussed.

At age 26, in the context of added responsibility and the stress at work, the patient experienced a three-week period of low mood, helplessness, poor concentration and attention, poor energy, anhedonia, decreased appetite, disrupted sleep, and passive death wishes. He saw his primary medical doctor, Dr. Osler, for complaints of fatigue and low energy. Dr. Osler referred the patient to a psychiatrist, Dr. Meyer, for evaluation of possible depression. Dr. Meyer diagnosed the patient with Major Depressive Disorder and started paroxetine, 10 mg PO daily, along with weekly psychotherapy. Paroxetine was titrated to 20 mg PO daily. However, the patient experienced significant sedation on this medication, making it difficult for him to function at work despite nighttime dosing. Paroxetine was discontinued, and the patient was started on fluoxetine, which he tolerated. The fluoxetine was titrated to 40 mg PO daily over the course of one month, and the patient continued with weekly supportive and insight-oriented psychotherapy for two months. Mr. Doe’s depressive symptoms resolved during these two months.

Until recently, the patient had no significant symptoms since age 26 and continued with visits to Dr. Meyer every other month. He is currently taking fluoxetine, 40 mg PO daily.

The patient denies any additional history of symptoms of hypomania/mania, anxiety, obsessions/compulsions, phobias, psychosis or cognitive difficulties. He denies any history of suicidal ideation of self-injurious behavior. He has no history of violence. He has never been hospitalized psychiatrically.

SUBSTANCE USE HISTORY:

Tobacco: no history of use
Alcohol: The patient began to drink beer on weekends in college, and had approximately 2 – 3 episodes per year as an undergraduate when he became “real drunk.” Currently, he drinks one glass of red wine every other evening with dinner. He denies any history of blackouts, tremors, delirium tremens, and seizures.
Marijuana: The patient smoked marijuana on three single occasions throughout his time in college. He has not used marijuana for 14 years.
Cocaine: no history of use
Amphetamines: no history of use
Opiates: no history of use
Other illicit: no history of use
Caffeine: The patient drinks three cups of caffeinated coffee each day and has consumed caffeine to that degree for ten years.

PAST GENERAL MEDICAL HISTORY:

Primary Medical Doctor:
Dr. William Osler, The Johns Hopkins Hospital
(410) 555-1212

The patient’s general medical history is notable for hypertension, diagnosed in 1997, and treated with enalapril since that time. He has no additional general medical history and has not been hospitalized medically except for the surgeries below.

The patient’s surgical history is notable for tonsillectomy and adenoidectomy at age 8 and an appendectomy at age 24, both of which were uncomplicated.

Allergies: NKDA
Current Medications: Fluoxetine 40 mg PO q AM
Enalapril 10 mg PO bid

MEDICAL REVIEW OF SYSTEMS:

General: Deceased energy, general malaise, and poor appetite with weight loss of fifteen pounds in two months.

All others negative: (Ear/Eyes/Nose/Throat, Cardiovascular, Pulmonary, GI, GU, Endocrine, Rheumatologic, Hematologic, Neurologic, Dermatologic)

FAMILY HISTORY:

Mother: The patient's mother, Joan Doe, is 62 years old. She has a high school education, and she is employed as a secretary. She suffers from Type II diabetes. Her psychiatric history is notable for a diagnosis of Major Depressive Disorder for which she sees an outpatient psychiatrist monthly and has been treated with various SSRIs (currently treated with sertraline 100 mg PO daily). She has never been hospitalized, and she has never engaged in self-injurious behavior. She has no substance use history. She is described by the patient as being a "warm, caring, emotional" person who "gets overwhelmed pretty easily." The patient describes their relationship as "we've always been close – very supportive."

Father: The patient's father, Jack Doe, is 63 years old. He is a college graduate and is employed as a car salesman. His general medical history is notable for hypertension and chronic obstructive pulmonary disease. He has no psychiatric history and no significant substance use history. He is described by the patient as being "a bit stand-offish and aloof," "a loner," and "a good provider." Their relationship is described as "not too close, but we care about each other."

Siblings: The patient has one older sister, Jan Williams, who is 39 years old. She is married and has two children. She is a teacher in Los Angeles. She has no history of general medical difficulties. Her psychiatric history is notable for multiple hospitalizations for the treatment of depressive and manic episodes, and she has been diagnosed with Bipolar I Affective Disorder. Her treatment has included multiple antidepressants, lithium, valproic acid, and ECT. She is currently maintained on gabapentin (dose unknown). She is described by the patient as "wonderful, kind, considerate, my best friend." Their relationship is "real good, very close." They communicate weekly by phone.

Extended Family: There is a history of colon cancer in multiple paternal family members. There is a history of "mood problems" in a maternal aunt and completed suicide by his paternal grandfather (specifics unclear). Additionally, there is a history of alcohol and marijuana use in a paternal cousin.

PERSONAL HISTORY:

Gestation/Birth: The patient was born in Baltimore, MD, and was the product of a normal pregnancy, spontaneous vaginal delivery without complications. There were no known intrauterine exposures. He was 8 lbs. 2 oz. at birth.

Childhood Health: The patient's childhood health history is notable for the normal exanthems and a tonsillectomy and adenoidectomy at age 8. There were no episodes of traumatic injury/loss of consciousness. He was bottle fed as an infant.

Early Development: The patient met his developmental milestones without difficulty or consequence. He was described by his mother as a "good baby" who "wasn't too fussy." There were no significant difficulties with toilet training, which was accomplished with a reward system.

Childhood Behaviors: There were no abnormal childhood behaviors, including no history of enuresis, encopresis, tantrums, running away, fire setting, animal cruelty, violence, or destruction of property.

Home Atmosphere: The patient was raised in a middle-class home in suburban Baltimore. His mother was the primary caregiver, and she remained at home until the patient became school-aged, at which time she returned to work. Other than his immediate family, there were no additional individuals residing in the home. His family remained in the same home, which they owned, during his entire life. The patient describes the home atmosphere as having been "real warm and caring" and denies any significant periods of concern or family distress.

Education: The patient began preschool at age 4 and adjusted socially without difficulty. He began kindergarten at age 5, again without difficulty or distress. He attended public school throughout his early years and did well, both academically and socially. He associated well with peers and teachers, and by high school became affiliated with "the smart crowd." He denied any history of behavioral difficulties, detentions, suspensions, or truancy. Additionally, there was no repetition of grades or courses. He graduated from high school at the top of his class and went on to attend Johns Hopkins University, where he continued graduated in 1987 with a degree in economics.

Occupation: The patient is currently a vice president of USA Bank in Baltimore, MD. He began working for the bank upon graduation from college and has done well professionally, having been promoted

to his current position two years ago. He states, “Until recently, I loved my work, and I used to be very good at it.”

Sexual History: The patient is heterosexual and has had four sexual partners in his lifetime. He is sexually monogamous with his wife. Mr. Doe uses condoms for contraception and denies any history of unprotected intercourse.

Sexual/Physical/Psychological Abuse: The patient denies any history of sexual, physical, or emotional abuse, either as recipient or perpetrator.

Relationship History: The patient has been married to his wife, Jill Doe, for the past 8 years. They initially met in college and began dating after graduation. His wife is 32 years old and is a lawyer in Baltimore where she practices malpractice law. He describes his wife as being a “bright, intelligent person who is very driven, but also warm and caring.” They both describe their relationship as “very strong – very supportive and loving.” They acknowledge some tension in the past year related to the idea of having children – the patient reports that he is eager to have children, but his wife wants to devote more time to her career.

Living Situation: The patient resides with his wife in their home in Towson, Maryland. They have lived there for three years, having previously resided in a condominium in downtown Baltimore.

Religion: The patient identifies himself as Christian but is not affiliated with any particular denomination. Mr. Doe states that religion was never a major component of his life, either as a child or adult. He does not participate in formal religious services.

Legal History: The patient has no history of contact with the legal system. His only offense was two traffic tickets he received during college.

MENTAL STATUS EXAMINATION:

Appearance and Behavior: The patient is alert and cooperative, with fair hygiene. He is wearing casual clothes that are slightly wrinkled. He exhibits poor eye contact, staring down at his hands during most of the interview. He is significantly psychomotor retarded. There is no posturing or waxy flexibility. There are no adventitious movements, tics, or tremors.

Speech/Form of Thought: Mr. Doe’s speech is of decreased rate and volume and is monotone. He frequently repeats, “I don’t know” and “Why should I bother going on?” His speech is impoverished with prolonged response latency. His thought processes are

organized and goal-directed with no evidence of formal thought disorder.

Affective State: The patient describes his mood as “awful.” He is tearful, with restricted affect. He endorses low energy, poor motivation, anhedonia, and poor concentration. He feels hopeless and helpless. The patient endorses passive death wishes and suicidal thoughts, stating that he “can’t stop thinking about ending it all by driving off the road.” He denies any homicidal ideation.

Sensory Misperceptions: The patient demonstrates no evidence of delusions and denies auditory or visual hallucinations, illusions, or ideas of reference.

Obsessions/Compulsions/Anxiety/Phobias: The patient denies any current or historical obsessions, compulsions, or phobias. He denies any anxiety or panic symptoms.

Cognition: The patient is alert and cooperative. His Mini-Mental Status Examination score is 27 out of 30 with one point off for attention/calculation and two off for recall. He is oriented to person, place, and time. His naming ability is intact. He is able to repeat a statement and read and write without difficulty. The patient can follow a three-stage command. His concentration is decreased as evidenced by his difficulty subtracting serial sevens from one hundred. He does not have any evidence of apraxia. His fund of knowledge is good, as evidenced by his ability to describe current events, as well as name the last eight presidents. The patient’s intelligence appears above average, based on his interpretation of proverbs and ability to complete similes. His insight into his illness is fair to poor. His judgment is currently poor.

PHYSICAL EXAMINATION:

Appearance: Alert, in no acute distress physically, well-developed, well-nourished

Vital Signs: T = 37.2°C
BP (sitting) = 138/88 P (sitting) = 88
BP (standing) = 132/88 P (standing) = 92
RR = 16
Weight = 185 pounds

HEENT: NCAT without scalp/sinus tenderness. PERRLA.
EOMI without nystagmus. Sclera clear. External
auditory canals clear bilaterally. Tympanic
membranes visualized bilaterally.
Nasopharynx/Oropharynx clear.

Neck: Neck supple without rigidity. Thyroid palpable without nodules/bruits. Carotids 2+ bilaterally without bruits. No lymphadenopathy.

Lungs/Back: CTA bilaterally without wheezes, rhonchi, rales. No CVA tenderness.

Cardiac: PMI nondisplaced; RRR, normal S1, S2 without murmur, gallop, or rub.

Abdomen: Nontender, nondistended; good bowel sounds; no masses or bruits. No hepatosplenomegaly.

Rectal: Heme negative with smooth, normal-sized prostate.

Genitourinary: Circumcised penis with no discharges or testicular masses.

Extremities: No clubbing, cyanosis, edema. Peripheral vasculature 2+ throughout.

Skin: No rashes, concerning nevi, lesions, (dis)coloration/pigmentation.

Neurologic: Alert, oriented. Cranial Nerves 2 –12 intact bilaterally. Normal bulk/tone; strength 4/4 in all extremities and muscle groups bilaterally; sensory exam intact to pin-prick, soft touch, temperature, vibration, and position in face/trunk and extremities bilaterally; finger-to-nose and heel-to-shin intact bilaterally; rapidly alternating movements intact bilaterally; gait within normal limits; tandem walk intact; Romberg negative; deep tendon reflexes 2+ throughout, downgoing toes bilaterally (plantar flexion); no evidence of frontal release signs.

LABORATORY STUDIES:

Pending as outlined in treatment plan.

FORMULATION:

John Doe is a 35-year-old white man with a strong family history of psychiatric illness (likely affective disorder), as well as a personal history of prior depressive episodes. He presents at this time with two months of worsening mood, diminished self-esteem, hopelessness, helplessness, passive death wishes, and suicidal thoughts. These symptoms occur in the context of continued use of fluoxetine, 40 mg PO daily, with which the patient claims compliance. Additionally, the patient is experiencing increased social stress secondary to additional responsibility at work and marital

discord. Although these symptoms may reflect a demoralized state or an adjustment disorder with depressed mood due to the aforementioned stressors, it is more likely that they represent a major depressive episode. In this way, the affective illness may actually be contributing to the difficulties the patient is currently having, both at work and in his marriage. The severity of the patient's symptoms and the pervasiveness of his hopelessness and suicidality warrant inpatient hospitalization for intensive treatment of this depressive episode.

DIAGNOSES:

Axis I: Major Depressive Disorder, recurrent, severe
R/O Adjustment Disorder with Disturbance of Mood
Axis II: Deferred
Axis III: Hypertension
Axis IV: Severe (occupational, marital)
Axis V: GAF: current 30
Past year 90

TREATMENT PLAN:

1. Admit to the Affective Disorders Service inpatient unit on a voluntary basis to begin intensive treatment as outlined below.
2. Place the patient on constant observation for twenty-four hours to insure his safety, given recurrent suicidality.
3. Monitor P.O. intake closely, including daily weights, given lack of food consumption recently. Monitor vital signs every shift. Consider Nutrition Consultation.
4. General laboratory studies and testing including comprehensive metabolic panel, hematologic studies, thyroid studies, RPR, B12, and folate levels, urinalysis, urine toxicology screen, and EKG to eliminate possibility of general medical conditions contributing to symptomatology.
5. Follow Hamilton Depression Scale daily.
6. Obtain release of information to contact Dr. Meyer for additional information and recommendations for treatment. Maintain regular contact with Dr. Meyer during the patient's hospitalization.
7. Continue fluoxetine and consider increasing its dose. Additionally, consider other somatic treatments including augmentation agents, alternative/additional antidepressants, and electroconvulsive therapy.

8. Engage the patient in daily individual therapy – supportive psychotherapy, insight-oriented psychotherapy, and cognitive-behavioral therapy.
9. Engage the patient in an education program regarding affective illness and treatment, including group education and support sessions.
10. Engage the patient and his wife in couple's therapy during the course of the hospitalization, and arrange for outpatient therapy after discharge.
11. Provide Occupational Therapy to enhance coping skills, relaxation techniques, and stress management techniques.
12. Consider neuropsychological testing for cognitive and personality assessment once depressive symptoms have improved.

Resident Physician
July 1, 2007

Hospital Progress Note

Patient: John Doe
Date: July 5, 2007
Hospital Day: #5

SUBJECTIVE:

Mr. Doe states that today he is “a little better” but that “things are still a long way from normal.” He states that he was able to read some of the information sheets on mood disorders, acknowledging that he continues to have to reread multiple times “to make any sense out of it.” He continues to refuse couples therapy with the social worker because “it’s no use – she should just leave me.” He states that his sleep was “rotten” and that his appetite “is a little bit better – the food is terrible, but I’m forcing myself.” The patient is caring independently for his ADLs. He attended two groups and was minimally social on the unit with select peers. He did not attend Occupational Therapy due to feeling “too tired.”

OBJECTIVE:

Nursing report reveals:

SLEEP: broken, with 4 hours total and the patient arising at 4:30 a.m.
APPETITE/P.O. CONSUMPTION: 50% breakfast, 75% lunch, 50% dinner

Vital Signs:

T = 37.1C
BP (sitting) = 130/81 P (sitting) = 76
BP (standing) = 128/82 P (standing) = 80
RR = 16
Weight = 188 pounds

MENTAL STATUS EXAM:

Alert, cooperative, fair hygiene, improved eye contact, less psychomotor retardation, no adventitious movements, tics, or tremors. Speech more spontaneous, less monotone, increased volume. No evidence of formal thought disorder. Mood described as “so-so” with restricted affect. Slightly improved motivation. Persistent passive death wishes, but no current suicidal ideation. The patient denies delusions, hallucinations, obsessions, compulsions, phobias, anxiety, panic. MMSE = 30/30. Insight and judgment improving.

Hamilton-D-17: 30

Laboratory Data: TSH = 1.20; Other lab results
unremarkable
Current Medications: Fluoxetine 60 mg PO daily
Enalapril 10 mg PO bid

ASSESSMENT/PLAN:

Major depressive disorder, recurrent, severe – some improvement.
Continue current treatment plan including the following:

1. Close observation – discontinue constant observation and initiate 15-minute checks due to the resolution of suicidal thoughts over the past 48 hours.
2. Continued use of fluoxetine 60 mg PO daily.
3. Consider augmentation with lithium
4. Continue individual supportive therapy.
5. Continue illness and medication education.
6. Attempt to engage the patient and wife in marital therapy.
7. Occupational Therapy referral for relaxation techniques, coping skills acquisition.

Resident Physician
July 5, 2007

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