



A Resident's Guide to
SURVIVING
Psychiatric Training

A Resident's Guide To Surviving Psychiatric Training, 3rd Edition

Edited by:

Tonya Foreman, M.D.

Leah J. Dickstein, M.D., M.S.

Amir Garakani, M.D.

Ayana Jordan, M.D., Ph.D.

Misty Richards, M.D., M.S.

American Psychiatric Association
1000 Wilson Boulevard, Suite 1825
Arlington, Virginia 22209
www.psychiatry.org
703-907-7300

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A resident's guide to surviving psychiatric training / [edited by]
Tonya Foreman, Leah J. Dickstein, Amir Garakani, Ayana Jordan, Misty
Richards.

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Preface to the Third Edition

In the spring of 1999, twenty-five psychiatry residents met in White Plains, New York, to begin their terms as Sol Ginsburg Fellows with the Group for the Advancement of Psychiatry. The fellows were asked to develop a meaningful project and, after much introspection, the Guide was born! As the Guide progressed, the fellows collaborated with members of the American Psychiatric Association's Committee on Women to ensure that the project addressed the needs of women and minorities. In 2006, Amir Garakani, M.D., then an APA/GlaxoSmithKline Fellow, approached the APA about producing a second edition. He believed strongly that in addition to using excellent online resources, psychiatric residents wanted a physical handbook they could drop in their pockets and read at their leisure. His tireless pursuit of the project led to the publication of the Guide's second edition in 2007. In 2015, Ayana Jordan, M.D., Ph.D., a former American Psychiatric Leadership Fellow, under the excellent mentorship of Leah Dickstein, M.D., M.A. and original Guide creator Tonya Foreman, M.D., helped to update, modify and edit the latest and third edition of *The Resident's Guide to Surviving Psychiatric Training*. Misty Richards, M.D., M.S., 2015-2016 President of the American Psychiatric Leadership Fellowship, added substantially to the Guide's impact by collecting residents' anecdotes and practical tips on the Guide's topics. A thoughtful appraisal of the second edition led to several new chapters that make this edition more timely and complete. Building on the vision of Drs. Foreman and Garakani, Dr. Jordan made special note to add new chapters addressing the diverse, cultural needs of trainees, as well as timely subjects such as social media, resident and patient suicide, and business skills.

Life as a resident can be quite chaotic, overwhelming, and difficult to manage. We've attempted to compile an amazing resource to help you navigate the challenges of training. To complete residency and become the physician you envisioned when you applied to medical school, you will have to develop skills that allow you to manage your own life while you take care of others. This book was written by psychiatric residents, fellows, early career psychiatrists, and seasoned attending physicians, especially for psychiatric residents with the sole aim of addressing your needs and concerns. We tried to pool collective experiences to produce a guide that will help you with day-to-day challenges. This is not a clinical handbook. 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 and we hope to provide some encouragement and advice to make your trip a bit easier.

Originally written by Tonya Foreman, M.D., 2007

Updated by Ayana Jordan, M.D., Ph.D., 2015

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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.

Leah J. Dickstein, M.D., M.A. Tonya Foreman, M.D., Amir Garakani, M.D., Ayana Jordan M.D., Ph.D., Misty Richards, M.S., M.D. December 2015.

Part 1:

You, the Psychiatrist: Coming Into Your Own as a Clinician and Maximizing Your Educational Experience

1 Psychiatrists are “Real Doctors” Too: Finding Your Place in the World of Medicine

Most psychiatrists realize early on that there is a bias against mental illness in our society. Despite our hopes that four to six weeks of exposure 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. Here, we offer a practical discussion of how to improve relationships with other specialties in order to “find our place” in today’s medical world.

The Physician Inside

First and foremost, remember that we are physicians. We invested many years in studying medicine, worked hard on our third year rotations, and have the same foundational knowledge as all other medical students. In 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 complete these requirements 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 (this is also true of many other subspecialties). Some psychiatric units encourage consultation for every general medical question that arises, for reasons ranging from liability concerns to workload. In more psychodynamically-oriented settings, concerns about transference and countertransference with regard to the physical exam also lead to 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. Furthermore, as our skills as psychiatrists develop, our physical examination, diagnosis, and treatment skills often atrophy (See Chapter 4, How to Maintain Your Basic Medical Skills).

The Psychiatric Island

Another factor that frequently contributes to the 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, for obvious reasons including the potential for dangerous behavior.

Your contact with other services might be limited to time spent on consultation-liaison services or self-initiated interactions, such as establishing friendships or moonlighting in facilities where other specialties are present. In-services are provided for other disciplines in the hospital (such as social work sessions with nursing), but collaborative exchanges between physicians of different specialties are less frequent.

Building Bridges

So how can you maintain your identity as a “real doctor?” First, you should regularly refer to the advice offered in Chapter 4, “How to Maintain Your Basic Medical Skills.” 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 take you so far.

Working on the consultation-liaison service may help you establish your identity within 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 other physicians. Don’t forget that psychiatry IS a biological science that is becoming increasingly technical. Advances in basic neuroscience, imaging, and even interventional psychiatry are occurring exponentially, and increase our interactions with other medical fields. As psychiatrists, 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 our work is any less legitimate. 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.



Tips for Developing your Physician Identity

- Maintain your basic medical skills! Examine your patients, check their labs, and read about their medical conditions.
- Network with colleagues while you're rotating on medicine, pediatrics, or neurology. You never know when overlapping interests can lead to a collaborative research or QI project.
- Make the most of your interactions with medical teams on the consult-liaison service. You have a lot to learn from them, and a lot to teach them as well. Remember that you are representing psychiatry to all other physicians. They are likely to know as little about it as you know about their field.
- Invite some of your medical colleagues to participate in Grand Rounds on an interesting multi-disciplinary case. Or, attend interesting and relevant Grand Rounds in other fields.
- Represent psychiatry residents on a GME, university, or hospital committee; or serve as a resident union leader.
- Participate in additional training or coursework geared towards residents of all types, for example in research, biostatistics, health policy, or leadership.
- Become involved in undergraduate medical education. Participate on resident panels, teach in multidisciplinary small groups or problem-based learning cases, or get involved in UME curriculum development.

-Tua-Elisabeth Mulligan, MD

2 Sleepless in Psychiatry: How to Survive Call

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

Understand Your Role

Know what you're in for. Talk to other residents. Some programs will have "call guides" developed by senior residents. Read these before call and ask questions. Other institutions have "learning the ropes" call or tandem call. While it may add to your already tight schedule, time with a senior resident in the actual location where you will be taking call can truly ease the pain of those first few nights. Here are some questions you'll want to ask your senior residents:

1. Where are the keys and the pager kept? If they aren't where they're supposed to be, what is the backup system? What designated times are you covering the pager? Do you sign it out to yourself?
2. Sign out: When and where? Who meets? Do you have to call the day consult or inpatient service to update them, or will they page you?
3. Is there a logbook? What types of organizational systems do residents use to keep track of unit issues, consults, and emergency room cases?
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? Is there free food?
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. Attending back-up: Who is the on-call attending? How do you contact them? Do they want to be called about every case, or just if you have questions? Which faculty members are more likely to be helpful? What if they don't call back?
10. Exactly what are the seclusion and restraint regulations? How often does an 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. Where is the legal/admission paperwork kept? Who has to sign?
12. What are the hidden perks – parking passes in nearby lots, etc.?
13. Get some sense of your responsibilities: 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?

In Our Experience... What residents wish they knew before intern year:

When you've received your 4th or 5th consult of the evening and the pager won't stop beeping with floor issues, take a minute to close your eyes and breathe deeply. It is important to center ourselves regularly while on call because we can encounter some of the most stressful experiences we will have in all of residency. Likewise, checking your counter-transference helps remind you that the patients we see on call are not at their best, and are likely being treated less optimally by ER/IM physicians and staff. We must remember to be their advocates when they can't advocate for themselves. Put your pager on silent mode with vibration. This will reduce the amount of noxious stimuli you receive from the device while on call, and may help prevent pager-PTSD.

-Michael Mirbaba, MD, MA, PhD, PGY 4, UCLA Semel Institute for Neuroscience and Human Behavior

Nurses are your best allies on call. Spending those extra few minutes to check in about any active patients, explain the treatment plan, or reassure them about a medical issue can save you many calls/pages in the middle of the night or while you are seeing patients in the ED. And also-human contact on call makes you feel less isolated!

-Amanda Harris, PGY3, NYU School of Medicine

Don't worry about knowing how to do everything – you will constantly be confronted with novel situations, including some that may scare you. There is no shame in asking your senior resident, if you have one, or, better yet, your attending on call, for guidance. They are there so you don't have to carry the burden of a patient's health and wellbeing all alone. Admitting your shortcomings and leaving room to learn and grow is an important skill in medicine.

-Hannah Roggenkamp, PGY 4, UCLA Semel Institute for Neuroscience and Human Behavior

Know the 80-Hour Work Week

In 2001, the Accreditation Council for Graduate Medical Education (ACGME) began requiring all residency and fellowship programs to monitor and limit the number of duty hours a resident or 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 related to patient care, the provision for transfer of patient care, time spent in-house during call activities, and scheduled academic activities (such as conferences). Duty hours do *not* include reading and preparation time spent away from the duty site. In 2011 the Duty Hour Standards were revised with three objectives in mind: the safety of patients in our teaching hospitals today; the safety of patients who will be under the care of today's residents in their future independent practice of medicine; and the establishment of a humanistic learning environment where residents learn and demonstrate effacement of self-interest in favor of the needs of their patients.

Summary of the 2011 ACGME Duty Hour Requirements:

Requirement:	The Details:
Maximum Hours of Work per Week	<ul style="list-style-type: none">▪ Duty hours must be limited to 80/week, averaged over a 4-week period, inclusive of all in-house call activities and moonlighting▪ Exceptions: A review committee may grant exceptions, up to a maximum of 88 hours to individual programs based on sound educational rationale
Moonlighting	<ul style="list-style-type: none">▪ Must not interfere with the ability to achieve educational program goals▪ Time spent in internal and external moonlighting counts toward 80 hours▪ Not permitted for PGY 1 residents
Mandatory Time Free of Duty	<ul style="list-style-type: none">▪ Residents must be scheduled for a minimum of 1 day free of duty each week (when averaged over 4 weeks)▪ One day = 24-hours free from all clinical, educational, and administrative duties.

<p>Maximum Duty Period Length</p>	<ul style="list-style-type: none"> ▪ At-home call cannot be assigned ▪ Duty periods for PGY 1 residents cannot exceed 16 hours ▪ Duty periods for PGY 2 and more senior residents may be scheduled to a max of 24 hours of continuous duty. Residents are allowed to remain on-site for an additional 4 hours to ensure effective transitions of care, but must not be assigned any additional clinical responsibilities
<p>Minimum Time Off Between Scheduled Duty Periods</p>	<ul style="list-style-type: none"> ▪ PGY 1 and intermediate level residents should have 10 hours, and must have 8 hours, free of duty between scheduled duty periods ▪ Intermediate level residents must have at least 14 hours free of duty after 24 hours of in-house duty ▪ Residents in final years of education should have 8 hours free of duty between duty periods, however there may be circumstances when these residents must have fewer hours free between duty periods
<p>Maximum Frequency of Calls</p>	<ul style="list-style-type: none"> ▪ Night Float: A resident must not be scheduled for more than 6 consecutive nights of night float ▪ In-House Call: PGY 2 and more senior residents cannot be scheduled more frequently than every third night (averaged over 4 weeks) ▪ At-Home Call: Must count toward 80 hours. Must satisfy the 1 in 7 free of duty requirement. Must not be so frequent it precludes rest or reasonable personal time for each resident

What Should you do if you or Your Program is Violating the Duty Hour Standards?

Speak up if you are being scheduled for shifts that don't comply with the duty hour standards or your clinical duties are extending beyond the scheduled time! You may have a lot of feelings about discussing duty hour violations ("I don't want to seem like a wimp who can't handle my work load, I need to suck it up," "I don't want to get my PD in trouble with ACGME," or "I am working too slowly."). But remember, you are your own biggest advocate! If you don't make "the powers that be" aware of these issues, changes cannot be made. Some suggestions to get the conversation started:

- Talk with co-residents about their schedules/on-call experiences.
- Reach out to the Chief Residents.
- Talk with faculty you trust, or bring your concerns to your program director/assistant program director.
- Another important way to inform your program about duty hour concerns is during the twice-yearly mandatory duty hour logging. Be honest! This is an account of how much each resident is working in "real time" that PDs have to review.

If you have taken the above steps, and do not feel like your concerns have been adequately addressed, contact your institutional Graduate Medical Education Committee, or the ACGME directly. You can contact the ACGME via phone at 312-755-5000, online at acgme.org, or by mail at ACGME Suite 2000 515 North State Street, Chicago, IL, 60610-4322.

Know Your Limits

Setting limits involves understanding yourself and your institution. Take time to process and get to know who *you* are on call – are you anxious, frustrated, excited, or exhausted? When you are sleep deprived 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 our colleagues was experiencing terrible heartburn. When he finally sought help his physician asked how much coffee he was drinking on a daily basis. After counting cups before rounds, during breakfast, before seminar, at dinner, and between admissions, he realized he was drinking more than 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 profession. If you go into call knowing what pushes

your buttons, you are less likely to become overwrought when someone pushes them. Here are some general strategies for self-care on call:

1. **Know what your responsibilities are on call, and stick to them.**
2. **Know your goal:** on call your job is to get people through to the morning safely. You do not have to (and frankly cannot) solve all of the patient's problems or nail a complicated diagnosis at 3am. Give thorough sign out to the day team, who will pick up where you left off (with more time, resources, and rest on their side!).
3. **Pay attention to nutrition:** it's not just coffee and fast food! Healthy meals and water are the fuel that will keep you going on call.
4. **Take short breaks:** even if you have multiple consults and admissions waiting, taking breaks is not a sign of weakness, rather a sign that you are aware of your needs, and want to be functioning the best you can. In psychiatry we, the providers, are the "tools." If we are frazzled, we will not be able to help anybody else. Even five minutes rest can mean a much smoother interview and better interactions with others.

The ACGME also offers recommendations for alertness management:

1. Fatigue Prevention Strategies:
 - a. get adequate sleep before call
 - b. treat all sleep-related illnesses
 - c. get adequate exercise and nutrition
 - d. reduce use of alcohol and hypnotics for sleep aids while off-duty
2. Fatigue Mitigation Strategies:
 - a. 10-45 minute naps
 - b. 1-2 hour naps increase efficacy but may result in sleep inertia
 - c. caffeine when sleepy (NOT when awake)
 - d. exercise/activity during duty
 - e. bright light

Lastly: Don't be afraid to ask for help! Remember, you are your own best advocate! You are still in training, and as such will not have all the answers. You deserve supervision and guidance in moments where you are unsure.

Marshal Your Resources

Whenever you are caring for patients you are working as part of a team. This may be difficult to remember while on call (when staffing is lower and it is easier to feel isolated), however this is when you need to utilize teamwork the

most! Here is a brief list of your on-call team members, and how you may be able to work together towards a smooth call and excellent patient care:

1. **Physician Back-Up [On-call attendings, chief residents, ED attendings]:** You are allowed (and should be encouraged) to discuss any case with these supervisors! Questions about disposition, medication or behavioral management, hospital politics, resources (hospital vs. community), and legal issues are all fair game. Talking out a case in a quiet environment can help you to realize something you missed, clarify a diagnosis, or lead you to your own conclusions about management. As above, don't be afraid to ask for help!
2. **Primary Team (if you are in the consulting role):** Get their help in contacting collateral or talking to family members. Give recommendations regarding disposition, but you do not have to manage this alone. Ask them to summarize the hospital course and/or clarify the consult question-this can sometimes decrease the amount of time you spend doing chart review.
3. **Medical/Surgical Consult Services:** If you feel you cannot manage a patient's medical issue – don't be afraid to call a consult. This also helps to establish rapport between services. If an issue is acute, call a rapid response or MRT.
4. **Nursing:** Ask about the patient's baseline to help you assess acuity. Ask what management strategies have been effective for the patient. Nurses can help you triage when you're slammed – Prep the nurse and have them try answering the patient's questions first. They can also assist with vital signs and blood draws.
5. **Social Work:** Can often help with insurance and placement issues (inpatient and outpatient).
6. **Clerk:** Can help with copying paperwork and calling transportation (within or between hospitals)
7. **Hospital Security:** Includes crisis management or behavioral code teams. Involve them when there are any safety concerns in interacting with a patient. This scenario absolutely should not be managed alone.

The Bottom Line

You will survive call! While it is one of the most challenging things we do as residents, it can also be one of the best learning experiences. Your comfort level will increase with each call you have under your belt. And don't forget...there are few things better than your post-call breakfast and nap.

3 Roadmaps: Sample Resident Admission Note and Hospital Progress Note

Documentation can be one of the most frustrating aspects of daily life as a resident. Most of us chose medicine to spend time with patients, not sit at a computer typing notes for hours. Nevertheless, documentation is not only necessary for reimbursement, it also enables efficient communication with other healthcare providers. As you continue your training, you will become increasingly appreciative of a well-written note (and increasingly frustrated with poorly written or inadequate notes).

The fundamental documentation concept to master is the balance between **thoroughness and brevity**. Psychiatry, in contrast to many fields of medicine (e.g., Orthopedics), has in some places developed a culture of long, verbose formulations. While notes do serve as a repository of information, which favors thoroughness, they also need to function as rapid communicators of information, which favors brevity. The goal of documentation, then, is to include all the information that is most relevant while avoiding wasted time on the part of the writer and future readers (i.e., “note bloat”). **A few tips on documentation:**

- **Write with your reader in mind** – If you are unsure if information needs to be included, ask yourself, “If I was a doctor taking care of this patient, would I want to know this information?”
- **Focus on information that will change management** – You may have heard the phrase, “Only order labs that will change management.” To a certain extent, this holds true in documentation as well, so use this standard to determine whether information is relevant enough for inclusion.
- **Put most of your effort into a good assessment and plan** – Supporting aspects of the history, such as family history and social history, are crucial and should not be ignored. However, the most frequently read part of your note will be the assessment and plan. Document your diagnostic formulation clearly and concisely, with particular emphasis on how this formulation has led you to your plan.

What follows is an example inpatient admission note based upon a fictional case. Each section contains notes, highlighted in gray, on what information is most salient, as well as practical advice on how to structure the section to convey the necessary information.

Adult Psychiatry Inpatient Admission Note

Patient Name:	Amy Zip
Patient MRN:	5555555
Date of Birth:	1/23/87
Patient Location:	Room 1515
Date of Service:	7/1/2015

Identifying Data:

Amy Zip is a 28 year-old Caucasian female with a history of major depressive disorder complicated by multiple past hospitalizations and one prior suicide attempt. She now presents with worsening depressive symptoms, increasing suicidal ideation with a plan to overdose or drive a car off a cliff, and 2 weeks of new onset bilateral lower extremity weakness.

Identifying Data should include a brief (1-2 sentences) description of the patient's age, gender, diagnosis, and circumstances leading to this admission. The goal is to set the stage for the rest of the note, not to provide a comprehensive history, so err toward brevity on this one.

Chief Complaint:

"My dad is in a better place now. I can't stop thinking that it might be better if I joined him."

Chief Complaint can take the form of either the primary reason for evaluation (e.g., evaluate for suicidal ideation) or a quote that succinctly illustrates the current level of pathology (which was used in this case).

History of Present Illness:

Amy Zip is a 28 year-old Caucasian female with a history of major depressive disorder. She initially presented to the Emergency Department complaining of bilateral lower extremity weakness with slow onset for two weeks prior to presentation. Neurology was consulted, and no focal neurological signs could be found on examination. In addition, CT Head revealed no abnormalities. The Neurology team had a high suspicion for a psychiatric etiology of her weakness, so Psychiatry was consulted.

On interview, the patient describes inability to move her legs which she initially interpreted as due to "tiredness." However, she became increasingly concerned when she was unable to get out of bed yesterday and spent the entire day in bed. Her mother Abigail became concerned when she had not heard from her for 24 hours despite multiple calls and text messages, so she came to the patient's house and discovered her

in bed unable to move. Abigail called emergency services who brought the patient to the Emergency Department.

When asked whether she feels depressed, the patient says, "I don't know. I've been depressed before. This might be another." The patient was then asked about symptoms consistent with a major depressive episode. She endorses insomnia (2-3 hours per night, without a feeling of being rested), anhedonia, hopelessness, decreased energy ("tired all the time"), poor concentration (can no longer read even a single page of a book), and decreased appetite (resulting in a 15 pound weight loss in the past two months). When asked about suicidal ideation, she pauses, then reports thoughts of driving her car off of a cliff. When asked if she would follow through with this plan, she says, "I think it sounds nice."

At this time, the patient does not report symptoms consistent with being in an acute manic episode. She denies decreased need for sleep, grandiose ideas ("If anything, I feel like I'm the worst"), changes in activity, or irresponsible behavior. She does not feel that she has had these symptoms in the past. She further denied auditory hallucinations, paranoia, or bizarre beliefs. She did endorse feelings of chronic anxiety, however, saying that she worries "all the time" about "every little thing." She reports having monthly nightmares about her father dying, but denies hyperarousal, hypervigilance, or feeling "on edge" on most days.

***History of Present Illness** should encapsulate the most salient points of the presentation, including the circumstances leading up to admission as well as a report of the patient's initial interview. More distant aspects of the patient's history such as previous episodes of mental illness, while highly relevant to the current circumstances, should be reserved for **Psychiatric History**.*

This section should also include sufficient information to suggest a diagnosis. In this case, the patient reports many symptoms consistent with a major depressive episode. In addition, a psychiatric review of systems can be reported to help rule out other major psychiatric illnesses such as schizophrenia or bipolar disorder.

*In some cases (e.g., mania or psychosis), the patient's interview may be limited secondary to thought disorganization or unwillingness to engage in an interview. For this reason, it is helpful to describe the source of the information. In this case, the information comes from the patient. In other cases, you could use a sentence such as, "Due to the patient's current level of thought disorganization, adequate history was not obtained. Please see **Collateral Information** for further history."*

Collateral Information:

Mother: Abigail Zip (555-123-4567)

Outpatient Psychiatrist: Dr. Bradley Ying (office: 555-234-5678)

Outpatient Therapist: None.

The patient consented for us to contact both her mother and her outpatient psychiatrist.

The patient's mother Abigail Zip was interviewed outside the patient's room. Per Abigail's report, she has been increasingly concerned about recent changes in the patient's behavior. Abigail reports that the patient has called in sick to work for the past two weeks. In addition, she has appeared increasingly preoccupied when visiting with her mother, and her mother has had to say her name several times before she responds on several occasions. Abigail states that she noticed similar behavior prior to her suicide attempt two years ago, and she is now "beside myself worrying about her. I can't bear to lose her too." When asked if she would be able to watch over the patient if she were to be discharged from the hospital, she says, "I would do anything for my daughter. I just worry so much that if I even take my eyes off of her for one second, that something bad will happen and it will be all my fault."

I spoke with the patient's outpatient psychiatrist Dr. Bradley Ying over the phone. Per his report, he last saw her two weeks ago and noted that she seemed "more down than usual." She denied suicidal ideation to him at that time, however, and he did not consider hospitalization, recommending instead an increase in Venlafaxine to 225 mg from a previous dose of 150 mg. He provides additional information on her history, reported in **Psychiatric History** below. In terms of acute management, he believes that she would benefit from inpatient hospitalization at this time.

***Collateral Information** should be sought for every patient you evaluate. Documentation should include not only the contact information for your sources (e.g., telephone numbers) but also a brief summary of their report. In this case, the patient's mother and outpatient psychiatrist were contacted. Other possible sources of collateral include roommates, other family members, friends, or witnesses to recent events (including the report from emergency services if they were brought in by police or an ambulance).*

As a further point, the presence or absence of consent to contact collateral should be clearly documented, as a patient's right to privacy must be maintained. In cases where the patient refuses consent to contact collateral, most states will allow for collateral to be contacted in emergency situations (e.g., if the patient is highly agitated, intoxicated, or obtunded). It should also be noted that the duty to maintain confidentiality does not prevent you from receiving unsolicited information (e.g., if the patient's roommate is present outside the room and wants to tell you something).

Psychiatric History:

Per the patient's report, she has struggled with depression since age 14, and was formally diagnosed with major depressive disorder by an outpatient psychiatrist at age 15. She was prescribed Sertraline 50 mg which she took for two years with good effect. At age 17, she decided in conjunction with her psychiatrist to discontinue the medication given that she was euthymic. She remained euthymic for three more years until age 20 when she had a 7-month major depressive episode for which she did not seek treatment. She was again euthymic until age 25 when she entered "the most severe depression I have ever been in" in response to her father's sudden death in a car crash in June 2012. Three weeks after her father's death, she attempted to overdose by ingesting a bottle of Acetaminophen. However, she began vomiting and "felt sick" to the extent that she called 911. She was hospitalized medically for two days, then transferred to an inpatient psychiatric unit for two weeks. She was re-started on Sertraline and titrated to 150 mg daily. At the time of discharge, she returned home to live with her mother in Los Angeles.

In August 2012, she began seeing outpatient psychiatrist Dr. Bradley Ying. Per his report, he suspected an underlying bipolar etiology and started Lamotrigine, uptitrating to 200 mg daily. Since that time, the patient reports having never entered a period of euthymia, although her symptoms have partially responded to the extent that she was able to return to work. Dr. Ying has attempted multiple medication changes, including switching to Escitalopram (20 mg, two month duration, discontinued due to lack of efficacy), Bupropion (150 mg, three month duration, discontinued due to "jitteriness"), Lorazepam (1 mg at night, six month duration, discontinued due to "feeling like I'm zonked out all the time"), and Venlafaxine, none of which resulted in any significant changes in her mood. She currently is on Venlafaxine 225 mg po daily and Lamotrigine 200 mg po daily. She briefly participated in supportive psychotherapy in early 2013, but stopped going as she "didn't feel like it was worth my time." She denies ever having participated in cognitive-behavioral therapy, dialectical behavior therapy, or any other modality of therapy. No history of electroconvulsive therapy. In regards to a possible bipolar etiology, Dr. Ying reports that he has not seen evidence of classic episodes of mania, but arrived at this diagnosis due to an "undercurrent of irritability" that he felt during his interactions with her.

- **Prior psychiatric hospitalizations:** One two-week hospitalization in July 2012 following a suicide attempt.
- **Prior psychiatric medication trials:** Sertraline, Escitalopram, Bupropion, Venlafaxine, Lorazepam, and Lamotrigine as above.
- **Prior suicide attempts:** One in June 2012 by Acetaminophen overdose.
- **History of self-injurious behavior:** No history of non-suicidal self-injurious behavior.
- **History of assaultive or violent behavior:** None.

Psychiatric History is one of the most crucial aspects of a complete evaluation, as it helps to assess severity of symptoms as well as guide treatment. For this reason, spending a little extra time on this section is well worth the effort. Any contact that the patient has had with psychiatric care, both inpatient and outpatient, should be clearly documented, with diagnoses and treatments described. Medication trials in particular can help to guide current treatment. A history of suicide attempts or violent acts should also be documented, as a history of either of these increases the likelihood of repeat events. Stylistically, it can be helpful to include a brief summary of the most salient parts of the history (as was done here).

Substance Use History:

The patient reports that she drinks wine with her mother a few times a month, but denies that this is a problem. Denies drinking more than two drinks at a time. CAGE screening was negative (0/4). She does not use tobacco, marijuana, or any illicit substances at this time. Remote history of occasional marijuana use in college on less than five occasions. Drinks “at least three” cups of coffee daily, and “sometimes up to six or seven.”

Substance Use History should be documented for all patients. Substances should include, at a minimum, tobacco, alcohol, marijuana, prescription medications with abuse potential, and illicit substances. (You can also consider assessing for caffeine use in patients with insomnia, depression, restlessness, or anxiety.) If use of any of these substances is present, assessing duration, frequency, and amount of use is important. In addition, determining last use of substances (alcohol in particular) is crucial for evaluating the risk for withdrawal. Finally, for patients with a complicated substance history, inclusion of treatment history (e.g., 12-step groups, medication treatments, inpatient rehabilitation programs, etc.) is recommended.

Social History:

Born in Long Beach, California. Only child of two parents who remained married until the death of her father. Grew up in Irvine, California. Moved to Seattle for college and graduated with a degree in International Communications at age 22. Unable to find work, she returned to live with her parents in Irvine and worked in her father’s dental office handling administrative tasks. In May 2012, she moved to New York City to complete a summer internship. This internship was interrupted by her father’s death and her subsequent suicide attempt as reported in **Psychiatric History**. She did not work for several months after that. She returned to work in winter of 2012 by working at a local coffee shop where she remains working to this day. She currently lives with her mother and does not pay rent. She reports feeling isolated and has few close contacts outside of her mother, saying, “What’s the point? Everyone always leaves me anyway.” Denies involvement with any club, group, or church.

Social History should paint a concise picture of the patient's life trajectory, including their family structure, educational history, and employment history. Current circumstances, such as living situation, source of income, and social supports, are important as well. The goal of taking a good social history is two-fold. First, it helps to humanize the patient by detailing their life course. Second, it can provide useful information on the nature and severity of their mental illness. Diseases like schizophrenia are often associated with a significant decline in functioning, whereas mood disorders can have preserved functioning in between episodes. Knowing the overall course of the patient's functional status can help to distinguish between different diagnoses when the symptoms overlap or are unclear (e.g., differentiating between schizophrenia with depressed mood versus major depressive disorder with psychotic features).

Developmental and Educational History:

Per mother's report, the patient was born at 38 weeks and experienced no complications during gestation, delivery, or post-natal course. She was a "pretty good" student in school and got "mostly A's and B's."

Developmental and Educational History is part of a comprehensive evaluation, but is not necessarily required for all patients. (It is unlikely to change management for an elderly patient with Alzheimer's dementia, for example.) It should be assessed in younger patients, including all child and adolescent patients.

Family History:

Father with major depressive disorder, never hospitalized, no suicide attempts. Mother with an unspecified anxiety disorder. Paternal cousin who committed suicide (reportedly soon after joining "a cult," although the patient has no further details).

Family History should include psychiatric diagnoses and outcomes for all first-degree relatives. A particular focus on suicide and suicide attempts is recommended, as suicidal acts can run in families. Family history for extended relatives can be included when relevant (in this case, a cousin who committed suicide is highly relevant to the current circumstances).

Past Medical History:

Allergic asthma, controlled with Loratadine 10 mg po daily and Montelukast 10 mg po daily. Otherwise negative for significant past medical history outside of being hospitalized for Acetaminophen overdose.

Past Medical History should be included. As mentioned previously use the metric of "Would this change management?" when deciding how much to include. As an example, a diagnosis of an active urinary tract infection requiring antibiotics should be included, whereas a remote history of a urinary tract infection that resolved several years ago is unlikely to impact current treatment. For relevant diagnoses, describe current treatments.

Allergies and Adverse Drug Reactions:

Cats and pollen. Otherwise no known drug allergies.

Allergies and Adverse Drug Reactions is relatively straightforward. Asking about allergies is especially important in acute situations where emergent medications may be needed.

Medication Reconciliation:

Venlafaxine 225 mg po daily for depression

Lamotrigine 200 mg po daily for treatment of bipolar depression

Loratadine 10 mg po daily for allergies

Montelukast 10 mg po daily for allergies

Vitamin D supplement (unknown dose) for “low Vitamin D levels”

*Completing a detailed **Medication Reconciliation** is one of the most important parts of the note and is never optional. Medications for both psychiatric and medical indications should be documented to facilitate decision making regarding which medications should be continued, held, or discontinued upon admission. Indications for medications should be included as well.*

Review of Systems:

Negative except as noted in the HPI.

General: Positive for **fatigue** for 3 months with no diurnal pattern. Positive for **unintentional weight loss** of 15 lbs, attributed to poor appetite by patient. No fevers or chills.

HEENT: Positive for **sinus congestion**. No visual or auditory changes. No headache. No cough or sore throat. No stiff neck or neck swelling.

Cardiopulmonary: No chest pain, palpitations, or shortness of breath.

Gastrointestinal: No nausea, vomiting, abdominal pain, diarrhea, or constipation. No hematemesis, hematochezia, or melena.

Genitourinary: No dysuria or hematuria.

Dermatologic: No edema or rash.

Neurologic: Positive for **bilateral lower extremity weakness**. No numbness or paresthesia.

***Review of Systems** should cover all organ systems, with a particular focus on ruling out life-threatening or other serious illnesses that would require admission to a medical or surgical unit. Positive responses should include follow-up information to guide medical decision making (e.g., specifying the amount of weight loss). Use clinical judgment to determine the level of severity required for inclusion. For example, a 3 lb weight loss is probably not relevant, whereas a 20 lb weight loss is.*

Physical Examination:

Pulse: 82 bpm

Blood Pressure: 116/84 mm Hg

Temp (Oral): 36.5 °C (97.7 °F)

Resp: 18

SpO₂: 100%

General: No acute distress, well developed, well nourished.

HEENT: Oropharynx pink and moist. Neck supple.

Cardiovascular: Regular rate and rhythm, S₁ and S₂ present, no murmurs, clicks, rubs, or gallops.

Chest: Clear to auscultation bilaterally with no rales, rhonchi, or wheezes. Good air movement with normal excursion and effort.

Abdomen: Soft, nontender, nondistended, with normoactive bowel sounds.

Extremities: Warm and well perfused, with no peripheral edema.

Skin: No bruising or rash.

Neurologic: Alert and oriented to person, place, situation and time. Normal bulk. 5/5 motor strength in upper extremities bilaterally. **0/5 motor strength in lower extremities bilaterally.** No resistance to passive movement of any extremities. 2+ deep tendon reflexes throughout. Normal coordination in upper extremities. **Unable to participate in coordination testing of lower extremities.** No focal sensory deficits in any extremity. Negative Babinski sign.

CN I (Olfactory): Not tested.

CN II (Optic): Visual fields intact.

CN III (Oculomotor), IV (Trochlear), VI (Abducens): Pupils equal, round, and reactive to light and accommodation. Extra-ocular muscles intact. No nystagmus, no ptosis.

CN V (Trigeminal): Face sensation intact to light touch, muscles of mastication intact.

CN VII (Facial): Face symmetric with good forehead wrinkle and smile excursion bilaterally, no facial droop.

CN VIII (Acoustic): Hearing grossly intact bilaterally.

CN IX (Glossopharyngeal), CN X (Vagus): Palate elevates equally bilaterally, uvula midline, no hypophonia.

CN XI (Accessory): Sternocleidomastoid and trapezius both 5/5 and equal bilaterally.

CNXII (Hypoglossal): Tongue midline without fasciculation.

*A complete **Physical Examination**, including vital signs, should be reported for all patients. Like the **Review of Systems**, this is to rule out major medical comorbidities or assess the status of existing comorbidities. As one example, a homeless patient with severe schizophrenia who has fallen out of medical treatment may not report shortness of breath during the review of systems, but physical examination would reveal crackles in the lungs and bilateral pitting edema, suggesting the need for a further cardiopulmonary work-up and treatment. A neurologic examination, including cranial nerves, should be reported as well.*

Laboratory Data and Studies:

Pending.

***Laboratory Data and Studies** should be reviewed for all patients. While standards vary between institutions, many psychiatric hospitals request basic "screening labs" such as a BMP and CBC prior to admission. Other labs with relevance to psychiatric management could include a CBC with differential (for patients on Clozapine or Valproic acid), thyroid stimulating hormone, RPR, vitamin B12, or folate. Finally, it can be helpful to obtain a urine drug screen for all patients regardless of their self-reported substance use. It is quick and inexpensive and has the potential to alter management significantly.*

Recent Imaging Results:

No recent imaging.

***Recent Imaging Results**, if available, should be reviewed. While most guidelines do not suggest routine head imaging for all patients with a psychiatric illness, some cases where the etiology is not quite as clear (e.g., new onset of psychotic symptoms in a 78 year-old patient) or where symptoms or physical examination may suggest an alternate etiology (e.g., presence of focal neurologic signs or symptoms) may raise the utility of imaging in determining a final diagnosis.*

Mental Status Examination:

Appearance: Adult Caucasian female, appears stated age of 28 years old. Tearful at times but in no acute distress. Adequately dressed but with matted, uncombed hair.

Behavior: Cooperative. Lays in bed with minimal movement. Poor eye contact, looks down at the floor for much of the interview.

Motor: Normokinetic in upper body. No movement detected in lower extremities. No psychomotor agitation or retardation. No tremor. No evidence of extrapyramidal signs. Normal bulk and tone. Gait was not assessed.

Speech: Normoverbal. Non-pressured. Normal volume. Intact articulation. Absent prosody.

Mood: "I have depression"

Affect: Dysthymic, with restricted range.

Thought process: Linear and logical.

Thought content: Positive for suicidal ideation with a plan to drive her car off of a cliff. Negative for homicidal ideation, auditory hallucinations, visual hallucinations, delusions, or paranoia.

Orientation: Alert and oriented to person, place, time and situation.

Memory: Immediate (seconds), recent (minutes to weeks), and remote (years) memory intact as evidenced by ability to recall details of the interview, report of events leading to her presentation, and overall memory of life events.

Concentration and Attention: Intact as evidenced by ability to appropriately answer questions throughout the interview.

Intellect/Fund of Knowledge: About average as evidenced by use of language.

Insight: Fair as evidenced by ability to verbalize an understanding of the symptoms of major depressive disorder and how they relate to her current circumstances.

Judgment: Poor as evidenced by desire to end her own life and ambivalence about whether or not she will act to make this happen.

*The **Mental Status Examination** is, in many ways, the psychiatric version of a physical exam. Just as conducting a physical exam helps to guide diagnosis of medical conditions, reviewing the mental status exam will inform psychiatric diagnosis.*

While there is no shortage of information available on how to do a mental status exam, let's briefly review the basics. First off, it should be noted that the mental status exam should be based only on what is directly observed by you. For example, things like poor appetite or difficulty sleeping wouldn't be included in the mental status exam because they're not observable. In addition, the mental status exam should not include your interpretation of events. If the patient appears internally preoccupied, you may document that, but do not say something like, "Acting psychotic," as that implies a specific interpretation of what you are observing. Finally, consider using concrete examples (noted here by the phrase "as evidenced by") to support the parts of the exam (such as insight) that require more judgment on the interviewer's part.

Suicide Risk Assessment:

Suicidal Ideation: Present.

Plan for Suicide: Drive her car off a cliff.

Lethality of Plan: High.

Firearms: The patient does not report having access to a firearm.

Access to a firearm is associated with an odds ratio of >3 for completed

Previous Suicide Attempts: One in July 2012 by overdosing on Acetaminophen.

A history of suicide attempts significantly raises the likelihood of a repeat attempt.

Relevant Mental Health Diagnoses: Major depressive disorder. Reportedly diagnosed with bipolar mood disorder but unclear history of manic or hypomanic episodes.

All mental disorders are associated with an increased risk of suicide attempts. Each additional diagnosis raises the risk further, with odds-ratios ranging from 3.9 for a single diagnosis to 28.2 for 6 or more diagnoses.

Static Risk Factors: The patient's static risk factors include a history of psychiatric illness, history of suicide attempts, and a pattern of poor coping.

Dynamic Risk Factors: The patient's dynamic risk factors include a lethal plan, hopelessness, and severe reactions to stress or loss.

Protective Factors: Protective factors include intact reality testing, an established relationship with mental health professional, and family support.

Summary: Given that there are no validated methods of predicting suicide attempts in the immediate future, the clinician's global impression remains the most useful tool for deciding if a patient would benefit from a higher level of care to prevent injury or death. In this case, the patient appears to be at a **high risk** for attempting suicide based upon her stated suicidal ideation, access to her stated means, history of a prior suicide attempt, and other risk factors as outlined above. The patient's risk of suicide will be mitigated by inpatient hospitalization with close observation.

*Given that mental illnesses are associated with the vast majority of suicides in the United States, a comprehensive **Suicide Risk Assessment** should be performed and documented for all patients. While there are many possible ways to document this assessment, an evidence-based approach is best (similar to the one used here). However, even with careful assessment of suicide risk, there is no validated method of accurately predicting which patients will attempt suicide in the near future, and it is helpful to document this in your assessment as well. If prediction is not a possibility, the goal then becomes foreseeability, which relies upon the clinician's judgment and the general standard of practice to decide which patients are in need of a higher level of care. In this case, the foreseeability of the patient attempting suicide is high enough to warrant inpatient hospitalization.*

Diagnostic Impression:

Mental Health Diagnoses and Relevant Medical Conditions:

Major depressive disorder, recurrent, severe, without psychotic features

Rule out bipolar mood disorder

Rule out substance-induced mood disorder

Rule out concurrent persistent depressive disorder

Rule out concurrent personality disorder

Conversion disorder

Rule out factitious disorder

Rule out primary neurologic disorder

Rule out malingering

Rule out generalized anxiety disorder

Significant Psychosocial and Contextual Factors:

Decrease in occupational functioning from previous capabilities

Lives with mother

Stable relationship with outpatient psychiatrist

Limited social support network

*At this point, you have presented all the information that you found relevant. The **Diagnostic Impression** is where you begin to put everything together into a coherent whole. List the diagnoses that you believe to be most likely. However, given that it is difficult to accurately diagnose mental illnesses during a single encounter, do not hesitate to include "rule out" diagnoses. These diagnoses will help to inform future providers about aspects of the history which may need to be clarified further. Substance-induced disorders can nearly always be included as a rule out diagnosis until there is sufficient evidence that substances are not contributing to the clinical picture (usually after a urine drug screen is performed). In addition, consideration of a comorbid personality disorder is important as personality disorders can often contribute to and/or present as mood or psychotic disorders. Including significant psychological, social, and environmental factors can also help to guide future providers towards aspects of the history that require attention, either by contributing to the severity of pathology or by interfering with recovery.*

Assessment and Plan:

Amy Zip is a 28 year-old Caucasian female with a history of major depressive disorder complicated by multiple past hospitalizations and one prior suicide attempt. She presented with four months of worsening depressive symptoms, worsening suicidal ideation with a plan to overdose or drive a car off a cliff, and 2 weeks of new onset bilateral lower extremity weakness. The patient's report on interview is consistent with an episode of major depression, recurrent given her past history of episodes. Social history is notable for a limited social support network and a chronic decrease in occupational functioning from baseline. Mental status exam is concerning for tearfulness, dysphoric affect, and suicidal ideation with a discrete plan. Notably, the patient makes statements suggesting a long chronicity to these thoughts (e.g., "It sounds nice," or "It might be better if I joined [my dad].") Given that the patient sees an outpatient psychiatrist and is currently on two medications to manage depression, it seems clear that she has failed outpatient treatment at this time. In addition, while the patient's mother reports that she would be willing to watch over her at home if she were discharged, she also endorses concerns about her ability to do. Considering these factors, it is likely that the patient will benefit from inpatient psychiatric hospitalization for safety monitoring, diagnostic clarification (i.e., whether there is an underlying bipolar etiology or contribution from a personality disorder which may require different management), and a higher level of care. She is to be admitted to the inpatient psychiatric unit at our hospital.

*The **Assessment and Plan**, as mentioned before, is where you want to put the majority of your effort, as it is certain to be the most frequently read and referenced part of your note. Your goal in the assessment is to succinctly (approximately one paragraph) summarize all of the most salient aspects of the history, including the **History of Present Illness** and any aspects of the overall history that most contribute to your clinical decision making. For the plan, your goal is to translate the history into a reasonable plan of care. Phrases such as "Given that," "Considering these factors," or "With this in mind" will be helpful in allowing future readers to trace the process of your clinical decision making.*

Psychiatric:

Major depressive disorder, recurrent, severe, without psychotic features:

- Admit to inpatient psychiatric hospitalization on a voluntary basis
 - If the patient requests to leave, she would likely qualify for an involuntary hold on the basis of dangerousness to self
- Constant observation for now given suicide risk
- Continue home Venlafaxine 225 mg po daily
- Continue home Lamotrigine 200 mg po daily for now pending further investigation into likelihood of bipolar etiology
- Follow-up admission labs
- Plan to obtain additional collateral with focus on ruling out underlying bipolarity versus concurrent persistent depressive disorder
- Consider psychological testing prior to discharge for formal assessment of personality
- Further management by receiving team
- PRN's:
 - Hydroxyzine 50 mg po qhs prn insomnia
 - Lorazepam 0.5 mg po tid prn agitation
 - Olanzapine 5 mg IM once prn emergency agitation

Conversion disorder: Given the negative neurologic work-up of the patient's recent onset of bilateral lower extremity weakness, a conversion disorder related to the patient's primary depressive disorder appears most likely.

- Consider physical and occupational therapy as an inpatient
- Low threshold to consult Neurology if focal neurologic signs develop

*The **Psychiatric** part of the plan should list all relevant psychiatric diagnoses as well as the plan of care for each. The primary diagnosis should contain the core aspects of the plan (e.g., admit to inpatient hospitalization). If multiple psychiatric diagnoses are present, make sure to pair medications with their appropriate diagnosis. You can also suggest directions for treatment that cannot be accomplished immediately (e.g., personality testing).*

Medical:

Allergic asthma: Well controlled. Patient does not report any use of rescue medications in past several years.

- Continue home Loratadine 10 mg po daily
- Continue home Montelukast 10 mg po daily
- Start Albuterol inhaler 90 mcg 2 puffs q6h prn wheezing or shortness of breath

Health maintenance:

- Continue home Vitamin D supplement once dose can be clarified

*The **Medical** part of the plan follows the same rules as above (i.e., pair treatments to their appropriate diagnosis).*

PRN/FEN/PPx:

- Pain/Fever: Acetaminophen 650 mg po q6h prn pain, headache, or fever
- Constipation: Magnesium hydroxide 400 mg/5 mL po daily prn constipation
- Dyspepsia: Aluminum-magnesium hydroxide-simethicone 400-400-40 mg/5 mL susp 15 mL po q6h prn indigestion or heartburn
- Insomnia: Hydroxyzine as above.
- Diet: Regular.
- Fluids: None.

*Consider including a section on **PRN/FEN/PPx** (for as-needed medications; fluids, electrolytes, and nutrition; and prophylaxis) for all patients. The majority of patients in the hospital will occasionally deal with the normal aches and discomforts of everyday life, so having basic medications such as Acetaminophen or Magnesium hydroxide at over-the-counter doses can prevent unnecessary delays in patient care, provide nursing staff with additional options for patient care, and save you from getting avoidable pages.*

Legal Status:

Voluntary, though if the patient requests to leave, she would likely qualify for an involuntary hold on the basis of dangerousness to self.

***Legal Status** should reflect the patient's current admission status (i.e., voluntary versus involuntary). Additional legal information, such as the presence of a durable power of attorney, should be indicated here as well. Finally, for the purposes of helping your colleagues on call, I recommend including contingency planning (in this case, what to do if this voluntary patient requests to leave), as it can communicate your wishes for this patient and prevent unfavorable outcomes (e.g., the patient being allowed to leave since she is on voluntary status despite being at a high risk for suicide).*

Code Status:

Full code.

***Code Status** should be obtained for all patients, regardless of age or medical comorbidity.*

Disposition:

To be determined. Likely back home once psychiatrically stable. Will consider intermediate level of care (e.g., partial hospitalization program) closer to discharge.

*While **Disposition** cannot always be predicted from the beginning, you should at least consider what the most likely plan for discharge is, with the knowledge that you can revise as more information becomes available.*

Note written by Dr. Jonathan Heldt, MD, PGY-II. This patient was seen and discussed with Dr. Carmen Ybarra, MD, attending psychiatrist, with whom the above assessment and plan were jointly formulated.

*Finally, indicating **Authorship** (including the contributions of medical students or other sources of information) is usually necessary for purposes of clarity, not to mention reimbursement.*



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Sample Resident Hospital Progress Note

In contrast with an admission note, which should contain sufficient information to paint an overall picture of the patient's lifetime clinical course, a progress note should serve as a brief overview of the past day's events. As with an admission note, however, the focus should be on information with the potential to change management. The recommendation to spend the most of your effort on a thorough Assessment and Plan holds true as well, as this is the part of the note that is most likely to be of help to your colleagues.

Adult Psychiatry Inpatient Progress Note 7/5/2015	
Patient Name:	Amy Zip
Patient MRN:	5555555
Date of Birth:	1/23/87
Patient Location:	Room 1515
Date of Admission:	7/1/2015 (Day 5)

Identifying Data:

Amy Zip is a 28 year-old Caucasian female with a history of major depressive disorder and generalized anxiety disorder complicated by multiple past hospitalizations and one prior suicide attempt. She now presents with worsening depressive symptoms, increasing suicidal ideation with a plan to overdose or drive a car off a cliff, and 2 weeks of new onset bilateral lower extremity weakness.

Interval History:

Guarded in her interactions with staff. Appeared dysthymic throughout the day. No suicidal ideation reported. Took all scheduled morning medications. Observed wheeling herself up and down the hallway in the afternoon. Came to dinner but was unable to tolerate sitting at the table for more than 5 minutes. Psychiatrist on call was paged who recommended holding Aripiprazole and giving a one-time dose of Propranolol 10 mg. Following this, patient reported feeling less nervous but still "on edge." Patient requested Hydroxyzine which was given at 21:40 with poor effect. Psychiatrist on call was paged and prescribed Lorazepam 0.5 mg. Following this, the patient calmed and was able to sleep. She slept approximately 6 hours. No emergency medications required.

*Interval History should contain a summary of reports from other observers of the patient's behavior (primarily nursing staff, but can include on-call psychiatrists, physical or occupational therapists, social workers, or other support staff). Things that the patient tells you personally about the past day should be reserved for the **Subjective** section.*

Subjective:

On exam, the patient reports that yesterday was “the worst day I’ve had here” and describes a feeling of restlessness and anxiety throughout the day. When told that this was possibly a side effect of her new medications, she reported, “Well I’m never taking that again then.” Alternative options for adjunctive treatment of her depression were discussed. At this time, she elects to proceed with starting a different antidepressant. Regarding her suicidal thoughts, she reports that she no longer is entertaining thoughts of killing herself but that she “still feels like there’s no point to going on.” She reports being frustrated by her lack of progress with moving her legs despite working with physical and occupational therapy for several days.

***Subjective** should contain what the patient told you personally during your interview. While you may discuss multiple topics with your patients, try to report on only those topics with clinical relevance. For example, there is probably no need to report that the patient didn’t enjoy her breakfast even if this is something that you talked about.*

Collateral Information:

Mother: Abigail Zip (555-123-4567)

Outpatient Psychiatrist: Dr. Bradley Ying (office: 555-234-5678)

I spoke with the patient’s mother over the telephone to give an update on the patient’s progress. I discussed her reaction to Aripiprazole and that we would be trying a different medication today. Mrs. Zip seemed relieved to hear that her restlessness was likely medication-induced, saying, “She sounded so bad on the phone last night.” She had no other questions or concerns for today.

I attempted to call Dr. Ying today but was unable to make contact. Voicemail left.

Current Medications:

Patient has received all scheduled medications during the interval. No psychiatric PRN’s required.

- Aripiprazole 5 mg po daily (discontinued 7/4/2015)
- Loratadine 10 mg po daily
- Montelukast 10 mg po daily
- Venlafaxine 225 mg po daily
- Vitamin D supplement 1,000 Units po daily

Objective Data:

Pulse: 76 bpm

Blood Pressure: 122/80 mm Hg

Temp (Oral): 37.1 °C (98.8 °F)

Resp: 16

SpO₂: 100%

Sleep: 5 hours

Meals: 0% of breakfast, 100% of lunch, 25% of dinner

Objective Data can include behaviorally relevant information such as hours of sleep or percent of meals eaten. For elderly patients or those on medications that can alter bowel function (e.g., opiates or Clozapine), keeping track of bowel movements can be helpful as well.

Laboratory Data and Studies:

None recent.

Recent Imaging Results:

None recent.

Mental Status Examination:

Appearance: Adult white female, appears stated age of 28 years old. No acute distress.

Behavior: Cooperative. Sitting in wheelchair. Good eye contact.

Motor: Normokinetic in upper extremities. No psychomotor agitation or retardation. No tremor. No evidence of extrapyramidal signs during this examination. Normal bulk and tone. Gait was not assessed.

Speech: Normoverbal. Improving prosody.

Mood: "Worst day I've had"

Affect: Dysthymic with constricted range. Does not smile throughout the interview.

Thought process: Linear and logical.

Thought content: Positive for hopelessness but no frank suicidal ideation today. Negative for homicidal ideation, auditory hallucinations, visual hallucinations, delusions, or paranoia.

Insight: Fair as evidenced by ability to verbalize an understanding of the symptoms of major depressive disorder and how they relate to her current circumstances.

Judgment: Fair, improving as evidenced by decreasing thoughts of suicide, though her judgment remains impaired compared to baseline by her ongoing hopelessness about her situation.

Your **Mental Status Examination** should be updated daily. Don't be afraid to include comparisons to previous exams (e.g., saying that her prosody is improving) to help track clinically significant changes.

Diagnostic Impression:

Mental Health Diagnoses and Relevant Medical Conditions:

Major depressive disorder, recurrent, severe, without psychotic features

Low suspicion for bipolar mood disorder

Conversion disorder

Significant Psychosocial and Contextual Factors:

Decrease in occupational functioning from baseline

Lives with mother

Stable relationship with outpatient psychiatrist

Limited social support network

Assessment and Plan:

Amy Zip is a 28 year-old Caucasian female with a history of major depressive disorder and generalized anxiety disorder complicated by multiple past hospitalizations and one prior suicide attempt. She initially presented with four months of worsening depressive

symptoms, worsening suicidal ideation with a plan to overdose or drive a car off a cliff, and 2 weeks of new onset bilateral lower extremity weakness. The patient was admitted to inpatient psychiatric hospitalization on 7/1/2015 for treatment of a major depressive episode and presumptive conversion disorder. Since admission, the patient has continued to report symptoms of depression. A detailed review of her history as well as an extensive discussion with her outpatient psychiatrist revealed little evidence of bipolarity, so Lamotrigine was discontinued on 7/3/2015. Aripiprazole 2 mg was started the same day for further antidepressant augmentation and then increased to 5 mg the following day. However, the patient reported symptoms consistent with akathisia on this dose, so it was discontinued. The patient remains interested in further pharmacologic management of depression. Given her difficulty sleeping, Mirtazapine may be a good option at this time. After discussion of the risks and benefits of this medication, the patient is amenable to starting Mirtazapine 15 mg po qhs tonight, with further monitoring for tolerability and efficacy. In addition, we will continue to offer groups and other supportive therapy while she is an inpatient. In regards to her continued bilateral lower extremity weakness, the diagnosis of conversion disorder continues to be most likely given the absence of focal neurologic signs. While she has made little progress thus far, available evidence suggests that conversion disorder often takes several weeks to remit even with adequate treatment of underlying psychiatric disorders. We will continue physical and occupational therapy. Overall, the patient is showing signs of progress towards being able to transition towards a lower level of care. Provided that she is able to tolerate Mirtazapine and continues to show reductions in her suicidal ideation, she will likely be stable for transitioning to a partial hospitalization program soon.

*As before, your **Assessment and Plan** is the most important part of your note. Use this section to include the most relevant information throughout the patient's hospital course, and don't be afraid to draw clear connections between the information presented and changes in your treatment (e.g., "A detailed review of her history revealed little evidence of bipolarity, so Lamotrigine was discontinued"). It is helpful to use this section as a running hospital course, which helps tremendously when it comes time to write a discharge summary.*

Psychiatric:

Major depressive disorder, recurrent, severe, without psychotic features:

- Continue inpatient hospitalization
- Continue voluntary status
- Continue routine observation
- Continue home Venlafaxine 225 mg po daily
- Discontinue Aripiprazole 5 mg po daily due to akathisia
- Start Mirtazapine 15 mg po qhs
- Will plan to obtain psychological testing the day prior to discharge for formal assessment of personality
- PRN's:
 - Hydroxyzine 50 mg po qhs prn insomnia
 - Lorazepam 0.5 mg po tid prn agitation
 - Olanzapine 5 mg IM once prn emergency agitation

Conversion disorder: Given the negative neurologic work-up of the patient's recent onset of bilateral lower extremity weakness, a conversion disorder related to the patient's primary depressive disorder appears most likely.

- Continue physical and occupational therapy

Akathisia secondary to Aripiprazole:

- Discontinue Aripiprazole as above

- Continue Propranolol 10 mg po tid prn akathisia for now

Medical:

Allergic asthma: Well controlled. Patient does not report any use of rescue medications in past three years.

- Continue home Loratadine 10 mg po daily

- Continue home Montelukast 10 mg po daily

- Continue Albuterol inhaler 90 mcg 2 puffs q6h prn wheezing or shortness of breath

Health maintenance:

- Continue home Vitamin D 1,000 Units po daily

PRN/FEN/PPx:

- Pain/Fever: Acetaminophen 650 mg po q6h prn pain, headache, or fever

- Constipation: Magnesium hydroxide 400 mg/5 mL po daily prn constipation

- Dyspepsia: Aluminum-magnesium hydroxide-simethicone 400-400-40 mg/5 mL susp 15 mL po q6h prn indigestion or heartburn

- Insomnia: Hydroxyzine as above.

- Diet: Regular.

- Fluids: None.

Legal Status: Voluntary.

Code Status: Full code.

Disposition: Likely back home once psychiatrically stable with transition to partial hospitalization program.

Note written by Dr. Jonathan Heldt, MD, PGY-II. This patient was seen and discussed with Dr. Carmen Ybarra, MD, attending psychiatrist, with whom the above assessment and plan were jointly formulated.

4 How to Maintain Your Basic Medical Skills

Maintaining our basic medical skills is increasingly essential as more psychiatrists find themselves in the role of primary care physician (for example, in many of the nation's VA hospitals) or in integrated settings. Modern psychiatry demands that we integrate general medicine with mental health. Here's an example of how this can strengthen our psychiatric practice:

A 70 year-old woman with chronic schizoaffective disorder is admitted for worsening depression and command auditory hallucinations to harm herself. During the intake interview, the admitting resident discovers she was successfully treated for breast cancer in her 40s and that her current symptoms began three weeks ago after she discovered a breast lump on self-examination. She does not have a primary care provider and is very concerned that she is going to die. The voices tell her, "You're going to die anyway, so just kill yourself." On physical examination, the resident notes a 2.5cm, fixed, non-tender breast mass. The team orders a mammogram that confirms a suspicious mass and coordinates her care with the oncology consult service. Together, they explain the diagnosis/staging workup and help to coordinate her cancer treatment after discharge. While she is initially distressed by the diagnosis, the patient quickly calms and notes that she feels more empowered. Her auditory hallucinations also subside without major medication changes and she no longer experiences suicidal ideation.

Make a Point of Finding 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 and internship.

- **Attend Grand Rounds Outside of Psychiatry:** 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.
- **Consultation-Liaison (C/L) Psychiatry:** Participation on the psychiatric C/L service is another 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. 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 questions. They are likely to enjoy your genuine interest in their practice area. This interaction can form the basis of collegial relationships and even new friendships.

- **Conduct Thorough Physical Exams on Your Patients:** Psychiatric patients frequently take medications with metabolic side effects, have co-morbid medical conditions, and do not have a primary care provider. Conducting physical exams on psychiatric patients (especially in emergency department or inpatient settings) is not only a great way to practice your medical skills; you may discover medical problems that, with treatment and/or referral, can greatly impact your patient's clinical course.

Read Outside your Specialty – Selectively

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 these “free” psychiatric journals are pharmaceutical-supported and may include studies that are not peer-reviewed or are potentially 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 in your office). For example, AMA members receive *JAMA* weekly for free. Many academic residency programs also provide free access to peer-reviewed medicine and neurology journals. Smartphone apps like Read by QxMD allow you to use your institutional subscription to create a customized “journal” that pulls articles from multiple sources into a format that's easy to browse during downtime. 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.

Read them with an eye towards drug-drug interactions and potential psychiatric manifestations of illness. Many medical textbooks such as *Cecil, Harrison*, or the *Washington Manual* are also available in digit format and perhaps even for free through your library. 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 UpToDate, an online clinical decision support resource. The information is regularly updated by experts and can be accessed quickly and easily.

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's also 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 through moonlighting (always keeping in mind ACGME duty-hour rules). In moonlighting positions, the admitting psychiatrist often performs the admission history and physical, as well as handles all general medical emergencies. Although not universally 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 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 referred for psychiatric care should it 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.

Additional Resources

Journals/Websites

- New England Journal of Medicine
- JAMA
- Neurology
- Pediatrics
- The Journal of Family Medicine
- UptoDate



Check out APA courses on Primary Care Skills for Psychiatrists. Available at a discount to RFMs on the **Learning Center:** education.psychiatry.org

Books

- **Cecil textbook of medicine, 25th edition.** Goldman L and Schafer AI. Elsevier: Atlanta, GA. (2015)
- **Washington manual of outpatient internal medicine, 2nd edition.** De Fer TM and Sateia HF. Two Commerce Square: Philadelphia, PA. (2015)
- **Harrison's principles of internal medicine, 19th edition.** Kasper D, Fauci A, Hauser S, Longo D, Jameson J, and Loscalzo J. McGraw-Hill Education: New York, NY. (2015)
- **Preventive medical care in psychiatry.** McCarron RM, Xiong GL, Keenan CR, Nasrallah HA. American Psychiatric Association: Washington, DC. (2015)
- **Current medical diagnosis and treatment 2016.** Papadakis M, McPhee SJ, and Rabow MW. McGraw-Hill Education: New York, NY. (2016)
- **Neurology for the non-neurologist, 6th ed.** Weiner WJ, Goetz CG, Shin RK, and Lewis SL (editors). Lippincott Williams & Wilkins: Philadelphia, PA. (2010)
- **Essentials of neuropsychiatry and behavioral neuroscience, 2nd edition.** Yudofsky SC and Hales Robert (editors). American Psychiatric Association: Washington, DC. (2010)

5 How to Get the Most Out of Your Psychotherapy Supervision

You may have 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, your supervisors will likely be determined by your current rotation. 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 how you spend that time. Take advantage of the gift of supervision – this is the only time in your career when supervision will be free. The following are suggestions that may be helpful in choosing and developing a good relationship with your supervisors. 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, choose physician supervisors with competence in evidence-based psychopharmacology, non-pharmacologic treatment options, and experience working with difficult-to-treat patients.
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. Your supervisor can assist you with self-observation. What you see and feel about each patient are all grist for understanding therapy, countertransference and how you function as a tool within 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.
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 substance misuse/abuse therapies. Ask each supervisor for his or her opinions about each method of therapy and when a different approach might be more appropriate.
4. Many supervisors have a toolbox of helpful techniques they've honed to capture therapy sessions. Although at first these techniques can be time-consuming for the resident, they are an extremely helpful addition to a beginning therapist's selective memory of the session. These techniques may include process notes or audio or

videotaping the sessions. Some therapy groups employ a co-therapy model where one co-therapist records while the other leads the sessions.

5. Many supervisors will suggest journal articles or book chapters for you. Read them – this information probably influenced them. Also be prepared to share the things that have influenced you. They might be interested in your influencers, as well. Remember, in the not-too-distant future you'll be peers.
6. Always consider your supervisor's advice, but 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.
7. You will be pleasantly surprised how small the world of psychiatry really is. The supervisory relationships you've cultivated in residency will often be revisited in your professional future when your former supervisors are now your peers 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 this is a relationship that can extend well beyond your years in training.



The APA Annual Meeting is a great place to reconnect with colleagues. Members also receive discounted registration. Find out more at:

[Psychiatry.org/AnnualMeeting](https://www.psychiatry.org/AnnualMeeting)

6 Your Role as a Team Leader

“Team leader” is one of the most important roles you’ll assume as a psychiatrist. Remember that mental health is multidisciplinary. The psychiatrist, whether a novice or an experienced clinician, is expected to lead a team of health professionals. Often these colleagues entered practice while you were still in school, so becoming comfortable with assuming a leadership position takes learning, trial, and error. It is difficult to overstate the anxiety of your first experience when a patient is escalating and a nurse asks you, **“So what are you going to do, doctor?”** This is where the “team” aspect comes into play. Don’t be afraid to look to more experienced team members for suggestions.

Tips for Team Leadership

Your supervisor and mentor can help you through this learning curve, but also keep these points in mind:

- **It is tempting to try to establish your authority at the expense of the team.** For example, how would you react after writing an order if another team member asked, “Doctor, don’t you think that Drug X is a better choice for this patient?” You may be frustrated and feel tempted to be defensive. Resist that temptation. Your goal should be to develop your autonomy while maximizing the functioning of the team and respecting each member’s contributions.
- **Everyone has a role and expertise in the team.** Each member wants to feel like an integral part of the team, but might have insecurities about his or her position.
- **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.
- **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.** Being dismissive of team members’ input will rapidly alienate your colleagues.
- **Follow basic rules of courtesy.** It will go a long way toward earning your team’s respect. If your suggestion to a team involves more work, you should explain why it’s important and listen for feedback.

Creating an Effective Team

Some of the more crucial moments for a team will occur during moments of crisis. Suicide attempts or completion, code responses for agitated patients, and violent outbursts can shake even the most experienced caregivers. **Taking the necessary time to debrief not only keeps the team healthy, but also trusting and cohesive.**

You will find that working in a team is at times like leading group therapy, highlighting how **one of the psychiatrist's hats is caregiver to the treatment team itself.** In some settings, a weekly meeting for the team members to communicate with one another in a non-threatening manner about team functioning can help pre-empt conflicts and grievances. The first meeting may be awkward – or be hijacked by patient care issues. A gentle reminder of the importance of focusing on how the team can work better together can help the meeting return to its primary goal.

As a consultation psychiatrist, you will be called to assist other teams, be it medical or surgical. The call to the psychiatrist usually has to do with mental health issues related to medical conditions. However, 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. **Remember that while these issues are bread and butter for psychiatrists, they can cause a great deal of anxiety for medical professionals in non-psychiatric fields.**

Difficult patients on the medical ward can also 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. 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 also meeting with the team to understand the nature of their difficulties.

Psychiatric residency will provide you with many opportunities to function as a team member and leader. **Cultivating your skills as a team player will help you work effectively as a clinician and teacher and prepare you for a myriad of other professional roles.**

7

See One, Do One, Teach One: How to Supervise Medical Students

In that cynical bible of medical internship, *House of God*, Samuel Shem notes, "Give me a medical student who only triples my work and I will kiss their feet." 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. You might wonder why you should strive to become a good teacher given these encumbrances and the paucity of support and recognition. 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 guidance of respected teachers that many of us chose our career paths.

Psychiatric residents have a unique opportunity to influence future physicians with their proximity to medical school experiences, their training in empathy and self-awareness, and their close interaction with rotating students. The psychiatric resident can reduce the stigmatization of both the patient and the entire specialty by demonstrating competence and compassion in all interactions with psychiatric patients while emphasizing the prevalence of psychological factors in medical illness.

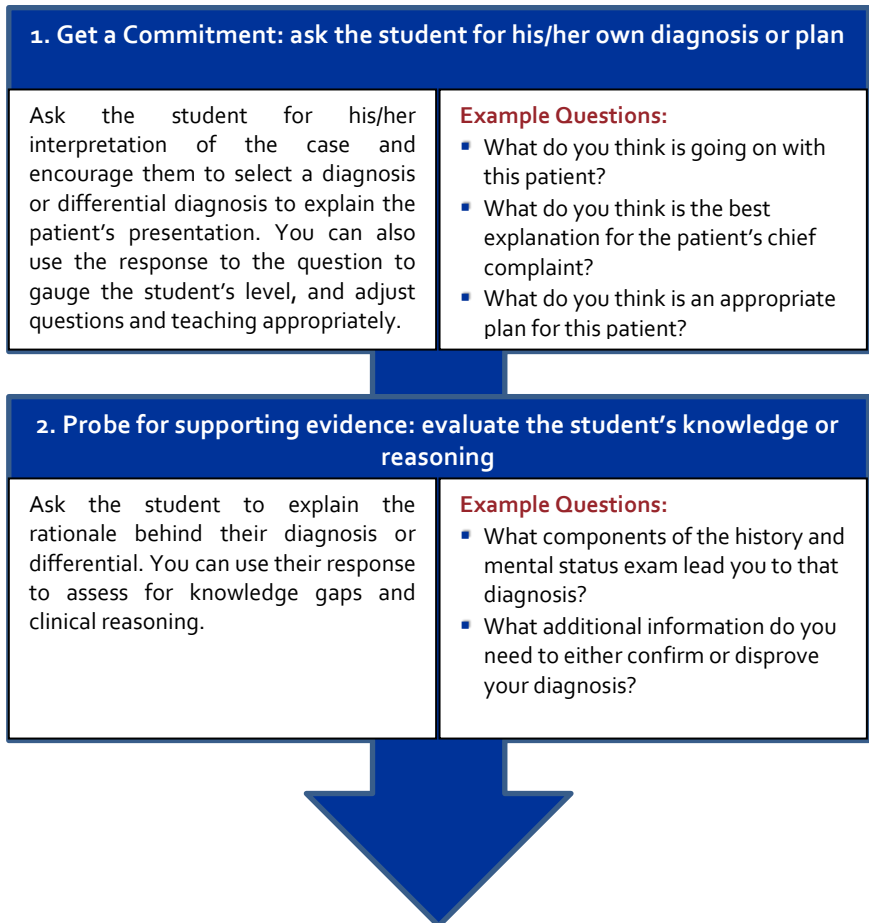
Teaching psychiatry to medical students is in some respects easy and in others very challenging. Factual information, DSM-5 criteria, and basic psychopharmacology are all reasonably straightforward and often well enough covered by didactic lectures to be regurgitated at the end of a medical student's 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, rote 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.

Serving as a mentor and supervisor is an integral part of what it means to be a doctor. 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 growth of the rotating medical student will contribute to the development of a more sophisticated and humane future physician.

Practical Nuts and Bolts for Being an Effective Teacher

THE ONE-MINUTE PRECEPTOR

The five-step “microskills” model, developed by Drs. Neher, Gordon, Meyer and Stevens in 1992, provides a useful framework for efficient clinical teaching. Also referred to as the “One Minute Preceptor,” these five steps can be used to help organize any teaching encounter:



3. Reinforce what was done well: provide positive feedback

Provide specific feedback regarding what the student did successfully in the encounter. This can range from establishing good rapport with a patient, giving a succinct and organized case presentation, coming to the correct diagnosis, or describing a thorough differential diagnosis.

Example Feedback:

- You did a great job of making the patient feel comfortable by normalizing the experience of auditory hallucinations in those experiencing severe depression.

4. Give guidance about errors and omissions: provide constructive feedback with recommendations for improvement

This feedback should also be specific. Each correction should be followed by the appropriate answer or recommendations for approach to the next case. This leads into the next microskill...

Example Feedback:

- Make sure to consider a major depressive episode with psychotic features as part of the differential diagnosis for auditory hallucinations.

5. Teach general rules: teach the learner common “take-home points,” basic principles, or “clinical pearls” that can be used in future cases

You may want to aim these points at an area of weakness for the learner that you have identified in the encounter.

Example Feedback:

- Before starting Depakote, always check a baseline CBC for platelets, and LFTs.
- An effective way to start a patient interview is to ask an open ended question regarding their reason for coming into the office or ED.

Providing a conclusion:

This last step serves to end the specific teaching encounter, and articulate a plan for how the teaching dyad or group will proceed next. For example, if you are evaluating a patient in the ED, you can conclude by saying “So we have decided the patient requires inpatient psychiatric hospitalization for a major depressive episode. Can you please grab the legal paperwork for me to fill out, and call the nurses to make them aware of the patient. We can then go together to explain the plan to the patient.”

How to Organize Teaching by Clerkship Phase

Beginning Phase:

- Clarify objectives and expectations: be as specific as possible
- Help students acclimate to the working environment: Review daily work flow, introduce them to the interdisciplinary team, demonstrate basic daily tasks (progress notes, treatment plans, lab draws etc)
- Help students become comfortable interacting with patients
- Connect the psychiatry rotation to the student's articulated interests and career goals. For example, if a student is interested in primary care medicine, set a goal to have a clear understanding of the diagnosis and management of depression and anxiety, as well as how to make an appropriate psychiatry referral.
- Master the mental status exam: Review sections and terminology. Have the student practice presenting the MSE after patient interactions or based on video clips. Begin to connect typical MSE findings to diagnostic categories.

Middle Phase:

- Interviewing skills: Provide a structured approach. Begin with student as observer, progress to resident as observer. Give constructive feedback in real time
- Case Presentations: keep concise and organized
- Diagnosis: Review DSM-5 diagnostic criteria and the biopsychosocial model. Encourage developing a complete differential diagnosis. Craft a plan for testing the working diagnosis.
- Treatment Planning: Consider domains of psychopharmacology, psychotherapy, medical, social supports, and after care plan
- Feedback: bi-direction feedback at mid-clerkship from resident to student, student to resident

End Phase:

- Case Formulations: Hone a thorough case formulation, including developmental factors and ideas about personality styles
- Increase autonomy: Encourage student to take the lead in daily interviews with old and new patients, and family and team meetings.
- Connect back to career goals: Help student consolidate skills learned that can be used in future rotations (i.e.: student interested in surgery feels comfortable with capacity evaluations).
- Feedback: end of rotation bi-directional feedback.



General Anxiety-Relieving Tips for Teaching

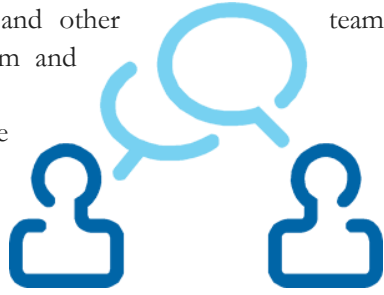
- Teach what you know – It is okay to encourage students to learn about a topic and teach back through short 5 min presentations.
- If you are a junior resident, encourage students to interact with and ask questions of more senior residents and attendings to broaden their learning experience (even if they are intimidated to do so!)
- Engage other team members in teaching students, including social workers, nurses, and specialists (i.e.: art therapists).
- Actively engage students in teaching by asking questions, capturing their attention, and making it fun!
- Be practical, targeted and realistic in choosing your teachable moments.
- Don't forget – You teach just by modeling your interactions with patients and other treatment team members.
- Showing students respect and supporting their autonomy goes a long way. If the student feels like they are an integral, appreciated part of the team, they will feel more enthusiastic about coming to work each day and contribute more. A positive and supportive environment promotes learning and prevents burnout!

-Amanda Paige Harris, MD

8 Giving and Receiving Feedback/Evaluations

Good feedback can have tremendous educational benefit. It allows residents to reflect on their performance and focus on specific areas of improvement. In addition, having strong communication and cohesiveness among residents, attending physicians, and other team members is beneficial for both the team and patient care.

Asking for and giving feedback can be hard. No one wants to hurt others' feelings, and giving/receiving feedback can be perceived as confrontational, triggering defensiveness. Luckily, there are several methods for soliciting the most meaningful feedback from team members.




Giving Meaningful Feedback

Feedback can occur under many contexts, including brief pearls of wisdom in passing, more formal critical analysis of particular patient encounters, and official feedback in the form of a mid or end of rotation review. As residents, we provide feedback to junior residents and medical students, whom we are asked to teach and guide. Dr. Jack Ende's landmark 1983 article offers several key principles for giving feedback. These include (with some adaptations):

1. Establish an alliance with the student

- Set aside time and find a private space to talk.
 - Ask the student about your own performance as well as how the student felt about their performance.
 - Use your feedback to work collaboratively to develop concrete, attainable goals
-
- Give specific examples about work-related actions or habits that may be detrimental to the team. Shy away from generalizations.
 - Facilitate a conversation in which mutual learning and team benefit are at the forefront of the conversation.

2. Offer feedback on observed incidents that are associated with modifiable behaviors



3. Give the appropriate amount of feedback per session

- Too much advice and feedback at one time can be overwhelming.
- This includes positive feedback. You may feel tempted to offer a deluge of compliments before noting areas for improvement, however appropriate positive feedback focuses on what went well with the task at hand. Instead of “You’re great!” try “That case presentation gave a very useful picture of the patient’s problem.”

- Choose non-judgmental words.
- Avoid assessing the learner based on subjective feelings or interpretations of student motives



4. Communicate using courteous language.

Receiving Feedback and Evaluations

When the rotation starts, clarify expectations and be open to feedback. As early as possible, ask a preceptor or other senior/junior residents who previously rotated on that service about your specific expectations. By identifying your role in the team, it will avoid ambiguity and hopefully reduce clinical redundancy and oversight. Some useful questions may include:

- Average shift time: When are sign-outs? Are you expected to give sign-out, and to whom?
- How many patients are residents expected to carry? What patient responsibilities are you expected to perform? Preceptors should make it clear to you how many patients you’re expected to take care of, as well as other responsibilities

During the rotation, don’t be afraid to ask for help. It’s much worse to be avoidant and sloppy than to just ask for help when you don’t know how to do something. Although sometimes it may be hard to ask seniors or attending physicians, our responsibility is to the patient first. If something is unclear, follow your gut instinct and stop to evaluate the situation. The outcome can be significantly worse than the embarrassment of asking for help.

Be proactive about asking for feedback. Ask for feedback early in the rotation, even as early as the first week. You should request specific pointers to help you grow as a learner. Consider learning about a variety of topics in the form of seeking advice, for example, you could ask:

- What is the proper terminology to use in notes?
- What are more descriptive word choices for the mental status exam?

- How do I ask better questions during a patient interview?
- What knowledge may be pertinent to a specific patient population?
- What note taking method do you recommend?

Maintaining a curious, enthusiastic mindset can help tremendously in your learning. Feedback does not always have to be formal. Brief, informal feedback, may be all you can get in certain circumstances.

At the end of your rotation, be sure to ask again for any further feedback points that can be useful for the future. Negative feedback can sometimes be hurtful and unfair, especially if not given in a constructive way. If preceptors say generally that your performance was lackluster, the feedback is really unhelpful because you don't know how to improve. Probe to see if there are specific identifiable behaviors that would improve the team dynamic, and what you would need to do personally. Keep in mind that feedback can be biased toward a select few memorable experiences that were either favorable or unfavorable, and does not always reflect the aggregate performance throughout the rotation.

It's important to be honest with yourself. If you did not perform to the best of your ability, reflect on what made the rotation hard and think about if your actions could have been misperceived. Are there salient challenges you had to overcome? What changes can you make to be a better team member? If you are unhappy with a particular rotation because of the subject matter, would you be able to find ways to be engaged and interested in order to maintain the best clinical care for patients? Long, grueling rotations are often the hardest because you will be stretched thin, and will find it difficult to keep your emotions at bay, and your head above water. However, keeping a perspective and understanding what you could improve upon, is useful for clinical experiences in the future.

Conversely, receiving bland positive feedback can be ego-boosting, but is also unhelpful. "You're doing great!" is very non-specific and does not offer any concrete way for you to reflect about your performance and how you can improve in the future. If you're told that, you can try to ask, "What in particular do you think I did well? Is there anything you noticed I can do better?" By being specific on areas to improve, you may receive more useful feedback.

9

Recognizing and Managing Agitated Patients

Learning how to safely conduct a psychiatric interview is imperative for psychiatric trainees. While programs devote a great deal of focus on assessing patients' risk of suicide, often there is significantly less attention paid to assessing patients' risk of violence. Unfortunately, in a 2012 review by Kwok, et al 25-64% of psychiatry residents reported having been assaulted by a patient. This is not to say all psychiatric patients are likely to be violent; in fact, most individuals with mental illness will not act out violently and the severely mentally ill are significantly more likely to be victims of violence than they are to be perpetrators.

We shouldn't be scared of our patients. But as psychiatrists, we need to know how to assess a patient's immediate risk of harm to both themselves and others, while ensuring our own safety and the safety of other clinical staff. Thus, it is extremely important for the psychiatric trainee to have at least a very basic understanding of violence risk, safe interviewing techniques, and strategies for recognizing and managing the agitated patient.

Recognizing the Risky Patient and the Risky Situation

Completing a comprehensive psychiatric evaluation is the first step in identifying features of a patient's presentation that increase the risk for violence. The evaluation should focus on psychiatric symptoms, but also take into account demographic, historical and environmental factors that may be related to an increased risk of violence. In particular, the following ten factors should be assessed:

- 1) Appearance of the patient
- 2) Presence of violent ideation and degree of formulation and/or planning
- 3) Intent to be violent
- 4) Available means of harm and access to the potential victim
- 5) Past history of violence and other impulsive behaviors
- 6) Alcohol or drug use
- 7) Presence of psychosis
- 8) Presence of certain personality disorders (e.g. antisocial and borderline)
- 9) History of noncompliance with treatment
- 10) Demographic and socioeconomic characteristics

Key Principles in Understanding Violence Risk

The next step when considering a patient's risk for violence is to assess for the presence of risk factors. There are many ways to group risk factors for violence, but a common and pragmatic approach is to distinguish between static and dynamic risk factors. **Static risk factors** are those that do not change over time (e.g. a history of violent behavior). **Dynamic risk factors** are those that have the potential to change over time; for example, ongoing substance abuse and non-compliance with medication. An overly simplified but helpful way to think about these two categories is to consider static risk as being associated with the "risky person" (e.g. a young single male with a low IQ and a history of violence) and dynamic risk as being associated with the "risky situation" (that same patient was just fired from his job, is now actively abusing substances and recently purchased a gun). This illustrates how individuals with a number of static risk factors can chronically be considered at an elevated risk of violence, while the dynamic risk factors have a substantial impact on our understanding of a patient's acute risk of violence.

So what are the factors that increase a mentally ill individual's risk of acting violently? Unfortunately, there is no simple answer to this question, as research has not produced a clearly uniform picture of the most important mental health variables associated with the risk of violent behavior. However, a few key principles can be surmised:

- **First**, substance abuse has been universally associated with a significantly increased risk of violence, far surpassing the contribution of serious mental illness.
- **Second**, non-mental health variables (e.g. socio-demographic factors such as young age, male sex, and low socioeconomic status) contribute more significantly to the overall rate of violence in the population than do mental health variables. In spite of this, as noted earlier, when compared to the general population, those with serious mental illness do seem to be at a moderately increased risk for violence.

Risk Factors for Violence

In the general psychiatric setting, there are a number of factors which have been shown to increase the risk for violence. Other clinical scenarios that raise the risk for violence while interviewing a patient include intoxication, agitation, first meetings, confrontation, and recent loss. Trainees commonly

encounter these situations in the emergency room, making it a potentially high risk clinical setting. Among psychotic patients, two symptoms related to violence risk are persecutory delusions and command auditory hallucinations (CAH), though research trying to understand their specific contribution to violent behavior has yielded mixed results.

There are also certain unique factors that contribute to violence risk on the inpatient unit. Not surprisingly, a history of previous assaultive behavior is the best long-term predictor of inpatient violence. Interestingly, although in the community men are more violent than women, this gender disparity is not seen in the inpatient setting. Clinical, rather than socio-demographic, risk factors have been shown to best predict aggression in the short-term, in the inpatient setting. Such clinical factors include:

1. Recent physical violence and threats of violence
2. Poor therapeutic alliance
3. A hostile attitude and irritable mood
4. Psychomotor agitation
5. Attacks on objects or property damage

Risk Factors for Violence in General Psychiatric Settings
(from Buchanan, et al.)

Past history	Present circumstances and mental state
Prior violence	Male under 40
Prior arrest	Noncompliance with treatment
Young age at time of first arrest	Access to weapons
Drug and/or alcohol abuse	Role of significant other and/or caretaker (either provocative or not protective)
Cruelty to animals and people	Sees self as victim
Fire setting	Lack of compassion/empathy
Risk taking	Intention to harm
Behavior suggesting loss of control or impulsivity	Lack of concern over consequences of violent acts

Safe Interviewing Techniques

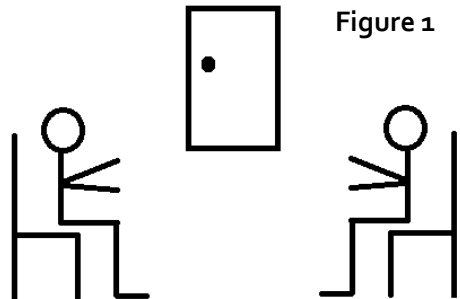
When conducting a psychiatric interview, the resident should always make their own safety the first priority! An appropriate psychiatric evaluation cannot take place if the trainee is more concerned with being harmed than with the information the patient is communicating. The interview should not move forward until measures have been taken to ensure that the resident feels safely able to complete the task at hand. Implicit in this is that the resident must be cognizant of his or her own emotions during the interview and take action to change the situation if he or she feels frightened.

The next consideration should be for the safety of the physical space where the interview will take place. First, a clear route of rapid egress from the room must be ensured. The next issue to consider is how to position oneself and the patient, in relation to the door. Unfortunately, there is no simple answer to this question. There is general agreement that patients, particularly those prone to paranoia, should be given easy access to the door and the clinician should not place themselves between the patient and the door. However, exactly where to place oneself is less clear. The safest choice is to

arrange seating such that the interviewer and the patient have equal access to the door without either acting as a barrier to the other's exiting (see Figure 1). One should also consider whether there are objects in the room that could be

potentially dangerous if used as a weapon and remove them, if possible. Additional, somewhat more extreme, measures one may consider when planning to interview a patient with a high potential for violence include tightly securing long hair and removing eyeglasses, neckties, and jewelry.

In outpatient work, any office is only as safe as the nearest available help and thus unsafe at times of day when no one else is around. Ideally, other staff should be within earshot and aware that you will be with a patient. If particularly worried, you can arrange to keep the office door partially open. In the emergency room, ensure patients have been searched and disarmed before your meeting and that security personnel are quickly available. Prior to



meeting with the patient, you should know how to urgently communicate the need for security personnel and should never hesitate to do so to ensure your own safety. On the inpatient unit, environmental factors linked to higher rates of assault include times of transition (e.g. change of shift), increased staff-patient interaction (e.g. during medication administration), crowded/high-traffic areas (e.g. hallways), and decreased staff to patient ratios.

Recognizing the Signs of Escalation

The first sign that something is amiss often comes from within the clinician themselves. Though not empirically tested, your own internal instinct is often the best tool available to determine whether a situation is safe. Despite recognizing that something isn't quite right, trainees may often suppress or ignore their own anxiety in unsafe situations. One potential contributing factor is that trainees may respond psychologically to the fear of being harmed by repressing or denying this consciously intolerable experience. To counter this tendency, try to be more aware of your own internal state. There is evidence that psychiatrists who are able to acknowledge such fear, but also express a desire to help, are less likely to be injured by a threatening patient.

Recognizing the signs of escalation begins with having an awareness of the process in the room between oneself and the patient. A patient who is engaged in the interview is at decreased risk of becoming violent, whereas a patient with poor adherence to the interview process or who becomes increasingly agitated by questions is at increased risk. Aggression rarely occurs suddenly and unexpectedly. There is often a prodrome of symptoms which precedes violent behavior, consisting of increased physical tension, increased volume of speech, verbal abuse and threats, increased motor activity, pacing, and clenching of fists. This increased motor activity is often repetitive and non-goal directed and may include behaviors such as foot tapping, hand wringing, hair pulling, and fiddling with clothes or other objects.

Approaching the Escalating Patient

From a practical standpoint, an escalating patient should be approached from the front or side. Approaching from behind can be perceived as threatening. Be mindful never to turn your back to the patient. Interventions which utilize **"talk-down" strategies** during the period of escalation may be

able to avert violent behavior, but you must first be sure the patient is capable of hearing and responding to these interventions. Volume, tone and rate of speech should be decreased, while being careful not to be perceived as insulting. You should “talk-down” the patient by focusing less directly on the content of their speech, but instead repeatedly validating the perceived emotional experience of the patient.

Other tactics for managing the escalating patient include maintaining active eye contact and using body language and speech in a way that signal attentiveness. However, prolonged or intense direct eye contact should be avoided as this can be perceived as threatening. Use active listening techniques, such as briefly paraphrasing what the patient is saying, to convey that you are trying to understand the patient’s experience. Providing the patient with choices may help to increase their sense of control over the situation. Finally, if possible, offer to accompany the patient to a calmer space with less stimulation.

Managing the Agitated Patient

In 2011, The American Association for Emergency Psychiatry outlined principles for best practice in the evaluation and treatment of agitation. They delineated **four main objectives of working with agitated patient**:

1. Ensure the safety of the patient, staff, and others in the area
2. Help the patient manage their emotions and distress and maintain or regain control of their behavior
3. Avoid the use of restraint when at all possible
4. Avoid coercive interventions that escalate agitation

They also outlined ten domains of de-escalation with key recommendations associated with each domain, summarized in the table below.

Domains of De-Escalation with Key Recommendations for each Domain

Ten Domains of De-Escalation	Key Recommendations for Each Domain
1. Respect personal space	▪ Respect the patient’s and your personal space
2. Do not be provocative	▪ Avoid iatrogenic escalation
3. Establish verbal contact	▪ Only 1 person verbally interacts with the patient ▪ Introduce yourself to the patient and provide orientation and reassurance

4. Be concise	<ul style="list-style-type: none"> ▪ Be concise and keep it simple ▪ Repetition is essential to successful de-escalation
5. Identify wants and feelings	<ul style="list-style-type: none"> ▪ Use free information to identify wants and feelings (free information comes from things the patient says, their body language, or past encounters)
6. Listen closely to what the patient is saying	<ul style="list-style-type: none"> ▪ Use active listening ▪ Use Miller's law ("To understand what another person is saying, you must assume that it is true and try to imagine what it could be true of")
7. Agree or agree to disagree	<ul style="list-style-type: none"> ▪ Try to find something about the patient's position with which you can agree
8. Lay down the law and set clear limits	<ul style="list-style-type: none"> ▪ Establish basic working conditions ▪ Limit setting must be reasonable and done in a respectful manner ▪ Coach the patient in how to stay in control
9. Offer choices and optimism	<ul style="list-style-type: none"> ▪ Offer choices (when you can) ▪ Broach the subject of medications ▪ Be optimistic and provide hope
10. Debrief the patient and staff	<ul style="list-style-type: none"> ▪ Important to do following any involuntary intervention for both patient and staff

An intensely angry patient may be intimidating and make you want to engage with logical or rational responses to the patient's requests, which unfortunately may only serve to further inflame the patient, and should ideally be minimized. One major de-escalation strategy is **affect management**, where the primary goal is to teach the patient to reduce his or her internal state of tension by verbalizing feelings without resorting to violent confrontation. This involves the clinician allowing the patient to ventilate his or her affect, acknowledging it, repeatedly validating it (when appropriate) and encouraging the patient to further discuss his or her feelings.

If these interventions are ineffective, it may be necessary to set limits with the patient. Utilized properly, **limit setting** can be therapeutic and avert violent behavior. The goal of limit setting is to contain and counteract maladaptive behavior that interferes with therapy and threatens the safety of others. Responding with punitive threats in an attempt to set limits is not helpful, and doing so may actually increase the risk of violent behavior by evoking feelings of impotence or humiliation. Effective limit setting involves

clear identification of the specific behaviors that need to be altered and precise articulation of the potential consequences. You must also assess whether the patient is capable of responding to limit setting (for example, this may be difficult for patients with significant cognitive impairment). If all else fails, do not hesitate to end an interview as a means of maintaining safety. In the outpatient setting, it may be necessary at this time to facilitate the patient's transfer to a setting capable of treating psychiatric emergencies.

The goal of medicating the agitated patient is not to sedate, but to calm. Timing is essential, as you do not want to rush to give medication, but also should not unnecessarily delay medication when it is needed. When medications are indicated, offer as many choices to the patient as are possible. For example, the first step might be to not mention medication at all, but to ask the patient what might be helpful to them in an attempt to try to get the request for medication to come from the patient himself. Giving the patient a choice in either oral or parenteral administration can help give the patient some control. If the patient chooses oral administration, one can also offer the choice of taking a pill, dissolving tablet, or liquid. The patient may willingly take medication if the means of administration is a choice, even if the administration of medication itself is not. Even when there is no choice but to give an injection, the clinician can give a choice as to which drug is to be used, emphasizing that one may have a more beneficial side-effect profile.

If the patient does not mention medication themselves and you believe it is indicated, state clearly to the patient that you think they would benefit from taking medicine. You can ask the patient what medication has helped them in the past, or try, "I see that you're quite uncomfortable. May I offer you some medication?" Gentle confrontation may also be useful to remind them that, for you to help them, they have to be calm enough for you to talk to them. Then ask whether they would be willing to take medication to achieve this goal. Another step just short of involuntary medication is informing the patient that they are experiencing a "psychiatric emergency" and that you are going to order them emergency medicine for this purpose. This strategy is authoritative and persuasive, demonstrating your self-assuredness, and expertise. Appealing to the patient's desire to stay in control and emphasizing the clinician's mandate to keep everyone safe is very important and can be effective in empowering the patient to stay in control. Finally, when verbal attempts fail, more coercive measures such as restraints or injectable medication may be necessary to ensure safety, but only as a last resort.

The Aggressive Patient

Not all agitated patients become aggressive. For the subset of agitated patients who do become aggressive, recognizing the type of aggression can guide you in approaching the patient. Moyer defines three types of aggression:

Aggression Type	Description
Instrumental Aggression	<p>Instrumental aggression is not driven by emotion, but instead is used by those who have found they can get what they want by violence or threats of violence.</p> <p>Response Tip: Threats of this nature are best responded to with vague statements such as, "I don't think that's a good idea."</p>
Fear-driven Aggression	<p>Fear-driven aggression is not self-defense, but is seen in patients who want to avoid being hurt and may attack to prevent someone from hurting them.</p> <p>Response Tip: Avoid exacerbating the patient's fear by giving them plenty of space, avoiding a show of force (if possible), and increasing his or her sense of safety in the environment.</p>
Irritable Aggression	<p>Can take two forms. The first generally occurs in the context of a boundary violation (e.g. the patient has been humiliated, cheated, or otherwise emotionally wounded). They will often identify the antecedent to their anger and strives to have his or her feelings validated.</p> <p>Response Tip: You can most easily de-escalate the situation by repeatedly validating the patient's perceived emotional experience.</p> <p>The second form of irritable aggression occurs in chronically angry individuals who are looking for an excuse to "go off." These patients often</p>

do not or cannot easily identify a clear acute stressor and achieve a sense of satisfaction from intimidating or confusing others.

Response Tip: Try not to get startled or defensive, but instead to be as emotionless as possible. Repeatedly provide the patient non-violent options to achieve their goals. Limit-setting may be necessary, but these patients are often the hardest to manage because they may test your limits by doing just what you've asked them not to do. It may be necessary to resort to involuntary medications and/or restraints.

Even one assault against a resident is more than should be tolerated. It is imperative that we learn how to safely manage ourselves, our patients, and our environment. Having an appreciation for the techniques described above should help you to stay safe during your training and beyond.



Help protect your practice with the APA course **Minimizing Risk When Treating Suicidal and Violent Patients**, available free to members. Search **Risk Management** on psychiatry.org for a complete list of risk management courses.

10

Dealing with Managed Care in the Outpatient Setting

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. 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, organized, and prepared you'll be ready to handle almost anything thrown your way.



Before the Patient Visit

Make sure you understand the clinic's billing policies before you begin to see patients. You may have a "billing integrity officer" or some similarly titled position within your program who reviews the billing guidelines and policies for incoming residents. They are responsible for ensuring the services that are billed match those performed so that, for instance, a fifteen-minute medication management visit is not billed as a sixty-minute therapy session. In addition to billing requirements, 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.

You should also check whether your clinic has special payment scales to assist patients in obtaining services, such as weekly psychotherapy, if they are fiscally challenged. These special arrangements are often not advertised, but might be available if you ask.

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 prevent headaches.

Be aware that 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 additional 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 “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.”



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, you usually start with the treatment plan form. If denied, you can call the insurance company to plead your case. Persistence often 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. You may discover this when a patient frantically calls 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 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 efficient as possible. Make sure you have adequate time for the call, as you may be on hold for what seems an eternity and the first number you dial is rarely the one you need.

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. Additionally, many pharmaceutical companies now have patient assistance programs that will provide free medication for several months, sometimes indefinitely. Eligibility and enrollment procedures vary.

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 may be even more overwhelmed by the process than you are. Most importantly, view all of this work as an educational experience that will prepare you for practice beyond residency.



The APA's **Practice Management Help Line** and **Coding Services** are available to help on a variety of day-to-day practical issues that arise in dealing with reimbursement, and managed care companies.

To access the Helpline, simply email your question to hsf@psych.org or call (800) 343-4671

11 Understanding Patients' Diverse Cultures

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, receive PRN medication at higher doses, and may be perceived to be more dangerous and violent than patients from other ethnic groups. African-Americans have also been shown to have more adverse effects to psychotropic medications. Asian-American populations also have varying experiences in psychiatry that are heavily impacted by family, expectations that medications should work immediately, and access to language-specific resources. With a greater understanding of the impact of culture on mental health, culture-bound syndromes, such as *ataque de nervios* in the Latino community or *koro* in the Chinese and Southeast Asian communities, that were previously seen as psychiatric illnesses are now being understood as cultural phenomena.

While culture has been defined as the beliefs, values, customs, and behaviors belonging to a particular ethnic group, it has become more complex when considering intra-ethnic differences. 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. 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 their psychopathology and help create an effective and culturally appropriate treatment plan. The changes in the DSM-5 reflect the need for better understanding of the impact culture can have on both the patient and the provider. The **Cultural Formulation Interview** in the DSM-5 expands on the outline for cultural formulation and gives psychiatrists a more process-oriented approach to cultural assessment. In order to better understand and gauge a person's perspective on illness, Arthur Kleinman came up with an explanatory

model of illness to explain and conceptualize to patients their condition. It's also as a way for clinicians to provide a framework for patients. Using these questions (many are in the cultural formulation interview) can help avoid assumptions that lead to poor outcomes:

- What do you think has caused your problems?
- Why do you think it started when it did?
- What do you think your sickness does to you?
- How severe is your sickness?
- Will it have a long or short course?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from this treatment?
- What are the chief problems your sickness has caused for you?
- What do you fear most about your sickness?

Cultural Implications in Illness Diagnosis, and Treatment

Each cultural group may experience illness differently and have a unique explanatory model of illness. For example, a Christian woman may believe that her recurrent nightmares are a result of past sins, 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 their illness and what they believe would alleviate suffering. Also recognize how Western medicine's explanatory model and your 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, they may feel the need to protect patients in similar environments. They may overstep professional boundaries that could have disastrous consequences for both patient and physician. We must recognize our own cultural biases to avoid imposing our own values on patients.

Culture may also affect presenting symptoms of illnesses and interfere with 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. "Cultural syndromes," such as *amok*, *mal de ojo*, or *susto*, occur exclusively in particular cultures.

Knowing the epidemiology of psychiatric illnesses and cultural syndromes increases the likelihood of an accurate diagnosis. Refer to DSM-5, which outlines 3 concepts that will help you conceptualize cultural issues:

1. Cultural syndrome: a cluster of invariant symptoms in a specific cultural group.
2. Cultural idiom of distress: a way of talking about suffering among people in a cultural group
3. Cultural explanation or perceived cause for symptoms, illness, or distress

Finally, consider culture when formulating a case and devising a treatment plan. Cultural factors influence presenting symptoms and affect treatment success or failure. For example, a large percentage of Asian Americans use herbal medications concurrently or instead of medication. It is important to ask patients about herbal formulations and explain the possible side effects when combined with other medications. 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 can enhance healing and improve outcomes.

Training Issues

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

1. Appreciate culture's impact 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 how these cultural aspects affect patients and their illness. Understand how these aspects influence their expectations of treatment
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. Repeatedly ask yourself, "Do I understand the patient's values, or am I imposing my own views?"

A Case Study in Understanding Patients' Diverse Cultures...

When I first met Ms. X, a young Japanese woman, she was crying uncontrollably on a gurney in the emergency room with a sheet covering her face. She had recently immigrated to the US for work and had never lived away from family. "I'm scared I'm going crazy," she told me. She revealed that she had become extremely anxious in social situations over the past 3 months. Even going to work caused debilitating anxiety.

She described her anxiety as "feeling like her heart would explode" and initially came to the emergency room to get her heart checked. After being told she was fine, she began thinking she was imagining everything. She denied any psychiatric history. In fact, she said when in Japan she was a "social butterfly." On a psychiatric review of systems, she endorsed depressive symptoms of difficulty falling asleep, poor concentration and attention, guilt for missing work, and decreased energy while also endorsing anxiety symptoms including worrying about everything from how clean her apartment was to how to make rent. She denied any desire to harm herself—even in these moments of extreme panic. She had never seen a psychiatrist before, but agreed to follow up with an outpatient psychiatrist. She wouldn't allow me to call any collateral, but said she would call the resources she was given the next morning.

2 weeks later, I was paged to evaluate a patient after a suicide attempt. I came to the ED where I found Ms. X. She was lying in bed staring at the wall, holding her friend's hand. She told me, "I'm sorry I'm here." Speaking with her friend, I learned Ms. X came from a very conservative Japanese family that did not believe in seeing a psychiatrist or even talking about mental health. She hadn't called anyone to follow-up because her parents told her to handle her problems herself. Believing she was a failure in life, she took 10 Ambien pills and her friends found her passed out in bed. I spent time talking to Ms. X, who was regretful and embarrassed that she had attempted to harm herself as this was "even worse for her family." She did not seek help out of fear of appearing "weak." She was subsequently hospitalized and there were numerous conversations with her family about her need for mental health support.

I walked away from that interaction realizing that there were many different cultural layers to consider when assessing a patient's likelihood of following up with a psychiatrist or therapist – everything from language to understanding their view of mental illness and medication. Especially important in working with Ms. X was understanding the familial perspective on psychiatry and its impact on her ability to access mental health services. Ms. X told me multiple times that in Japan, her family didn't tell "outsiders" their problems and even our conversation felt shameful to her. Understanding that her culture viewed her as weak because of our interaction was necessary for me to be able to provide her culturally competent care. I tried to reframe our interaction to highlight the similarities between medical and psychiatric treatment and normalize her perspective while also emphasizing the need for safety and hopes to ease her anxiety.

Ultimately, in an emergency room setting, my role in her continued care was limited, but I will continue to remember how important it is as an initial provider to ensure patients receive follow-up that is culturally sensitive and to ask both the patient and collateral about their barriers to accessing care.

12 Cultural Psychiatry

Traditionally, psychiatry has focused on the individual patient and his or her subjective experience of a psychiatric disorder or psychological conflict. Discussions of outside forces that might impact the patient's psychological and biological development tend to concentrate on the patient's family, romantic interests, and traumatic events. Cultural psychiatry asks both the patient and the psychiatrist to consider forces in the social environment which might color the psychological experience and support or restrain recovery.

Cultural Formulation

Since DSM-IV, psychiatry has highlighted the importance of having a cultural formulation for each patient. DSM-5 now includes questions to guide the psychiatric interview to provide a better understanding of the patient's conceptualization of symptoms. Based on your style and allotted time, you may ask these questions during intake or over the course of your working relationship. Let the patient educate you on their individual experience and worldview so you do not push your belief system on the patient.

One of the benefits of having a cultural formulation is that it enables you to understand patients beyond their chief complaints and most prominent psychiatric symptoms. It is an essential step in acknowledging the uniqueness of the person sitting in front of you. This will make the patient feel heard, thus strengthening the therapeutic relationship.

Everyone is Part of a Culture

Much research in cultural psychiatry focuses on the mental health of disadvantaged groups, such as sexual and racial minorities and women. But we need to be mindful that everyone is subject to cultural constraints. Wealthy, educated, heterosexual, white men are indeed bestowed with expectations that stem from the dominant culture. For instance, it might be useful to consider the aggravated insult caused by a disabling psychiatric disorder in a man that lives in a culture that values strength and independence, regardless of his background. In other words, every patient belongs to a specific culture and using a cultural formulation is necessary to understand them, even if they don't come from a disadvantaged group.

The Psychiatrist Also Belongs to a Culture

As a psychiatric resident and human being, you also belong to a larger culture. Just like the patient can be constrained by culture, the psychiatrist can be biased in ways that might be difficult to acknowledge. Among the questions you may want to ask yourself during residency training may include: Do I treat female patients differently from men, in a way that affects the quality of their treatment?

- Do I perceive certain ethnicities as physically threatening? Do I prescribe higher medication doses to them than are actually needed?
- Is it possible that I am pathologizing behavior in people of low socioeconomic status, which are otherwise normal in higher statuses?
- What cultural factors affect the way I diagnose a patient?

All these questions are difficult to answer honestly, but it is important to reflect on them. As just one implication, evidence suggests patients can be diagnosed and treated differently depending on their race. Both therapy and supervision are good places to start reflecting on these very difficult questions.

Local vs. Regional

There are many different “Americas.” The U.S. is highly heterogeneous, although we might not always see it in our everyday lives. Humans have the tendency to associate with people similar to themselves. Therefore, we cannot assume that other people experience the world the same way we do. The ethnic and racial composition, economic status, and history of a place might distinguish it from other parts of the country. This is true on a smaller scale, as different neighborhoods within a city can also be very divergent. The more you learn about the area in which you practice, the more you will be able to understand your patients’ social environment and the associated constraints.

Some questions that can help you better understand your surroundings include: How do people commute? What kind of work do they do? What’s the graduation rate? What is the median income and unemployment rate? What is the crime rate? How many people lack health insurance? How many people are involved in the criminal justice system? Where do refugees live? Is daycare a feasible option? You can easily answer these questions and many others through the U.S. Census Bureau’s website. Most cities also provide detailed information about their demographics.

13

Boundary Issues in Psychiatry

A therapist should understand that the only personal gain from their practice should be helping patients overcome problems, and the only monetary gain should be the standard fee for services provided. The “slippery slope” concept refers to a progressive series of behaviors that increase the risk of boundary violations. These can develop from strong feelings for, or from, a patient. **Factors that might indicate boundary violations include:**



Connecting and interacting with a patient on **social media**

Tip: Refer to the “Professionalism and Social Media” chapter.



Gift-giving, especially if expensive or of personal relevance

Tip: Thank the patient for their thoughtfulness, but advise them that you’re unable to accept gifts from any patient.



Taking **off-hours telephone calls**

Tip: Take off-hours phone calls only in an emergency



Extended and or/frequent sessions and after-hours appointments

Tip: Conduct patient visits during office hours only, maintain standard session durations, and practice only within the office setting. Fees should be set, even if for a token amount.



Inviting **socialization beyond the therapeutic encounter**

Tip: 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.



Any **physical contact** between therapist and patient, even if innocent, can greatly increase likelihood of later boundary lapses (possible exception of nurturing contact with young children).

Tip: Use good judgment to avoid risky physical contact, especially of a sexual nature. Refer a patient elsewhere, if necessary.



Dual relationships with patients – as in obtaining goods or services through their business – can lead to unspoken expectations.

Tip: Avoid personal disclosures. Bartering for services is also considered risky, though may be the norm in rural areas.

Are Boundary Violations Ever Acceptable?

The context of the situation should always be taken into account.

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 inappropriate. Visiting a patient in the ICU (e.g. after an overdose) or at home (e.g. is seriously ill) can be necessary at times.

Psychiatric patients can be at risk for potential exploitation due to low self-esteem, poor judgment, and prior familiarity with boundary transgressions in their own families. They may identify the therapist as an ideal parent who can gratify their wishes or rescue them from pain. Patients with a history of sexual abuse are particularly at risk. Any perceived wrongdoing by the therapist, accurate or not, may lead patients to allege improper behavior on the part of the therapist. It is advisable to have a chaperone if there are doubts about the patient's perception of your actions.

Finally, occasionally a therapist and patient find what they believe to be a genuine love relationship. This is perhaps the most difficult situation. The APA's Principles of Medical Ethics holds that "sexual activity with a current or former patient is unethical." **This means that sexual activity with a patient is unethical forever, even if the therapeutic relationship has long since ended.** Sexual transgressions are never considered the patient's fault, even if they were the aggressor. Simple boundary crossings may be used to demonstrate sexual misconduct. For example, why the patient consistently had the last appointment of the day? Or why didn't this patient have to pay for services?

The consequences of boundary violations can be severe and include license revocation, dismissal from professional organizations, civil lawsuits, and criminal prosecution. Malpractice insurance typically does not cover sexual misconduct (transference-countertransference issues may be covered). These recommendations may seem stringent, but the possibility of losing everything, including occupation, reputation, and family, cannot be discounted. Always use your best judgment!

14

When It's Time to Say Goodbye: Terminating with Patients Before you Leave

Terminating with patients, particularly long-term psychotherapy patients, is an inevitable part of residency training. Learning to terminate gracefully and therapeutically is a crucial skill to develop. At least three individuals will be affected by the termination process: the outgoing clinician, the patient, and the new clinician.

"Some residents report feeling in 'goodbye overload' and become numb to their own feelings of sadness about leaving individuals they have come to know well."

Saying Goodbye to Your Patients

You may be terminating with your patients at the same time you're preparing to move to another city and leave your residency friends and mentors. These stressors can 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 might be surprised by which patients have the most difficulty with termination. Some seem to sail through it easily, while others will struggle. Announcing your departure far in advance provides time to process it in therapy and for each patient to work through it.
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.
3. **Use your departure to assess whether or not a given patient needs to continue in therapy.** You and the patient might decide that most of the goals have been met and that your leaving provides a logical time to conclude therapy.
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 might 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 might convey your feelings to the patient and sabotage his or her ability to form an alliance with the new physician.
6. **Be particularly vigilant for boundary violations around the time of termination.** You might be tempted to loosen your boundaries as you prepare to leave. Be careful not to burden the patient with your own issues of loss. Supervisors can be especially helpful in offering suggestions about how to share your feelings with the patient, deciding how much information to share with your patients about where you will be going, and whether or not to accept small gifts.
7. **Termination can provide an opportunity for you to assess your development as a clinician.** Summarize your progress with individual patients and your personal progress as a therapist.
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 might be surprised when some patients tell you how much of a difference you made in their lives. Use the kind words to replenish your professional self-esteem.

Handing Off to the New Clinician

As you look toward your next assignment, you might be tempted to skimp on chart work for the patients you are leaving. Don't do it! If you have ever been the recipient of shoddy off-service notes, you know how disruptive it is for patient care. Leaving appropriate off-service notes shows respect for the next clinician and your patients. Here are some tips to make it 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. Write your note after your last appointment with each patient. For patients seen 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 the 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. The incoming clinician will be overwhelmed and unprepared to complete paperwork for unfamiliar patients.
5. **For especially complicated patients, you might 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 summary of the treatment course.
6. **Don't leave the new physician with a "train wreck."** If you have a particularly difficult patient, let the new clinician know where you can be reached if questions arise during the transition.
7. **Termination is a transition in which fragile patients might fall through the cracks.** Consider calling a few weeks after you leave to make sure the sickest patients have contacted their new clinicians.

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.

15 Developing a Mentoring Relationship

Many of us chose medicine because of a role model. Now that you're in training, how do you choose a new mentor? How do you cultivate that relationship? A mentor can offer guidance on balancing relationships, professional opportunities, and your growth as a clinician.

Finding a Mentor:

1. **Decide which professionals you most want to be like and why.** Are your general interests similar? Do you envision yourself in their roles?
2. **Spend time observing them.** Are they good teachers, or do they give the same canned lecture years in a row? Are they good leaders? Do they appear to enjoy what they are doing?
3. **Talk with others who have worked with your potential 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?
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. **Evaluate the mentor's team.** 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. **Research on your mentor's activities outside your institution.** Do they review for peer-reviewed publications? Are they leaders in professional organizations?
7. **Don't be afraid to ask.** A good mentor will make time for a protégé even if they're busy.

Developing a Mutually Respectful Relationship with a Mentor:

1. **Be industrious and proactive.** Make suggestions about how you can help. Learn their working style by getting involved in their research and other activities. Read their publications and understand their area of expertise. Initially (and rightly so), the mentor should give you simple tasks. Do them well and promptly. You should be rewarded with trust and increasing inclusion into your mentor's activities.
2. **Expect the relationship to change over time.** As you mature professionally, try to keep a healthy balance of mutual respect and dedication. Both of you should be clear on expectations. Work hard and consider, not necessarily act on, all advice your mentor offers. Your mentor should, in turn, understand that his or her commitment to you includes helping you develop in your areas of interest.
3. **Take professional risks as guided by your mentor.** If he or she has faith in you to research/publish/present something, do it. Don't be afraid to discuss authorship if you've made significant contributions.
4. **Watch and learn, especially during your mentor's stressful times.** Watching your mentor deal with stressful situations can teach you to prioritize and 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. Also be aware that each of you brings experiences, positive and negative, from other partnerships. Overcompensation, stereotyping, and self-deprecation may be attempts to work through a previously unhappy relationship. Maintain a healthy balance between your personal and private life to avoid blurred boundaries.
6. **Take inventory occasionally on your progress toward your short and long-range goals.** What have you been able to accomplish and what would you still like to learn from this person?
7. **Become a mentor.** Make a commitment to someday pass on the important things you've learned.

16 Mastering the PRITE®

You may think after medical school you are exam free until your board certification exam. But ominously waiting in the wings are the in-service training exams. For psychiatry residents, the beast in question is the Psychiatry Resident-In-Training Examination, known as the PRITE®. In-service testing was introduced in 1964, after a high failure rate of neurosurgery board certification candidates. Consequently, each medical specialty began adopting their own exams to evaluate progress and improve board pass rates. The American College of Psychiatrists (ACP) designs the PRITE®, and began offering it annually in 1982. Today, nearly all U.S. psychiatry residents, and many in Canada, take the exam three to four times throughout their residency training (once per year).

PRITE®: The Essentials

- Consists of 300 multiple-choice questions
- Taken in two parts – 105 questions and 2.5 hours each
- Typically held in the Fall, between late September or early October
- Results are delivered to your program director by mid-December
- Some programs do not require interns sit for the exam because of their limited clinical psychiatric exposure
- Neurology topics comprise 15-20% of the total questions, consistent with the ABPN psychiatry board certification exam

PRITE® Content Areas

Neurology and Neurosciences

Growth and Development

Adult Psychopathology

Emergency Psychiatry

Behavioral Science and Social

Psychiatry

Psychosocial Therapies

Somatic Treatment Methods

Patient Evaluation and Treatment

Selection

Consultation-Liaison Psychiatry

Child Psychiatry

Alcoholism and Substance Abuse

Geriatric Psychiatry

Forensic Psychiatry

Preparing for the PRITE®

As with all exams, there are different philosophies for preparation. Many early-career residents will devote more time to studying. Senior residents, who are more familiar with the material, may not feel the need to study at all. Some residents intentionally do not study in an effort to gauge their current knowledge base and areas of weakness. A few tips as you prepare:

- If on –call the night before the exam, ask your program director to schedule a make-up date. It’s in your best interests to be physically and mentally rested before taking the exam.
- Bring a sharpened #2 pencil and a good, white eraser.
- Study from previous years’ PRITE® questions – usually available from your program coordinator or program director
- Many residency programs have developed their own review programs, typically held in mid-to-late summer. Make time to attend.
- Consider using board prep materials. Here are a few resident favorites:
 - Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry
 - First Aid for the Psychiatry Boards
 - Psychiatry for the Boards
 - Kaufman's Clinical Neurology for Psychiatrists (7th Edition)
 - Stahl's Essential Psychopharmacology

Four Reasons to Take the PRITE® Seriously

There are several reasons you should take the PRITE® seriously:

1. It can help you assess your learning progress. It’s an effective measure of your understanding of clinical topics and problem-solving skills.
2. Many psychiatry training directors use PRITE® scores as one of many assessment tools of their residents’ progress. Some even require residents achieve a minimum score. Those not meeting the score may have required remediation or be restricted from moonlighting.
3. There is a strong correlation between PRITE® scores and ABPN Part 1 Board Certification scores.
4. Camaraderie! Many programs have a post- PRITE® celebration, and some even use the scores to select their representatives for the APA’s MindGames competition (see Psychiatry.org/residents for more info)

17 Keeping up with the Literature

The transition from medical student to resident marks a fundamental change in your fund of knowledge. Acquiring new information is no longer an exercise in completion with the goal of passing a shelf exam. Rather, as a resident, you are challenged to incorporate cutting edge information into your clinical practice. Becoming well versed in the scientific literature gives you the tools to stand toe-to-toe with peers and attendings and confidently discuss your patient care choices. While research can be intimidating, especially to residents without a research background, keeping up to date on what's new in the field can actually be relatively low stress if you build a consistent routine.

Textbook references remain excellent resources; however, textbook knowledge typically incorporates studies at least 2-4 years old or older. In order to really have a "cutting-edge" grasp of the field, it's important to get into the literature. But, the psychiatric literature is constantly expanding and there is no possible way to read everything published. For a resident just getting started, it can be difficult to distinguish what is important from what's less so. Classically, residents start off optimistically inclusive, are quickly overwhelmed, and, as the joke goes, soon eschew reading entirely to eat dinner or sleep instead. The good news – there are affordable and time efficient strategies to acquire and incorporate research into your fund of knowledge and clinical practice. This chapter suggests how to approach four main aspects: access, selection, evaluation, and management.

Access Literature Efficiently

In general, there are two approaches to accessing the scientific literature. If you have a specific question that you are trying to answer, you should perform a directed and systematic literature review. This involves using a bibliographic database, such as PubMed, to search through articles in an organized way using key terms. Being able to perform a comprehensive systematic literature review is an indispensable skill, but somewhat beyond the scope of this chapter. For more information, PubMed offers an excellent and thorough tutorial on its website. Once PubMed is mastered, additional databases, such as the Cochrane Research Database, may provide specialized

reviews, such as meta-analyses. Cochrane reviews are extremely thorough but can be very dense and statistically intensive, which may limit their practical use for most residents. Depending on the topic, there are likely topical literature reviews already published and accessible on PubMed that can give you a head start. Some topics are so new that there simply hasn't been much published to date. In these situations, it is often a good idea (and usually very impressive to attendings) to search for any registered ongoing clinical trials related to your topic at clinicaltrials.gov. Academic center librarians are also invaluable resources in the literature review process and can coordinate ongoing personalized search programs for narrower areas of interest.

Of note, there are alternative search tools to PubMed that can be quite useful. Google Scholar has emerged as an excellent tool for finding journal articles. A unique feature of Google Scholar is that search results are listed in order of total number of citations. Practically, this means that if you search for a topic and get a list of articles, the most cited (and likely most important) articles are at the top. This can be a huge time saver for a busy resident.

The second approach to accessing the literature is more useful if you do not have a specific question in mind, but simply want to review updates in the field. In this situation, it is useful to register with a service like MedScape and sign up for daily e-mail updates on medical news. When you have a few spare moments in the morning, glance at the updates and click on articles that look interesting. Another strategy is to save the URL's for journals you like and glance through the tables of contents. If you find interesting articles, do a cursory read of the abstract, discussion, and conclusions. If you think the article is worth studying more completely, add it to your "must read" list.

Never forget the old fashioned way of accessing journals; having the hard copies mailed right to your home. As a resident this is inexpensively accomplished by joining the APA or other professional organizations that sponsor journals and other clinical publications.

Create Your Reading List – and Be Picky!

Remember, you don't have to read everything and you should be highly selective in what you choose to read thoroughly. But how do you know which journals give the most bang for your buck? 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 2015, the ten psychiatric journals with the highest impact factor, in descending order, were:

1. Molecular Psychiatry
2. JAMA Psychiatry
3. World Psychiatry
4. American Journal of Psychiatry
5. Biological Psychiatry
6. Psychotherapy and Psychosomatics
7. Schizophrenia Bulletin
8. British Journal of Psychiatry
9. Journal of the American Academy of Child and Adolescent Psychiatry,
10. Neuropsychopharmacology Journal

Citation Reports, available at isiwebofknowledge.com, has the complete list arranged by subject (e.g. Psychiatry, Neuroimaging, Neuroscience, Psychology, Geriatrics and Gerontology, Substance Abuse). While a helpful starting point, keep in mind that impact factors are not considered by all experts to be the best judge of a journal's importance. Impact factors may underestimate a journal's importance if that journal publishes on niche or specialized topics. Thus, a journal in a highly specialized area of study may reach a limited audience of experts and have a small impact factor compared to JAMA or AJP, but nonetheless represent the leading journal in that field. Another tip for selecting your reading is to utilize aggregation publications that publish summaries of recent findings:

- **Journal Watch:** A publication providing a review and commentary of articles in over 50 journals.
- **Psychiatric News:** Bi-monthly e-newsletter published by the APA with updates on various topics, including Clinical & Research, Government& Legal, and in the Community.
- **Psychiatric News PsychoPharm** – Bi-monthly e-newsletter with latest news on the use of medication to treat psychiatric disorders.
- **ClinicalPsychiatry News:** Independent monthly newspaper for psychiatrists on clinical developments that impact patient care
- **Psychiatric Times:** News, Special Reports, and clinical content related to psychiatry for psychiatrists and allied health professionals who treat mental disorders.
- **Faculty of 1000:** Website providing brief synopses and ratings of journal articles in all areas of psychiatry.

Evaluate the Literature

How to critically appraise scientific literature is beyond the scope of this short chapter, but, suffice to say, it's a skill worth acquiring. Having this skill will help you compare conflicting results and apply 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*. To help better understand statistics and methodology as it pertains to mental health, a useful read is S. Nassir Ghaemi's *A Clinician's Guide to Statistics and Epidemiology in Mental Health: Measuring Truth and Uncertainty*.

Managing your Literature Consumption

Once you've 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 amount of time each day or week. The amount of time available to dedicate to reviewing the literature will vary depending upon your clinical practice and schedule. However, if you develop the habit and skill of critical literature review early in residency, you will find yourself able to be conversant with the literature with only a few hours of review per week. As few residents have the time to drop everything and spend hours cruising through PubMed, it is helpful to develop strategies that allow you to incorporate reviewing the literature into your routine. 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 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 critical appraisal skills. Involve yourself regularly in journal clubs and give presentations when opportunities arise. These are excellent incentives for keeping up with the literature and will keep you on task.

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.

18

A List of Psychiatric and Related Journals

The list below is fairly comprehensive of the most important references for psychiatric literature. Journals listed vary widely in the degree of specialization in different topic areas. This list is meant to be a reference to select from – NOT an all-inclusive required reading list for residency. Thus, do not be overwhelmed! For the average resident who is just trying to stay up-to-date, you cannot go wrong by regularly reading the following journals:

- American Journal of Psychiatry
- British Journal of Psychiatry
- JAMA Psychiatry

Also, never forget about the *American Journal of Psychiatry – Resident’s Journal*. This journal is published electronically monthly with the AJP and serves as a forum for medical students, psychiatry residents and fellows to share ideas and experiences in training, clinical practice, research, and careers with colleagues.

Note: These journal titles, publishers and websites are subject to change. The information below is accurate as of March 2015.

Journal Title	Website
Academic Psychiatry	springer.com
Acta Psychiatrica Scandinavica	onlinelibrary.wiley.com
Addiction	addictionjournal.org
Addiction Biology	onlinelibrary.wiley.com
Alcohol	alcoholjournal.org
Alcohol and Alcoholism	alcalc.oxfordjournals.org
Alcoholism -Clinical and Experimental Research	onlinelibrary.wiley.com
Alzheimer Disease & Associated Disorders	journals.lww.com
American Journal of Geriatric Psychiatry	ajgponline.org
American Journal of Medical Genetics Part B: Neuropsychiatric Genetics	onlinelibrary.wiley.com
American Journal of Psychiatry (AJP)	ajp.psychiatryonline.org
AJP – Resident’s Journal	ajp.psychiatryonline.org/residents_journal
American Journal of Psychoanalysis	palgrave-journals.com/ajp/
American Journal on Addictions	onlinelibrary.wiley.com
Annals of Clinical Psychiatry	aacp.com
Autism: The International Journal of Research and Practice	aut.sagepub.com
Behavioral and Brain Sciences	bbsonline.org
Behavioral Medicine	tandfonline.com/loi/vbmd20

Behavioral Neuroscience	apa.org/journals/bne
Behavioural Brain Research	elsevier.com/locate/bbr
Biological Psychiatry	elsevier.com/locate/biopsychiat
Bipolar Disorders	onlinelibrary.wiley.com
BMC Psychiatry	biomedcentral.com/bmcpsychiatry
Brain Research	elsevier.com/locate/brainres
British Journal of Psychiatry	bjp.rcpsych.org
Canadian Journal of Psychiatry	publications.cpa-apc.org
Cerebral Cortex	cercor.oxfordjournals.org
Child and Adolescent Psychiatric Clinics of North America	childpsych.theclinics.com
CNSDrugReviews	onlinelibrary.wiley.com
CNSDrugs	link.springer.com/journal/40263
CNS Spectrums	journals.cambridge.org/jid_CNS
Comprehensive Psychiatry	journals.elsevier.com
Current Opinion in Psychiatry	co-psychiatry.com
Current Psychiatry	currentpsychiatry.com
Dementia and Geriatric Cognitive Disorders	karger.com/dem
Depression and Anxiety	onlinelibrary.wiley.com
Developmental Psychobiology	onlinelibrary.wiley.com
Drug and Alcohol Dependence	elsevier.com/locate/drugalcdep
Epilepsy and Behavior	journals.elsevier.com
European Archives of Psychiatry and Clinical Neuroscience	link.springer.com/journal/406
European Journal of Neuroscience	onlinelibrary.wiley.com
European Neuropsychopharmacology	elsevier.com/locate/euroneuro
European Psychiatry	journals.elsevier.com
Experimental and Clinical Psychopharmacology	apa.org/journals/pha
FOCUS: The Journal of Lifelong Learning in Psychiatry	focus.psychiatryonline.org
General Hospital Psychiatry	journals.elsevier.com
Harvard Review of Psychiatry	journals.lww.com
Hormones and Behavior	journals.elsevier.com
Human Psychopharmacology	onlinelibrary.wiley.com
International Journal of Eating Disorders	onlinelibrary.wiley.com
International Journal of Geriatric Psychiatry	onlinelibrary.wiley.com
International Journal of Methods in Psychiatric Research	onlinelibrary.wiley.com
International Journal of Neuropsychopharmacology	journals.cambridge.org/jid_PNP
International Journal of Psychoanalysis	onlinelibrary.wiley.com
International Psychogeriatrics	journals.cambridge.org/jid_IPG
JAMA Psychiatry	archpsyc.jamanetwork.com/journal.aspx
Journal of Addiction Medicine	journals.lww.com
Journal of Affective Disorders	elsevier.com/locate/jad
Journal of Anxiety Disorders	elsevier.com/locate/janxdis

Journal of Attention Disorders	jad.sagepub.com
Journal of Autism and Developmental Disorders	link.springer.com/journal/10803
Journal of Child and Adolescent Psychopharmacology	liebertpub.com
Journal of Child Psychology and Psychiatry	onlinelibrary.wiley.com
Journal of Clinical Psychiatry	psychiatrist.com
Journal of Clinical Psychology	onlinelibrary.wiley.com
Journal of Clinical Psychopharmacology	psychopharmacology.com
Journal of Clinical Sleep Medicine	aasmnet.org/JCSM
Journal of Consulting and Clinical Psychology	apa.org/journals/ccp
Journal of ECT	journals.lww.com
Journal of Geriatric Psychiatry and Neurology	jgp.sagepub.com
Journal of Nervous and Mental Disease	jonmd.com
Journal of Neuroimaging	onlinelibrary.wiley.com
Journal of Neurology, Neurosurgery, and Psychiatry	jnp.bmj.com
Journal of Neuropsychiatry and Clinical Neurosciences	neuro.psychiatryonline.org
Journal of Neuroscience	jneurosci.org
Journal of Neuroscience Research	onlinelibrary.wiley.com
Journal of Pain	jpain.org
Journal of Psychiatric Practice	practicalpsychiatry.com
Journal of Psychiatric Research	elsevier.com/locate/jpsychires
Journal of Psychiatry and Neuroscience	cma.ca/jpn
Journal of Psychosomatic Research	elsevier.com/locate/jpsychores
Journal of Sleep Research	onlinelibrary.wiley.com
Journal of the American Academy of Child Psychiatry	jaacap.com
Journal of the American Academy of Psychiatry and the Law	jaapl.org
Journal of the American Medical Association (JAMA)	jama.ama-assn.org
Journal of the American Psychoanalytic Association	apsa.org
Journal of the International Neuropsychological Society	journals.cambridge.org/jid_INS
Journal of Traumatic Stress	onlinelibrary.wiley.com
Lancet, The	thelancet.com
Lancet Psychiatry, The	thelancet.com/journals/lanpsy
Developmental Disabilities Research Reviews	onlinelibrary.wiley.com
Molecular Psychiatry	nature.com/mp
Nature	nature.com
Nature Neuroscience	nature.com/neuro
Nature Reviews Neuroscience	nature.com/nrn
Neurobiology of Aging	elsevier.com/locate/neuaging

Neurobiology of Learning and Memory	journals.elsevier.com
Neuroimage	elsevier.com/locate/ynimg
Neuropsychobiology	karger.com/nps
Neuropsychologia	journals.elsevier.com/neuropsychologia
Neuropsychology	apa.org/journals/neu
Neuropsychopharmacology	nature.com/npp
Neuroreport	neuroreport.com
Neuroscience	elsevier.com/locate/neuroscience
Neuroscience and Biobehavioral Reviews	elsevier.com/locate/neubiorev
Neuroscience Letters	elsevier.com/locate/neulet
New England Journal of Medicine	nejm.org
Pain	elsevier.com/locate/pain
Pharmacopsychiatry	thieme-connect.com
Primary Care Companion for CNS Disorders	psychiatrist.com/pcc
Proceedings of the National Academy of Sciences of the United States of America	pnas.org
Progress in Neuro-Psychopharmacology and Biological Psychiatry	elsevier.com/locate/inca/525488
Psychiatric Annals	healio.com/psychiatry
Psychiatric Clinics of North America	psych.theclinics.com
Psychiatric Genetics	psychgenetics.com
Psychiatric Quarterly	link.springer.com/journal/11126
Psychiatric Services	ps.psychiatryonline.org
Psychiatry: Interpersonal and Biological Processes	guilfordjournals.com/loi/psyc
Psychiatry Research	elsevier.com/locate/psychres
Psychiatry Research: Neuroimaging	elsevier.com/locate/psychresns
Psychodynamic Psychiatry	aapdp.org/index.php/publications/journal/
Psychological Medicine	journals.cambridge.org/jid_PSM
Psychoneuroendocrinology	elsevier.com/locate/psyneuen
Psycho-Oncology	onlinelibrary.wiley.com
Psychopathology	karger.com/psp
Psychopharmacology (Berlin)	link.springer.com/journal/213
Psychosomatic Medicine	psychosomaticmedicine.org
Psychosomatics	psychosomaticsjournal.com
Psychotherapy and Psychosomatics	karger.com/Journal/Home/223864
Schizophrenia Bulletin	schizophreniabulletin.oxfordjournals.org
Schizophrenia Research	elsevier.com/locate/schres
Science	sciencemag.org
Sleep	journalsleep.org
Substance Use and Misuse	informahealthcare.com/sum
Translational Psychiatry	nature.com/tp
Trends in Cognitive Sciences	trends.com/tics
World Journal of Biological Psychiatry	informahealthcare.com/wbp

19 Reading List and Reference Guide

Making a “must-read” list for the field of psychiatry is daunting. It would take a lifetime to digest even a moderate portion of the psychiatric literature. Therefore, this list is meant only as an introduction to some of the landmark psychiatric publications.

Books in print can be found at major booksellers or medical school book stores. Books from American Psychiatric Publishing are available online at appi.org or at the Annual Meeting. APA Resident and Fellow Members receive a 25% discount. Finding out-of-print items may be trickier; usually academic librarians can help. Some web retailers sell used editions – though you may need to use a search engine to find rare items.

The following list is not comprehensive, nor is it intended to replace your own program’s recommendations. It also is not an endorsement of any particular author or publisher. It is 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, 5th Edition:** DSM-5. American Psychiatric Publishing; 5th edition (2013)

Comprehensive Texts

- **Psychiatry.** Allan Tasman, Jerald Kay, Jeffrey Lieberman. Michael First, Michelle Riba. John Wiley & Sons; 4th edition (2015)
- **Kaplan and Sadock's Comprehensive Textbook of Psychiatry (2 Volumes).** Benjamin J Sadock, Virginia A. Sadock, Pedro Ruiz. Lippincott Williams & Wilkins; 9th edition (May 2009)
- **The American Psychiatric Publishing Textbook of Psychiatry.** Robert Hales, Stuart Yudofsky, Laura Weiss Roberts. American Psychiatric Publishing, 6th edition (2014).
- **New Oxford Textbook of Psychiatry (2 Volumes).** Michael G. Gelder, Nancy Andreasen, Juan J. Lopez-Ibor, John Geddes. Oxford University Press, USA, 2nd Edition (2009).
- **Gabbard's Treatments of Psychiatric Disorders.** Glen O. Gabbard. American Psychiatric Publishing; 5th edition (2014)

Board Preparation/General Study

- **Massachusetts General Hospital Psychiatry Update & Board Preparation.** Theodore A. Stern, John B. Herman, Tristan Gorrindo. MGH Psychiatry Academy; Revised edition (2012).
- **Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry.** Benjamin J. Sadock, Virginia A. Sadock, Pedro Ruiz. Lippincott Williams & Wilkins; 11th edition(2014).
- **Kaplan & Sadock's Study Guide and Self-Examination Review in Psychiatry.** Benjamin J. Sadock, Virginia A. Sadock, Pedro Ruiz. Lippincott Williams & Wilkins; 9th edition(2011).
- **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: Expert Consult - Online and Print.** John C. Spiegel, John M. Kenny. Saunders (2013)

Review Books

- **The Massachusetts General Hospital/McLean Hospital Residency Handbook of Psychiatry.** Hospital Residents and Faculties. LWW, 1st edition (2010)

Forensic Psychiatry

- **Clinical Handbook of Psychiatry and the Law.** Thomas G. Gutheil, Paul S. Appelbaum. Lippincott Williams & Wilkins; 4th edition (2006)
- **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. American Psychiatric Publishing, 2nd Edition (2010)

Psychopharmacology

- **The American Psychiatric Publishing Textbook of Psychopharmacology.** Alan F. Schatzberg, Charles B. Nemeroff. 4th edition (2009)
- **Stahl's Essential Psychopharmacology: Neuroscientific Basis and Practical.** Stephen Stahl. Cambridge University Press; 4th edition (2013)
- **Clinical Handbook of Psychotropic Drugs (Spiral-bound).** K.Z. Bezchlibnyk-Butler, J.J. Jeffries. Hogrefe and Huber Publishers, 20th Edition (2013)

- **Handbook of Psychiatric Drug Therapy.** Lawrence A. Labbate, Maurizio Fava, Jerrold F. Rosenbaum, George W. Arana. Lippincott Williams & Wilkins; 6th edition (2009)
- **Kaplan & Sadock's Pocket Handbook of Psychiatric Drug Treatment.** Benjamin Sadock LWW; 6th edition (2013)
- **Manual of Drug Interaction Principles for Medical Practice: The P450 System.** Gary H. Wynn. American Psychiatric Publishing; 1st edition (2008)
- **Clinical Manual of Electroconvulsive Therapy.** Mehul V. Mankad, John L. Beyer, Richard D. Weiner, Andrew Krystal American Psychiatric Publishing; 1st edition (2010)
- **Brain Stimulation in Psychiatry: ECT, DBS, TMS and Other Modalities.** Charles H. Kellner. Cambridge University Press, 1st Edition (2012)

Neuroscience/Neuropsychiatry

- **Neurobiology of Mental Illness.** Dennis S. Charney, Pamela Sklar, Joseph Buxbaum, Eric J. Nestler. Oxford University Press; 4th edition (2014)
- **American Psychiatric Publishing Textbook of Neuropsychiatry and Clinical Neurosciences.** Stuart C. Yudofsky, Robert E. Hales. 5th edition (2007)
- **Neuroscience for the Mental Health Clinician.** Steven R. Pliszka. The Guilford Press (2004)
- **Neurology for the Non-Neurologist.** William J. Weiner, Christopher G. Goetz, Robert K. Shin MD, Steven L. Lewis. LWW; 6th edition (2010)
- **Management of Adults with Traumatic Brain Injury.** David B. Arciniegas, Nathan D. Zasler, Rodney D. Vanderploeg, Michael S. Jaffee. American Psychiatric Publishing; 1st edition (2013)
- **Clinical Neurology for Psychiatrists.** David Myland Kaufman. Saunders; 7th edition (2013)

Psychosomatic Medicine

- **Massachusetts General Hospital Handbook of General Hospital Psychiatry: Expert Consult - Online and Print.** Theodore A. Stern. Saunders; 6th edition (2010)
- **The American Psychiatric Publishing Textbook of Psychosomatic Medicine: Psychiatric Care of the Medically III.** James L. Levenson, Lawson Wulsin. American Psychiatric Publishing, 2nd edition (2010)
- **Psychosomatic Medicine.** Michael Blumenfeld, James J. Strain. Lippincott Williams & Wilkins (2006)
- **Manual of Psychiatric Care for the Medically III.** Antoinette Ambrosino Wyszynski, Bernard Wyszynski. American Psychiatric Publishing (2004)

Emergency/On-Call Psychiatry

- **Emergency Psychiatry.** Arjun Chanmugam, Patrick Triplett, Gabor Kelen. Cambridge University Press; 1st edition (2013)
- **Clinical Manual of Emergency Psychiatry.** Michelle B. Riba, Divy Ravindranath. American Psychiatric Publishing, Inc.; 1st edition (2010)
- **Emergency Psychiatry: Principles and Practice.** Rachel Lipson Glick, Jon S. Berlin, Avrim Fishkind, Scott L. Zeller. LWW; Har/Psc edition (2008)
- **On Call Psychiatry.** Carol A. Bernstein, Ze'ev Levin, Molly E. Poag, Mort Rubinstein. Saunders; 3rd edition(2006)

Inpatient Psychiatry

- **Principles of Inpatient Psychiatry.** Fred Ovsiew, Richard L. Munich. LWW; 1st edition (November 6, 2008)
- **Manual of Inpatient Psychiatry.** Michael I. Casher, Joshua D. Bess. Cambridge University Press; 1st edition (2010)
- **Inpatient Group Psychotherapy.** Irvin D. Yalom. Basic Books; 1st edition (1983)

Child Psychiatry

- **Dulcan's Textbook of Child and Adolescent Psychiatry.** Mina K. Dulcan. American Psychiatric Publishing (2009)
- **Lewis's Child and Adolescent Psychiatry: A Comprehensive Textbook.** Andres Martin, Fred Volkmar. Lippincott Williams & Wilkins; 4th edition(2007)
- **Pediatric Psychopharmacology.** Andres Martin, Lawrence Scahill, Christopher Kratochvil. Oxford University Press, 2nd edition (2010)
- **Green's Child and Adolescent Clinical Psychopharmacology.** William Klykylo, Rick Bowers, Julia Jackson, Christina Weston. Lippincott Williams & Wilkins; 5th edition (2013)
- **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.** David C. Steffens, Dan G. Blazer, Mugdha E. Thakur. 5th edition (2015)

- **Clinical Manual of Geriatric Psychopharmacology.** Sandra A. Jacobson. American Psychiatric Publishing, 2nd Edition (2014)

Addiction Psychiatry

- **The American Psychiatric Publishing Textbook of Substance Abuse Treatment.** Marc Galanter, Herbert D. Kleber. 5th edition (2014)
- **Lowinson's and Ruiz's Substance Abuse: A Comprehensive Textbook.** Pedro Ruiz, Eric Strain. Lippincott Williams & Wilkins; 5th edition(2011)
- **The ASAM Principles of Addiction Medicine.** Richard K. Ries, David A. Fiellin, Shannon C. Miller, Richard Saitz. LWW; 5th edition (2014)
- **Clinical Manual of Addiction Psychopharmacology.** Henry R. Kranzler. Domenic A. Ciraulo. American Psychiatric Publishing, Inc., 2nd Edition (2013)

General Interest

- **Neurotic Styles.** David Shapiro. BasicBooks (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)
- **Rethinking Psychiatry: From Cultural Category to Personal Experience.** Arthur Kleinman. Free Press(2005)

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)
- **Sims' Symptoms in the Mind: Textbook of Descriptive Psychopathology.** Femi Oyeboade. SaundersLtd.; 5th edition (2014)

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.** GlenO. Gabbard. American Psychiatric Publishing; 5th edition (2014)
- **Supportive Therapy: A Psychodynamic Approach.** Lawrence H. Rockland. Basic Books (2003)
- **A Primer of Supportive Psychotherapy.** Henry Pinsker. The AnalyticPress;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).
- **Psychodynamic Therapy: A Guide to Evidence Based Practice.** Richard F. Summers, Jacques P. Barber. The Guilford Press; Reprint edition (2012)
- **Psychodynamic Psychotherapy: A Clinical Manual.** Deborah L. Cabaniss, Sabrina Cherry, Carolyn J. Douglas, Anna R. Schwartz. Wiley; 1st edition (2011)
- **Becoming a Therapist: What Do I Say, and Why?** Suzanne Bender, Edward Messner. The Guilford Press; 1st edition (2003)
- **Existential Psychotherapy.** Irvin D. Yalom. Basic Books (1980)

Memoirs/Personal Accounts

- **Man's Search for Meaning.** Viktor Frankl. Beacon Press (2006)
- **The Center Cannot Hold: My Journey through Madness.** Elyn Saks. Hachette Books (2008)
- **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)
- **Drinking: A Love Story.** Caroline Knapp. Dial Press Trade Paperback (1997)
- **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)



Prefer to learn online? Through the Supplemental Education and training program, or **SET for Success**, RFMs have free access to more than 50 educational activities on the APA Learning Center. For a list of available courses, visit psychiatry.org/SET.

20 Doing Research as a Resident

Many residents are not exposed to research during training, and may not have the interest, opportunity, or time anyway. Nonetheless, research can be a rewarding experience that complements your training and enhances your development professionally and personally. This chapter provides reasons to become involved in research as a resident, reviews types of psychiatric research, and offers suggestions for participating in research as a trainee.

There is Research...and There is Research

There are a variety of research areas in psychiatry:

- **Basic neuroscience research** includes laboratory or bench research and neuroimaging.
- **Clinical 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.
- **Clinical phenomenology studies** characterize specific diagnostic groups of patients.
- **Medical education and quality improvement** are other potential areas for scholarship outside the realm of traditional research.

As researchers begin to pose and answer questions, the type of study necessary starts to take shape:

Descriptive Study	The most basic study in which one simply describes a particular finding such as a 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.
Analytic Study	More complicated, 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.
Experimental Study	The most complex, here 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 finding the requisite time and grant money. In reality, many projects start small and progress from a single experience to a more complex project. Many medical centers offer small grants to resident investigators. Here are some ideas of how a resident in training can gain experience in psychiatric research:

1. Start with an idea. An idea can arise from everyday clinical work in the form of treatment responses, an unexpected side effect, or a particularly interesting patient.
2. Create a list of faculty members and their current research interests from your department website. 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 potential research projects 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 faculty members.
3. 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.
4. Many residency programs have research tracks with protected time for research and an explicit goal of producing physician-scientists. For some programs, a PhD or other advanced research-related degree is recommended to participate in these tracks. Some more time-consuming types of research, for

As a new resident with minimal research experience in Psychiatry, I decided to get involved first by responding to a research attending's email looking for assistance with a research review publication. Although it was a foreign topic to me, the attending was excited to have resident participation and I learned a lot about a new subject. Once I completed this project, the attending thought of me for a variety of future publications. My best advice for getting involved as a new resident is to read those random emails and don't be afraid to set up meetings with potential collaborators. You have a lot to offer, even without a ton of prior experience!

-Tua-Elisabeth Mulligan, MD

example basic science research, are best achieved with support from a residency program through a research track.

5. Negotiate whether you'll receive authorship credit should the work be published. If you do a significant amount of work on a project, make sure that you get the proper academic credit for doing so.
6. Get involved in research-related activities in your department, such as journal clubs and grand rounds presentations.
7. Find out if your institution offers post-residency research fellowships.
8. Attend professional meetings such as the American Psychiatric Association Annual Meeting or sub-specialty organization meetings. Many national organizations offer travel funds or research fellowships to help you finance your trip.
9. 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.

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 nimh.nih.gov.



	<p>Use your APA membership to access research opportunities:</p> <ul style="list-style-type: none">▪ Apply for the Psychiatric Research Fellowship▪ Submit an abstract to the Resident Poster Competition▪ Apply for the Kempf Fund for Development Research in Psychobiological Psychiatry <p>Visit psychiatry.org/residents for more details.</p>

21 Getting Published During Residency

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 positioned to contribute to the psychiatric literature. 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 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 and developing a clinical niche following training.

What do Residents Publish?

- **Original research articles and brief reports** describe experiments that have been conducted to answer clinical, translational, or basic science questions.
 - **Tip: A senior investigator may already have raw data that can be rapidly analyzed to generate an original publication**
- **Review articles** describe, critique, and synthesize existing studies that relate to a common clinical or scientific theme. Book chapters can serve a similar purpose.
 - **Tip: Can be split among several authors to save time**
- **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.
 - **Tip: Best written soon after the inspiring clinical encounter**
- **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.

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:

- ***American Journal of Psychiatry***: runs a section called Introspections which features brief personal vignettes, some of which have been written by trainees.
- ***Residents' Journal***: published electronically monthly with the *American Journal of Psychiatry*, it serves as a forum for psychiatry residents and fellows to share ideas and experiences in training, clinical practice, research, and careers with colleagues.
- ***American Psychiatry***: frequently publishes articles on the residency training process
- ***Psychiatric Services***: publishes a special series called TRAINING rounds designed specifically for trainees' work related to the delivery of care
- Several widely-read journals, including *Psychosomatics*, *The Primary Care Companion to the Journal of Clinical Psychiatry*, *CNS Spectrums*, and others, publish case reports by residents

How Can Residents who want to Publish Get Started?

Writing can be an intimidating process, especially early in your career. It is always a good idea to enlist the support of a supervisor with publication experience in the relevant field. They can point you to existing literature, help develop and focus your ideas, and provide feedback on drafts. In addition, if they are credited a senior author, it lends instant credibility to the work, a significant advantage during the peer review process. It is always a good idea to contact the journal editor first to ensure that the manuscript fits the journal's scope and would interest the editorial board. Of course, this does not guarantee acceptance, but is useful to gauge their interest. 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.

22 When Disaster Strikes

Disasters affect everyone. Americans have realized that we are not immune to manmade or natural catastrophes. Whether disasters are caused by terrorists, hurricanes, snowstorms, or earthquakes, being prepared can significantly help you and your patients. Having disaster management skills is like insurance – you hope to never use it, but you would not want to be caught without it. The following are insights from a resident who worked in New York City on September 11 and in New Jersey during Superstorm Sandy.

1. **Disasters are unpredictable so being prepared is the number one rule.** Be prepared personally and professionally. Emergency kits for each person in your household are essential and should include three days of food, cash, can opener, water, batteries, non-electric radio, flashlights, appropriate clothing, blankets, cell or smartphone and adapters. Keep informed about natural disasters and keep a full tank of gasoline before a predicted storm. During hurricanes and earthquakes, basic utilities, such as gas, electricity, or water, can be cut off at any time. In addition, register your cell and home phone number with your town, hospital, and utility services in order to get emergency alerts. Be familiar with your hospital's disaster plan. During the Boston Marathon attacks, the preparedness, flexibility, and training of Boston's first responders and hospital staff saved many lives.
2. **Stay informed.** Get enough information to plan your strategy. However, do not become obsessed with rewatching traumatic events. Turn off the television, computer, iPhone, etc. if there are traumatic pictures of disasters being shown again and again. You can gauge how much you need to know. Many adults and children after September 11 were traumatized by watching the events on TV repeatedly. Although being informed is important, re-experiencing visual trauma is not helpful. Recommend that patients and staff limit television time. Social media is important but gauge the reliability of the information source.
3. **Take care of yourself and your family.** Learn to conserve your energy. If you don't take care of yourself, you will burn out quickly. Find out if your family and friends are okay. Staff members who were able to contact loved ones were reassured and better able to take care

of others. At the end of the day, return phone calls to your loved ones. During disasters, hospital staff members are sometimes so busy taking care of patients that they forgot to take care of themselves. (One of my colleagues was so busy caring for patients, he did not plan for his own evacuation during Superstorm Sandy. Luckily he and his family escaped their flooded house in time.) Do not take nonessential items with you. They can all be replaced, human life cannot. If ordered to evacuate an area, do so and follow your state's evacuation route.

4. **Remember the pneumonic HALT.** If you are Hungry, Angry, Lonely, or Tired, you need to step back and take a break. A resident who is hungry, angry, lonely or tired is not helpful. Do not forget to eat, drink, and get enough sleep. Carry food and bottles of water with you.
5. **Carry your hospital photo ID with you at all times.** Hospital Security is usually heightened during disasters. In addition, you may get additional resources to perform your job. In Monmouth County, essential hospital staff carrying photo ID had access to gasoline at State facilities during the aftermath of Superstorm Sandy.
6. **Know your hospital's protocol.** Most likely your hospital's emergency generators will be operational, which means your hospital will be operational. Communicate with your direct psychiatric supervisor and find out the new objective(s). Is it to establish new roles for the residents? After September 11, psychiatric residents were asked to provide support for first responders in the medical emergency room, including calling families per patients' requests, volunteering more hours in the psychiatric emergency room, and supporting the families who arrived looking for loved ones. Essential hospital services take over during disasters. The hospital (in coordination with the city or county) may implement their own disaster plan. For example, one of NYC's disaster command centers was fully operational in Bellevue hospital during the Y2K scare. During disasters, the psychiatric and medical emergency rooms may start triaging patients based on priority of need.
7. **Be flexible.** After September 11, Bellevue psychiatric staff had to adapt to the needs of the community. The psychiatry department needed to provide both short and long term specialized services to accommodate the new patient population. For example, alcohol use dramatically increased in first responders during the first six months after the attacks and Bellevue had a protocol to treat them.

8. **Follow your leaders, and do not reinvent the wheel.** Most residents realized quickly that they were more effective working through organizations and their hospital 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 show up at the designated disaster site as an unknown individual.
9. **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.
10. **When seeing traumatized people, first introduce yourself and ask if they want to talk.** 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 did not eat or drink for two days because she was consumed with finding her missing fiancé).
11. **Reassure people that the government, the hospital, the police, and the establishment are still functional.** Your patients may look to you to reassure them. One of the biggest fears for psychiatric patients is that after a disaster, our normal routine and normal institutions will fall apart. It is our job to help them slowly get back into a normal routine while in a surreal environment.
12. **Some patients want to talk. Some don't. Respect this.** Sometimes patients just want to be reassured that they are okay. Gauge this. If patients want to talk, ask patients to tell you what had happened and what they were feeling when the disaster occurred. Then try to normalize what they are feeling, whether it is sadness, anger, guilt or disbelief. A therapeutic alliance is helpful but not necessary. Most people just need concrete support.
13. **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 let people know there are services available to help them.
14. **Give people a referral number in case they need help in the future.** Ask people if they need things such as a water, food, or access to a phone. Mobilize people's family and friends around them. Make sure

they have a way to get home (People can be so overwhelmed that they forget this).

15. **Use medications, such as benzodiazepines and sedatives, sparingly.** Do not give more than a one-week supply without following up. If there are symptoms that interfere with the patient's normal function after one month, refer them to outpatient psychiatric and/or therapy sessions.
16. **Consult colleagues in social work, psychology, medicine, and critical care.** Most trauma patients will see primary care doctors first and be referred to psychiatry. Become known to primary care doctors.
17. **Remember that trauma does not just affect people at the disaster site.** It can affect your neighbors, friends, family, and colleagues.
18. **Take care of your staff.** To help after Superstorm Sandy, Saint Barnabas Health Care System immediately gave emergency grants to staff members directly affected by the storm. One of the doctors whose house and car were heavily damaged revealed that the grant helped tremendously in allowing her to stay focused on her job because her family's essential needs were met.
19. **Beware of your own prejudices and feelings when helping diverse populations.** People revert to old prejudices and ways of coping when there is a disaster. One of the Bellevue psychiatric attendings revealed in process group that he had to initially deal with his own hostility toward a Middle Eastern doctor before he could work with him. We are all human and it is normal to be afraid or angry but it is not okay to express anger to strangers who don't deserve it. Be cognizant of your own xenophobia.
20. **Remember that in times of crisis, psychiatrists are privileged to have services to offer those in need.** In both disasters, it was wonderful to see the city and hospital communities come together. Be grateful that you can intervene in ways that are enormously meaningful to people who are suffering. It will be meaningful for you too.

23 Advocating for Psychiatric Patients

Organizations such as the National Alliance for the Mentally Ill (NAMI), The Treatment Advocacy Center (TAC), and the American Psychiatric Association (APA) provide various resources to help patients and psychiatrists advocate for those with mental illness. The Bazelon Center for Mental Health Law also provides an excellent list of Mental Health and Disability Advocacy Resources.

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 quitassist.com. Call or request as many kits as you need, and they will mail them to you at no cost. 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.
- Encourage your patients and their families to visit the APA’s Patient and Families webpages to learn more about their diagnosis.

Provide Your Patients with Financial Resources

- SAMHSA provides 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) helps 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 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. The Treatment Advocacy Center offers up to date summaries and detailed information about mental health laws. Go to youthlaw.org for information specific to children and the law. Your local APA State Association or District Branch should also be able to help.
- 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, available free from SAMHSA.

24 Patient Suicide during Residency

As one attending physician put it, “It’s not a matter of *if* one of your patients will commit suicide, it’s a matter of *when*.” For many psychiatrists, the death of a patient to suicide is likely to occur *during* their residency.

Approximately half of psychiatrists can expect to experience the loss of at least one patient to suicide. And after a patient suicide, close to 40% of psychiatrists will develop severe distress and some will score high on indices for acute stress disorder and PTSD. For these reasons, patient suicide is increasingly recognized as an “occupational hazard” for psychiatrists that may threaten psychological health and overall sense of wellbeing.

For psychiatrists in training, the emotional impact of a patient suicide can be particularly devastating. Emotional reactions often include feelings of guilt, shame and a profound sense of personal failure. The high prevalence of residents experiencing a patient suicide has been attributed to the fact that psychiatry trainees often care for the most chronically ill and suicidal patients in both inpatient and emergency room settings. Even though suicide risk assessment and prevention is considered a “core competency,” few training programs prepare trainees for the eventuality of a patient suicide. As a result, some training programs are now developing curricula that emphasize suicide “postvention,” that is, what to expect *after* a patient commits suicide. Sacks et al. described four phases of a trainee reaction to a completed suicide:



The first phase, shock and disbelief, is often associated with grief, guilt and depressive rumination in search of something that might have been missed. This phase may also be accompanied by significant anxiety, insomnia, intrusive thoughts, avoidance and fear of dealing with suicidal patients. In a study of 48 residents after a patient suicide, 39% reported difficulty with decision-making and hospitalizing their patients more frequently to prevent another suicide.

The journey from shock and disbelief to resolution may take six months to two years. Another researcher described three phases based on time elapsed since the event:

- “acute” (hours to two months)
- “clarification and initial working through” (two to six months) and
- “relative resolution versus ongoing doubt” (six months to approximately two years)

My Case Study...

During my second year of training while on call overnight, I was emergently called to rush back to the inpatient unit. One of the patients had performed a very serious suicide attempt. In the aftermath I remember initially feeling angry, wondering who was to blame for allowing such an act to occur, and then later questioning myself, wondering if I could have done something differently to prevent this incident from happening. While I have been fortunate enough to avoid the personal patient suicide experience, a few of my fellow residents have not. In talking with them, they experienced similar feelings of self-doubt and failure. In addition, there was a sense of weakness because they, and not their other colleagues, experienced patient suicide. At my program, the directors encourage each resident who experience similar events to reach out to their supervisor and the director, regardless if one is feeling distressed or not shortly after finding out about the tragic event. After talking with my program director, she made an obvious, but profound statement. She simply said that residents and staff cannot always control and prevent patients from making poor decisions. A patient who strongly desires to complete suicide will do everything in their power to carry through with this act. I would strongly encourage residents at other sites to reach out to their program directors and supervisors. Having a strong support team around can help you process these difficult moments. If you are unfortunate enough to learn that one of your patient’s has completed suicide, understand that this not a rare event and that seeking help should not be seen as a sign of weakness.

-Seth Judd, D.O.

Invariably, eventual resolution after a patient suicide requires support. Fellow residents are often reported to be the most helpful supports for residents struggling with the loss of a patient. Indeed, patient suicide impacts not only the resident but also the resident’s peers and the entire program. Program directors and mentors not involved in the case are often able to provide residents with much needed perspective by sharing their own

experiences. Indeed, more often than not, trainees find it difficult to see their patients in the context of a chronic, terminal illness.

Site supervisors often serve as an invaluable source of emotional and professional support for residents after a patient suicide. Supervisors may share their own grief and sense of responsibility thus reassuring the resident that they are not alone. More importantly, supervisors are responsible for reviewing the case with the resident and assisting in the preparation for the inevitable critical incident review (residents should not hesitate to ask their supervisor to attend if the offer is not readily extended).

Although the approach of a critical incident review may seem daunting, the process is usually constructive and their outcomes are often positive. The goal is to provide the entire treatment team with an opportunity to review their interventions and to advise as to whether procedural changes need to be implemented. Critical incident reviews usually involve the participation of experienced clinicians who are also committed to supporting the educational and emotional needs of their residents.

Supervisors and program directors are there to explore any possible legal implications of a patient suicide and may provide guidance as to how to communicate with surviving family members. Although residents may benefit from speaking with families and attending funerals, there are times when communication by a resident may not be helpful or advisable.

Resolution after the loss of a patient to suicide is a deeply personal journey for which spouses, family members and friends can play a vital part. For some, resolution may require the help of a psychotherapist. Seeking professional help must never be viewed as a weakness, but a strength that can facilitate both reflection and recovery.

Finally, Menninger advised that patient suicide must first be anticipated in order for a clinician to adaptively cope and grow from the experience. Indeed, curriculum aimed at making residents aware of the eventuality of patient suicide, common reactions to the experience and available resources for support should be a key feature of every residency program.

25 Coping with Changes in Medicine that Affect Residency Training

Picture this: you arrive at work only to find that the bustling inpatient unit that you left yesterday is no more. Worse, the building sign indicates that the hospital is now affiliated with the university across town. What happened?

One Word: Money

As hospitals compete for dwindling reimbursements, they are forced to make decisions based on financial interests. Outpatient clinics often terminate unprofitable managed care contracts, suddenly restricting you from seeing patients you have been treating for months. Inpatient units get consolidated or shut down with little warning as hospitals and universities shift affiliations.

For residents, it can be particularly frustrating as you worry whether or not you are receiving adequate training in such an unstable environment. Sometimes changes occur within a program that are not directly related to the managed care environment. Often, these changes are financially driven. In most programs, affiliate sites pay the program or university for the residents' services. These lines of funding dictate how many residents rotate at a certain site. If one site provides more funding lines, a larger proportion of residents will be required to rotate there. Affiliates may pull lines of funding if they believe their needs are not being met, compounding feelings of instability.

What Can I Do as a Resident?

Most importantly, remember that you need to be flexible and adapt to the changes. Although names and scenery may shift, there are opportunities to learn in every setting and with every patient. 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 them. If you feel overwhelmed, talk to your supervisors. They can provide advice for dealing with these difficult, but increasingly common, obstacles. Remember that you have every right to bring up your questions and concerns with your training director. Don't be afraid to speak up for yourself. Residents should be informed about any program changes in a timely manner. Be tolerant of transitions, but play an active role in your education by advocating for opportunities to rotate at affiliate sites in your interest areas.

26 Couch Time: Psychoanalytic Training

"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

"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."

-Sigmund Freud

chapter sheds light on what often seems a mysterious, foreign proposition, by answering some questions and providing resources for further exploration. Probably the best way to learn more about psychoanalytic training is to speak to those doing it. You might also start your own treatment with a psychoanalyst (analysis or otherwise) and go from there (more on that later)!

Analytic training 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)
- demonstration of clinical proficiency with several control cases (usually of each gender), conducted under supervision

Few experiences in life are as shocking as seeing unconscious forces at work in your own life. As an analys (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 considering analytic training, enter psychotherapy with a training analyst at your local institute to avoid starting from scratch on the couch.

Most of us become analysts because we love it. 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 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 (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. Go to one of the semi-annual conferences where you can try the prospect of becoming an analyst on for size 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.
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 after training, though most live where they trained.
4. **The money issue is real.** The cost of analysis and tuition at the institute, coupled with the lost income incurred by seeing your own training cases at often-reduced fees, naturally spooks prospective candidates. 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, 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.

Part 2:

**You, the Professional: Balancing Life, Leadership,
and Career During Residency and Beyond**

27

Your Personal Mental Health and Whether to Get Your Own Psychotherapy

Remember that nobody, not even a physician, is immune to serious mental illness. 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, colleague, 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. Recall the old adage “he who has himself for a physician is a fool.” Ask your primary care physician, state medical society, or someone in your department for a referral. You don’t have to say who the referral is for if you feel uncomfortable. You have worked hard to reach your goals. If you think you need professional help, get it immediately. In this situation, you come first.

Weigh the pros and cons when deciding whether to receive psychotherapy as a resident. While there is no clear evidence that personal therapy can *quickly* improve your psychotherapeutic skills, it can be rewarding in terms of personal growth and your ability to empathize with patients.

**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.
-Sigmund Freud (1937)**

Obviously the most important consideration regarding psychotherapy is personal need. If you have a diagnosed psychiatric disorder, there is little question about the importance of therapy. Lacking such diagnosis, residents may seek therapy for acute problems, including those created by the stress of the residency. It is important not to confuse difficulties particular to being a new doctor—role confusion, frustration, social isolation, even depression—with psychopathology requiring long-term therapy. Brief or supportive therapy might be what is indicated for routine job stress or for a relatively normal transition through age-appropriate developmental stages.

Lacking any crisis, you may ask, “Why do it?” If you are coping well and begin therapy for professional reasons only, the experience may be distorted by a lack of motivation for personal change. On the other hand, psychiatrists have used their own therapy as training for years, without evidence of having been damaged by it. This could be 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 examining those reactions risks compromising your professional development.

A resident may inject their own unconscious needs into their practice if they avoid patients’ issues that bring up a personal conflict, or if they mistake the office as a place for personal support – giving new meaning to the term supportive therapy. Examining such phenomena in your own therapy can yield great personal rewards, as well as (eventually) make you a better therapist. But do not mistake supervision for personal therapy. Get your own therapist.

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.

Lacking any compelling need, the decision to get psychotherapy involves weighing many factors, including the possibility that it may initially make training 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 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.

28

Charting Your Course: Balance in Your Personal and Professional Life

According to Medscape's recent article, "Medical Resident Burnout Reaches Epidemic Levels," despite a reduction in duty hours by the ACGME, a majority of the participating residents met criteria for burnout. While the DSM does not contain a 'burnout disorder,' Ishak, et al. describes it as "triad of emotional exhaustion (emotional overextension and exhaustion), depersonalization (negative, callous, and detached responses to others), and reduced personal accomplishment (feelings of competence and achievement in one's work)."

While surgical and internal medicine residents in the study had the highest rates of burnout, psychiatry residents were ranked in the middle despite a generally more friendly call and work schedule. This probably comes as no surprise to any psychiatry resident. Psychiatry allows residents to spend more time with patients to understand their stressors, traumas and everyday struggles. We spend a significant amount of time analyzing difficult situations. Psychiatry patients are at higher risk for suicide, but can also display aggressive and violent behavior. Residents often deal with difficult, and sometimes hostile, family members. Each of us decided to pursue psychiatry because we love the challenging work this field offers, but during our training it is not uncommon to find yourself emotionally and psychologically drained.

Balancing Your Personal and Professional Lives

One of the most important skills you can learn is effectively balancing the different aspects of your life. According to the survey, top contributors to burnout were:

- Lack of time to exercise, take care of oneself, and/or engage in enjoyable activities outside of work
- Conflicting responsibilities between work, home, and family responsibilities
- Time spent on electronic records and documentation

The question, then, is how to avoid burnout and obtain the elusive ideal of work-life balance? The journey to becoming a medical professional is both rewarding and exhausting. Each of us has had to make significant sacrifices along the way in order to compete in the demanding world of medicine. There is almost an unspoken rule in medicine to keep quiet and keep working

because the challenges are simply part of the process. Many of our faculty and attendings trained when duty hours were less, if at all, restricted, which likely further compels current residents to sacrifice almost anything for their work. Meanwhile, the topic of work-life balance is gaining more attention in corporate America. From business reviews to self-help books, medical residents can take advantage of the wealth of information being circulated to maintain more balanced lives. Business leaders have “discovered through hard experience that prospering in the senior ranks is a matter of carefully combining work and home so as not to lose themselves, their loved ones, or their foothold on success.”

From surveys collected from thousands of executives, three common themes are especially applicable to resident life:



Define Success

First, residents must define what success means for them. There is no right or wrong answer, but it is important to clearly identify this in order to prioritize in a way that best suits your personal needs and goals. Once you have determined what success means to you, you can begin setting goals that will allow you to achieve your specific ambitions. Many people regularly set goals in their professional lives, but 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 and fulfillment you gain from life outside of work. 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, you may set goals to go on frequent dates, annual vacations, 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 you are more likely to successfully complete your goals if you avoid trying to change too much all at once.

The second theme is keeping work at work by managing electronics. It's important to occasionally set aside electronics outside the clinic or hospital and engage in meaningful conversations with your partner, family, or friends.

Manage Technology

Build Support Network

The third theme is building a support network. This is vitally important for residents because many of us move to programs where we initially have no family or friends. During your residency training, establish relationships with mentors, colleagues and local community organizations and/or church groups. Beyond these three themes it is critical to learn to say no and avoid feeling guilty for doing so. Learning to let go of the smaller things can help you accept that it is not necessary or advisable to take on every extracurricular activity available to you. Finally, protect the days and times you have off; make sure to have some fun because you definitely deserve it.

In My Experience...

Learning to achieve balance in my own life has been challenging, and I am continually shifting priorities in an attempt to maintain equilibrium. While burnout is probably the greatest during intern year, it can happen during any stage of training. I experienced symptoms of burnout during my third year while I was serving as the chief resident. I recall getting myself involved in too many extra activities - research, moonlighting to lessen the burden of student loans, and taking on additional leadership and clinical responsibilities. I felt exhausted and depleted, and I questioned my decisions, both as a clinician and as a leader. Prior to this time I avoided reaching out to colleagues, mentors and other faculty. I didn't want my burnout to be seen as a sign of weakness, especially while serving as chief resident. Eventually I was able to muster up the strength to reach out to one of my mentors and my program director. After doing so, I wish I would have done it earlier. Since then I have set goals to reduce my extra-curricular work and moonlighting hours and to spend more time with family and friends.

-Seth Judd, DO

Please know if you are experiencing burnout, you are not alone; in fact, you are the norm. Reach out to your program director, mentors, family and friends and learn to take time for yourself. Keep an eye out on your colleagues who may be reluctant to speak up. **Finally, understand that achieving a balanced life is a dynamic process that will need to be re-evaluated from time to time as goals and life circumstances change.** While obtaining balance may not be easy, remember that most good things in life require some dedication and practice. 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.

Suggested Reading

1. **Manage Your Work, Manage Your Life.** Groysberg B, Abrahams R. Harvard Business Review, March 2014.
2. **8 Ways To Achieve Better Work-Life Balance.** Smith J. Forbes, April 18, 2013.

29

Parenthood and Residency: Negotiating Parental Leave

There are no randomized controlled trials about the right time to have children. While starting a family during residency is certainly a challenge, it can also be incredibly rewarding. If you and your partner are ready for children, the demands of residency should not be a roadblock. We've grown accustomed to deferring our "real lives" to advance through college and medical school, and at some point we approach the "generativity" developmental stage. If that is where you are, residency is not a contraindication for having a child. Life loses much predictability once a baby is born. In preparing for your child, you and your partner should negotiate the multiple stages of this process with your residency program, from the first trimester to the fourth (a.k.a. the first three months of your child's life). There are ways to make the experience simpler for you and your program throughout the planning process so that all parties feel supported.

"There are no randomized controlled trials about the right time to have children."

Planning

During pregnancy, it is important to focus on your needs now and after the baby comes. You may choose to frontload your schedule with more difficult rotations to get them out of the way, or opt for a more relaxed schedule if your pregnancy is particularly challenging. Your mental health and the wellbeing of your developing child should be the priority.

When thinking about having a baby, it is important to evaluate how much energy you have right now. If you are already stretched, something will have to go once the baby comes. Think about your priorities—sleep, exercise, nutrition, relationships, work, studying, travel, hobbies – and what you are prepared to place on hold. With proper preparation, you will better tolerate these temporary sacrifices. Before meeting with your program director:

- Clarify your own needs and wishes
- Review your residency program's leave policies, including how patient responsibilities are handled. Who coordinates patient coverage while you're on leave?
- Networking is crucial! Talk with other residents who have had children

as well as the residency program administrative staff. These individuals will be your advocates, can offer advice, and are your best resource for practical information

- The timing of your formal pregnancy announcement to your program director is an individual decision. While more notice is helpful for planning coverage during maternity leave, there may be other reasons to delay discussing your plans

Garner support by taking the time to meet with co-residents to foster the spirit of camaraderie. You're in this together as your maternity leave will likely impact their training experience, as well. During pregnancy, consider covering your co-residents' pagers, as you will likely depend on several of them to cover your pager during maternity leave. Depending on how you feel during pregnancy, you may consider frontloading your calls during the first or second trimester, so you can rest in preparation for baby during your third trimester. Of course, this completely depends on your mental and physical state as you advance through pregnancy.

Know Your Rights

- **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 and parental leave. 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.
- **FMLA (Family Medical Leave Act):** The FMLA is a federal law stating that any employer with more than 50 employees must offer those who have worked more than a year 12 weeks of paternal, maternal, family, or sick leave. This rule applies to most (if not all) residencies. There is no requirement that the leave be paid, and you should review your disability insurance and employment policies. You will have to make up any missed rotations in order to graduate, but you will still be entitled to the time off work.

30

Spirituality and the Psychiatric Resident

While in the past the acknowledgement of the role of religion and spirituality may have been excluded from the psychiatric approach to care, 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 physical and emotional health as psychiatrists.

Religion and Psychiatry

Psychiatry’s once held view of religion/spirituality as “universal obsessional neurosis” has taken a sharp turn in the last few decades. Contrary to the portrayal of religion as pathological in the DSM-III-R, in 1994 the DSM-IV acknowledged for the first time a non-psychopathological category entitled “Religious or Spiritual Problem” under the section “Other Conditions That May Be a Focus of Clinical Attention” and this category has been included unchanged in DSM-5. 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. Further, clinical and didactic training on religion and spirituality is required for psychiatry residents by the ACGME. In 2014, the APA initiated the **Mental Health and Faith Community Partnership**, a collaboration between psychiatrists and clergy aimed at fostering dialogue, reducing stigma, and accounting for spiritual dimensions as patients seek care. Many psychiatry residents are now trained in the **Cultural Formulation Interview**, which includes spirituality in the history gathering and is outlined in DSM-5. Culturally sensitive care is increasingly considered the standard of practice in medicine and religious beliefs and practices are acknowledged as commonly intertwined in cultural identity.



Learn more about Cultural Formulation with the **Cultural Formulation Interview Handbook**, available at appi.org.

The Psychiatric Resident as a Spiritual Being

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. Seventy-six percent of psychiatrists consider themselves religious or spiritual, compared to 86% percent of the general population. In the interest of inclusivity, “belief in God” is increasingly substituted for more broad definitions of religion or spirituality. 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.

Since 1977, Engel has encouraged the medical illness model to be understood from a biopsychosocial perspective. Over the last 40 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?**

As psychiatry residents we can increase our feelings of fulfillment, and lower chances of burn out, by engaging appropriately in a spiritual and emotional way with our patients. Helping a patient find peace with their place in the world and in spiritual domains is easier if the residents themselves have considered similar concepts. Many feelings arise in countertransference with patients, and including spiritual and religious aspects in the understanding of our countertransference experience ensures that we will optimize our interpretation of the patient’s presentation.

Spirituality can take many forms. For some people, organized religion offers comfort through ritual and membership in a community of faith, though it is only one avenue through which people may express their spirituality. Service to patients as a psychiatrist may become a way of serving a higher power, and fulfilling an obligation to help those who suffer may in itself be a spiritually fulfilling experience. Residency can be the most stressful period of one’s career. The potential benefits of finding a spiritual practice that feels appropriate for an individual resident’s philosophy, should not be overlooked.

In My Experience...

Religion has been omnipresent in my life starting with my Lutheran pastor father, passing through Druidry and Gnostic Christianity, landing on a spiritual practice rooted in Eastern traditions, foremost Taoism. Residency will challenge what you believe happens after death, and what suffering means; I encourage new residents to meet these challenges head-on with the patient as their teacher. Do not be afraid to ask a patient about their understanding of a higher power - it is often a fundamental aspect of their gestalt of themselves and others, and informs how they may wish to live and die. Learn about the religions to which your patients adhere, and demonstrate your reverence for the human experience by helping them share this aspect of themselves with you and others, both in health and times of need. Recall the oath that you took when you find yourself disagreeing with some religious practices - 'first do no harm' when finding conflict in your divergent beliefs. Know also that atheism/agnosticism is to be respected as much as a religious or spiritual preference. Relish this time with patients at the most extreme moments in their lives.

-Hannah Roggenkamp, M.D., UCLA

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 which combines didactics, workshops, expert panels and process groups to provide exposure to various religious and spiritual practices. If the resident is taught to view the patient's spiritual practices as salient and valuable resources, they can be used to promote and maintain mental health and can help residents anticipate treatment challenges. For many trainees, residency may be their first encounter with severe medical and psychiatric illness, managing emergency situations, and coping with death. These experiences have the potential to elicit strong emotions. Residents and residency programs need to ensure that resources are available to address psychological and spiritual sequelae of the residency experience.

Argument for Spiritually-Informed Approach to Psychiatric Care

Increasingly, patients want and expect a spiritual or religious aspect of care in the psychiatric setting. Especially in times of illness, questions arise about life's meaning, current or previous relationships with a higher power,

notions of punishment and reward in a religious or spiritual context, and a patient-centered approach does not shy away from addressing these vital aspects of a patient's inner life. Epidemiological studies demonstrate that religious involvement in ill patients enables improved coping and psychological growth from negative experiences. High intrinsic religiousness can predict more rapid remission of depression, especially in those patients with poor physical functioning. Religious and spiritual involvement appears to buffer patients from stress, and offering religious or spiritually oriented patients therapies augmented with a spiritual component is associated with increased efficacy of treatment. Mindfulness-based meditation, developed from Eastern religious practices, has been studied extensively and is now validated as a treatment for a large variety of psychiatric maladies including major depression, anxiety, and borderline personality disorder, among many others. Multiple studies have demonstrated the protective effects of belonging to a religious or spiritual community, including lower cardiovascular mortality. In some parts of the world, spiritual or religious interventions are often the only accessible treatment for mental health. Not only is it valuable to acknowledge the importance of these therapies for patients, but also to consider that these therapies may represent an aspect of human consciousness that we have not yet learned to fully quantify, let alone study. The potential importance of religion and spiritual experience in every facet of a patient's life can't be ignored. The following questions were developed by a consensus panel of the American College of Physicians as **a basic approach to the spiritual history**:

1. Is faith (religion, spirituality) important to you?
2. Has faith been important to you at other times in your life?
3. Do you have someone to talk to about religious matters?
4. Would you like to explore religious or spiritual matters with someone?

These questions are valuable jumping-off points both for patient care, and for the psychiatric resident to explore basic elements of their own spiritual or religious beliefs.

The 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. Psychiatric residents can and should examine their own spiritual and religious beliefs for their wellbeing and that of their patients. Acknowledging the fundamental importance of examining patients' experience of a higher power in medical research and treatment is now not only evidenced based, but the standard of care.

31 International Medical Graduates in Residency

Beginning residency is one of the most exciting and challenging experiences a doctor will ever have, particularly for international medical graduates (IMGs). It is a great achievement to be able to secure a psychiatry residency in the United States, opening doors to a wonderfully fulfilling career.

Every IMG has their own unique story as to how they came to the US. In the 2014 Main Residency Match, 30% of matched psychiatry applicants were IMGs. Fortunately, many psychiatrists recognize the valuable contribution IMGs can make to a residency program and the psychiatric profession. **IMGs have the potential to enrich the experience of those around them.** IMGs, by their very nature, often show resilience, flexibility and cross-cultural sensitivity, and can bring a breadth of experience to a program. Some IMGs have experience from training in a different specialty and can apply many transferable skills to their new career. Others bring the perspective of a different health care system and different ways of delivering healthcare. Some IMGs may have worked extensively in academia or practiced in a part of the world where they have treated disease processes that are not common in the US. In a time when healthcare in the US is becoming increasingly expensive and systems are looking for innovative ways to deliver care, IMGs are poised to help drive change. **Reflecting on the unique qualities you bring to a residency will help you be an active participant in the ever changing medical field.** Depending on your story, there may be challenges in language and communication, cultural acclimatization, learning a new health system, discrimination, helping loved ones adjust, and leaving loved ones behind. Below is some advice to help you navigate the road ahead and equip you to get the most out of your residency.

Forms, Forms, and More Forms: The IMG Paper Trail

As an IMG there is a lot of paperwork you need to complete, ideally before applying to residency, certainly before starting at a program. In addition to some national deadlines to be eligible to participate in the Match and start residency, particular programs may have their own rules with further requirements. If you want to match to a particular program, it's important to research their requirements on their website or reach out to them by phone or email. If a program really likes you as an applicant, they may be willing to make exceptions, but don't count on this. The most important advice for any IMG is

to do your research and have all your paperwork and credentials in order as far ahead of time as possible, including:

- **Educational Commission for Foreign Medical Graduates (ECFMG) certification:** all IMGs must be certified prior to starting residency. IMGs don't necessarily need to be certified to participate in the Match, but programs may look more favorably at your application if you have this completed by the time you submit your rank order list. Getting certified includes passing USMLE Steps 1 and 2, graduation from a medical school listed in the International Medical Education Directory (IMED), identity verification, and submission of your medical school diploma and transcripts.
- **USMLE Steps 1, 2CK and 2CS:** To participate in the Match you must have passing scores on all of these tests. Some programs may require passing with a minimum or within a certain number of attempts.
- **Work authorization:** You must have an appropriate work authorization to begin residency if you are not already a US citizen or permanent resident. There are several options for work authorization. The **J1 "Exchange Visitor"** category is the most common visa used for foreign graduates. This visa allows physicians to participate in a maximum of seven years of training and requires the physician to return home for at least two years following their training. Exceptions to this 2 year rule can be made through the **"Conrad State 30"** program, wherein the psychiatrist is offered full-time employment in a medically underserved area for a period of three years. IMG's who are interested in applying for the **H1B visa** must pass USMLE Step 3 in addition to having a valid ECFMG certification. H1B authorization requires visa sponsorship directly through the teaching hospital and cannot be transferred to another institution.
- **Postgraduate Training Authorization Letter (PTAL):** If you are interested in programs in California you will need a PTAL issued by the Medical Board of California. While there are no further tests you need to take to get this, it usually takes months from first applying to being issued with the PTAL and incurs a fee.

Language and Communication

Depending on which country you are coming from, English may not be your first language. In our specialty in particular, communication and the development of a therapeutic relationship are used as powerful healing tools.

As such, having a very good grasp of English is essential. In addition, we must be able to communicate clearly and effectively with other members of our team to ensure safe patient care. Patient care is documented in most cases on a daily basis in the chart and you will be expected to be proficient in writing high quality, succinct notes. Other difficulties IMGs may experience include difficulties with the use of brand names of drugs, instead of their chemical composition, and different technical vocabulary to what you might be used to. Gaining mastery over language takes time and commitment. The process is made simpler when you are simultaneously learning to develop nonverbal behaviors and listening skills. Asking open-ended questions, listening carefully and keeping the person at the center of the decision-making will make conversation a more enjoyable and richer experience as well as help develop a therapeutic relationship. An easy way to begin developing communication skills is to engage in 'small talk.' Sports are of enormous interest, especially American football, basketball and baseball. Other topics which could facilitate conversation include current events, holidays, and upcoming travel plans.

In the context of therapy, every therapist brings their own unique set of attributes and qualities that can promote or inhibit projection or transference from occurring within the session. This could include one's gender, age, marital status, whether you have children, amongst other things. For the IMG from another country, it's important to consider that the very fact of being foreign could play out in the session. Many patients feel like strangers next to their family or friends, due to their psychiatric symptoms or traumatic history, and therefore may relate better with someone the patient perceives as an "outsider." At other times, the patient may act out aggressive feelings toward the therapist and voice racial remarks. There is always meaning behind a patient's behavior, and both patient and therapist will have to do some exploration together to get to the root of this. To do so, the therapist should be aware of their personal qualities and be able to tolerate difficult feelings.

Coping with Stress and Navigating the System

Starting a new job is always daunting, and internship year is no exception. The vast majority of residents at some time feel overwhelmed in their intern year. As an IMG you are likely to have additional challenges, making you more susceptible to burnout. There are many ways to help minimize this, including:

- Make time outside work to explore your new home. Find a hobby.
- Arrange for friends or family to visit. Consider taking vacation time to visit them. If not possible, Skype and FaceTime are great alternatives!

- You are in this together. Regularly check in with friends, colleagues and significant others – don't keep problems to yourself.
- If having significant problems with stress, low mood, or feelings of hopelessness utilize your institution's mental health services.
- Bottom line, have a healthy work-life balance and support network

Your primary role as an intern or resident will be to supervise patient care and learn to coordinate care with the clinical team. As your level of experience increases, you will be given more responsibilities and opportunities, like teaching medical students, publishing manuscripts, and presenting abstracts at meetings. Online resources like Pubmed, Up-To-Date and Cochrane Database, and mobile-friendly apps like Epocrates, provide instant access to clinical information. Being new to the system, it is important to actively seek out feedback from supervisors and engage in self-improvement. Historically IMG pass rates for board certification examinations have been lower than their American counterparts. In-training exams like the PRITE have an excellent predictive capability for performance on the boards, so you should take them seriously (see Chapter 16, Mastering the PRITE).

Discrimination

There may be unfortunate occasions when an immigrant faces discrimination, either in the workplace or elsewhere. Discrimination can come in many forms and initially may not be obvious. Every institution has a mechanism in place for dealing with such issues, including training in cross-cultural sensitivity and ways to report such incidents. It can be demoralizing to be a part of an environment which makes one feel stigmatized. There are a host of other reasons which may contribute to a challenging work environment for an IMG. It could stem from a lack of cultural awareness and understanding, the language barrier itself, a high stress environment, or even the perceived feeling of being different. If you think you are being discriminated against, speak to someone you trust within your institution.

American Life

The United States is a vast country with an exceptionally diverse and dynamic population. Americans are passionate people who are proud of their country and united in their desire to continually improve. However, people often have very differing ideas about how to improve and you will hear views from either end of the spectrum and everything in between. Americans cherish their Constitution and not least their freedom of speech; this often leads to

very public and national debates about major issues such as racial discrimination, abortion, gun laws, LGBT rights, and the economy, to name but a few. In order to become an effective participant in the vibrant cultural, economic and political life of this country, it is a good idea to learn more about its history and stay up-to-date with the most significant issues; doing so will allow you to feel more invested and connected to your new home.

Although it is very important to learn about and keep abreast of what is happening in the national arena, it is equally important to keep an eye on what is going on in your surroundings. To have a better understanding of your new community, you might want to do some research on the town in which you live. Another thing to do is to step out of the hosting academic institution or teaching hospital and connect with the people that surround you. Joining exercise, social, or volunteer groups can be useful. If you find reaching out a daunting task, remember that technology has made it easier to connect with people. There are many apps you can download that will broaden your social circle. Keep in mind that feeling at home will require some work and patience.

Cost of Living

The cost of living in the US is highly variable depending on your location. A paycheck will go much further in Minnesota than in Manhattan. Your assessment of the cost of living in the US will depend on where you are from. Europeans will find US cost of living to be comparable or even lower, whereas those from South Asia may find it much higher. Resident salaries are lower than fully-boarded psychiatrists, so expect your finances to be tight during training. If your work authorization allows, you may be able to moonlight. This can be a great way to supplement your income and gain valuable experience. It is a good idea to save a little each month so you can cover unexpected expenses. Keep in mind that people in the US pay out-of-pocket for services that citizens in other countries do not. For instance, daycare is usually not part of residents' benefits and can be very expensive. Co-payments due when you receive medical care or fill prescriptions are also common. Consider opening a Health Savings Account to save tax free for medical expenses. Transportation may be another significant expense, as you may have to drive or take public transportation to different training sites. Depending on your circumstances it may not be possible to save during residency, and that is fine; budget wisely and avoid serious debt.



Some Practical Tips from IMGs to IMGs

1. **Get a Social Security Number:** There is very little you can do without it. You'll need it even just to begin the application for California PTAL residencies.
2. **Open a bank account:** When you do, also apply for a credit card. Shop around for the right card, many offer cash back rewards, travel points, or no fees on foreign transactions. It is important to start building your credit history in the US so you can later borrow to make larger purchases, like a house or car. Use your credit as much as possible, but make sure you pay your balance on time. Remember, if you only pay the minimum amount due you will accrue interest.
3. **Get a driver's License:** You may have to take a practical and multiple choice test. Even if you won't be driving immediately, it is important to build a "driving history" so you can get insurance when you eventually need to drive. All you need to do to build a good driving history is NOT have an accident, so it's easy to start building that record when you don't have a car. If you don't have a car, you may need to rent one for the test. You'll need your international driving license to do so.
4. **Get a US smartphone:** This one needs no further explanation!
5. **Get health insurance:** As soon as you begin residency, enroll with your employer's health plan and visit a primary care doctor ASAP. You will get sick at some point, and it's helpful to have an established relationship with a primary care to get a last-minute appointment.
6. **Get a letter from your program:** It should state that you are a resident physician and your salary. Because you likely won't have an established credit history, this will be helpful in renting an apartment so the landlord can confirm your employment.

-Stuart Downie, MD, MRCPsych, Dale Sebastian, MD,
Guillermo Valdes, MD, MBA

As of 2013, African Americans comprise 6.8% of psychiatry residents and 6% of psychiatrists in practice. Considering that African-Americans make up approximately 13% of the U.S. population, the number of African-American Psychiatrists is disproportionately low. Underrepresentation of African-Americans in medicine impacts not only patients' medical and mental health, but also physicians' clinical and educational practice environment.

Psychiatry has moved away from a "culturally neutral" approach to an increased focus on Cultural Psychiatry and incorporation of patient-specific and -sensitive care. As applied to peoples of African-American and African descent, the Cultural Psychiatry approach first requires the recognition that there is not one overarching African-American culture. The term "African-American" includes at least three major and significantly different groups of people—Americans of African descent, Afro-Caribbeans, and immigrants from Africa. All are affected by a history of slavery and colonization. Members of the latter two groups may come into residency as international medical school graduates, each with their own unique set of challenges.

The dearth of African-American psychiatrists impacts African-American psychiatry residents considerably. Because there are fewer practicing psychiatrists of this group, there are fewer opportunities for these residents to be mentored by African-American psychiatrists. Also be aware of challenges for African-Americans in academia, as many academic institutions' administrations historically lack diversity and may have a history of discrimination in hiring and tenure approval. Mentoring, while it can occur between any resident and faculty member, is best cultivated when the mentor and mentee have similar interests, and in some cases, similar backgrounds. A resident may feel more comfortable approaching a psychiatrist mentor of similar background when sensitive racial issues arise, such as racism from attending physicians, fellow residents, nurses and other staff, or when racist comments are made by patients or their family members. It is not simply an issue to be discussed in the context of countertransference. When such incidents arise, it may help to discuss them with someone who can understand the context of the learning and practice environment. In addition, mentors may be privy to support networks the resident is not aware of. In more extreme cases, a mentor may be able to serve as a representative for the resident.

Given the number of African-American academic psychiatrists, a resident may not even come into contact with potential African-American mentors during their rotations. If you are comfortable, you can contact your department's leadership to be connected with African American faculty. However, a resident's comfort with approaching the leadership of a residency program is heavily dependent on the culture created by the Chair and Program Director of each residency program. It is important to emphasize that these connections are not only important to the resident individually, but to the department as a whole. These efforts foster the education of African American residents and may eventually lead to the retention of some residents as faculty, a step which is critical in recruiting medical students into Psychiatry. If this environment is not present, administrative staff or other minority faculty members may be able to guide the resident in finding an African American mentor.

The presence of African-American mentors and co-residents can serve to alleviate the isolation African-American residents may feel in programs where they are one of few African-Americans or persons of color. At times, these residents may be looked to for the minority voice to represent a racial group in case discussions, even when it is not appropriate. By the same token, it may be harder for that lone resident to speak up in a room of their peers when a racial disparity is noted for fear of being noted as "angry" or "too sensitive" about racial matters. It is the environment created by the leadership of the residency program, as well as the culture created by co-residents that drives the comfort level with these discussions.

All residents benefit from an open and honest conversation about race, as almost inevitably every physician will have African-American patients. Recent events should serve as kindling for discussion about race in America; however, that is more difficult in environments that lack the wealth of diversity in this country. Some hospital systems have adopted Minority House Staff Organizations that can help with the isolation residents may feel within their department. These organizations serve educational and social functions. Personal psychotherapy may be helpful, although residents may face challenges in finding a mental health provider with a similar racial background. Nonetheless, having a forum where you can speak without inhibition may be helpful. Religion may also play a critical role in the lives of many African-American residents. Connecting with a faith community can be a resource for support in difficult times during training. Having an outlet outside medicine can offer a more balanced approach to the intense years of residency training.

My Case Study...

"I don't want to be treated by that Black b**ch...
I want a white, male doctor."

Unfortunately, sad, but true; that was a statement that was shouted to me by one of the patients on the inpatient psychiatric hospital, during my chief year of residency. I felt angry, embarrassed, but mostly hurt. I had trained hard, studied long, and gained the necessary skills to prove I "belonged." That I, was indeed deserving of the position of "chief." The truth is, it wasn't about my skill or qualifications, in the eye of the patient. I was being judged on the color of my skin, unfortunately, due to race relations in this country, and simple racism. In that moment, I felt alienated and needed to process the interaction, with a community that would understand.

Racial minorities, particularly Blacks or African-Americans report the highest rate of mistreatment and discrimination, such as harassment, verbal abuse and personal denigration during training (Liebschutz, et al 2006). For all these reasons, it is useful to have medical societies or housestaff organizations that focus on the specific need of under represented minorities. Examples of these groups at Yale include, the Solomon Carter Fuller (pioneering African American psychiatrist) Society which was formed to aid in the mentorship of residents and medical students of African-American or African descent. Another organization with similar goals is the Minority Housestaff Organization. Amongst varying missions, these two programs, focus on the specific challenges and prejudices faced by African American residents and support therein. From increasing awareness of discrimination, such as microaggressions faced by some residents daily, to understanding and promoting change to eliminate health disparities, these organizations provide an opportunity to foster a sense of community amongst minority populations. Personally, having a close connection to residents within these groups, was extremely useful and essential in helping me deal with such a difficult experience.

-Ayana Jordan, MD, PhD

Having African-American co-residents that are peers, as opposed to solely work colleagues, impacts non-minority psychiatrists. Bridging cultural and racial gaps between themselves and their African-American patients is made more difficult when there are few African-American peers with whom to explore culturally and racially sensitive topics. All residents can expand their cultural literacy through journal clubs and non-scientific publication-based discussion groups on topics such as health care disparities and internal barriers

to accessing mental health care. However, psychiatry by nature involves deeply personal interactions, and these resources cannot compare to the value of interacting with and learning from African-American colleagues.

At times, the hidden curriculum of a residency program may be that African-American patients would not benefit from specific types of psychotherapy. In the 1970s, a bias was noted favoring selection of Caucasian patients for long-term psychotherapy over African American patients. It was observed that this significantly impacts the richness of training in geographically diverse areas. This problem still persists today. African-Americans have long struggled to ensure a comprehensive education not only for themselves, but also for all residents in this regard. This can only occur when disparities are acknowledged, even when it may be difficult.

The future and, in fact, the relevancy of the field of Psychiatry to the communities it serves is dependent on understanding the cultural and racial context not only of the patients, but of the residents and attending physicians providing care as well. This understanding can only occur in residency programs that include African-American residents and attending Psychiatrists, thereby nurturing and promoting open discussion, reflecting the communities they serve.



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Sexual and Gender Identity in Residency

Fortunately, being a lesbian, gay, bisexual, transgender, or queer (LGBTQ) psychiatry resident today is easier than for our predecessors in the 1970's who labored to remove homosexuality from the DSM. Same-sex marriage is now legal nationwide, many institutions have adopted LGBTQ-inclusive non-discrimination policies, and an increasing number of health insurance policies (including Medicare) cover gender-related medical and surgical procedures.

However, LGBTQ residents still encounter many challenges. Many institutions do not include sexual orientation or gender identity in their non-discrimination clauses or offer gender-neutral restrooms. The internet makes it harder to keep our professional, personal, and family lives separate and private. Some of us may encounter offensive, ignorant, or even aggressive actions from colleagues, staff members, or supervisors. They may even practice or support forms of therapy that repress LGBTQ-associated feelings or desires based on the unfounded assumption that it is a form of mental illness (therapies opposed by both APA and SAMSHA). These experiences may inform our decisions to come out to our colleagues. Although the decision to reveal one's sexual orientation or gender identity remains only with that person, everyone deserves to work in a safe and affirming environment.

If you are working through feelings about your sexual orientation or

My Case Study...

In our first session, a psychotherapy patient tells me that she can't work with me because I'm gay. Having not "come out" to her, I was confused. I guess she could just "read" it from my mannerisms or dress. For three weeks, the patient talked angrily about how she couldn't even stand to look at me and how her reaction made her feel ashamed. Meanwhile, I felt terrible; questioning my skills as a therapist and wondering if I could help this patient. I arranged to meet with an openly gay attending who discussed the case but, more importantly, my feelings about this part of my identity being attacked. He validated my feelings and helped me find empathy for how scared this patient was that I couldn't help her. The next session, I explained my concern that discussing me wasn't helping her to feel better and in fact it was making her feel worse. She agreed to use "distress tolerance" skills as a way to move forward. Over the next two weeks, her demeanor softened and we began to focus on the issues that brought her to treatment. Mentorship helped me cope with my feelings and to develop an unlikely therapeutic alliance.

-Jeremy D. Kidd, MD, MPH

gender identity, it may be helpful to discuss with a mental health provider or with someone you trust. In many areas, you can find providers who openly identify as LGBTQ or LGBTQ-affirming. Several LGBTQ-focused professional organizations like the Association of Gay and Lesbian Psychiatrists (AGLP) and the Gay and Lesbian Medical Association (GLMA) have online provider directories and mentorship programs. Seeking guidance and/or treatment is a sign of maturity and mental health! Attending a national meeting of one of these organizations and/or contacting a member can be helpful, particularly if they reside in your geographic area. The APA and psychiatric sub-specialty organizations also offer sexual and gender identity-focused committees.

Depending on your institution's resources, you and your colleagues can form a local professional group for residents or health professionals who work to improve the lives of LGBTQ patients and providers. A similar organization may already exist in your area. This is important because many medical schools and residency programs neglect teaching important healthcare concerns that affect LGBTQ patients. While LGBTQ-identified residents shouldn't be expected to be the designated educator on these issues, we are often called on to ensure our colleagues treat LGBTQ patients professionally and appropriately address the mental health challenges of these populations.

Selected LGBTQ Health Academic Journals

- Journal of Gay and Lesbian Mental Health (a publication of the AGLP)
- Journal of LGBT Health
- Transgender Health
- Journal of Homosexuality
- Journal of LGBT Health Research
- International Journal of Transgenderism
- Archives of Sexual Behavior

LGBTQ-Focused Professional Organizations

- APA LGB Caucus
- Association of Gay and Lesbian Psychiatrists – aglp.org
- Gay and Lesbian Medical Association – glma.org
- Group for the Advancement of Psychiatry LGBT Issues Committee
- World Professional Association for Transgender Health – wpath.org

Additional Resources

- **The course of gay and lesbian lives: social and psychoanalytic perspectives.** Cohler BJ and Galatzer-Levy RM. University of Chicago Press: Chicago, IL. 2000.
- **Psychotherapy with Gay Men and Lesbians: Contemporary Dynamic Approaches.** Drescher J, D'Ercole A, Schoenberg E (eds). Harrington Park Press: New York, NY. 2003.
- **Trans bodies, trans selves: A resource for the transgender community.** Erickson-Schroth, L. New York, NY: Oxford University Press. 2014.
- **Sexual Orientation and Psychodynamic Psychotherapy: Sexual Science and Clinical Practice.** Friedman, RC and Downey, JI. Columbia University Press: New York, NY. 2008.
- **LGBT Mental Health Syllabus.** Group for the Advancement of Psychiatry. Available at aglp.org/gap/
- **Addictions in the Gay and Lesbian Community.** Guss JR, Drescher J (editors). The Haworth Press: New York, NY. 2000.
- **Avoiding Heterosexist Bias in Psychological Research. In: Psychological Perspectives on Lesbian, Gay, and Bisexual Experiences.** Herek GM, Kimmel DC, Amaro H, et al. Garnets LD, Kimmel DC (editors). Columbia University Press: New York, NY. 2003.
- **The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding.** Institute of Medicine. 2011.
- **Being Homosexual: Gay men and their development.** Isay, R. Vintage Books: New York, NY. 2009.
- **Becoming Gay: The Journey to Self-Acceptance.** Isay, R. Henry Holt and Company, Inc: New York, NY. 2009.
- **Commitment and Healing: Gay Men and the Need for Romantic Love.** Isay, R. Wiley and Sons, Inc: Hoboken, NJ.
- **The LGBT Casebook. American Psychiatric Association:** Levounis, P; Drescher, J; Barber ME. Washington, DC. Omoto AR. 2012.
- **Sexual orientation and mental health: examining identity and development in lesbian, gay, and bisexual people.** Kurtzman HS. American Psychological Association: Washington, DC. 2006.
- **Standards of care for the health of transsexual, transgender, and gender nonconforming people: Version 7.** World Professional Association for Transgender Health.

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Resident and Peer Suicide

Physicians are no strangers to stress. Residency, in particular, is a time of great transition, with a steep learning curve and tremendous newfound responsibility. While the remarkable growth that takes place during this time can feel invigorating and rewarding, the workload and pressure may be overwhelming. Feelings of burnout, exhaustion, frustration, social isolation, inadequacy, self-doubt, hopelessness, and depression are not uncommon. For some, these feelings may seem insurmountable, especially set against a backdrop of personal struggles, underlying mental illness, or substance use.

Because of the stigma associated with mental illness, healthcare providers may be reluctant to seek the help that they need. However, studies show that physicians are impacted by mental illness and are much more likely to complete suicide compared with the general population. For these reasons, you should be watchful for depression and suicidal ideation in your peers.

Those in distress will often open up about their thoughts and feelings, and it is important to always

**Suicide Prevention Lifeline:
800-273-8255**

take them seriously. You may need to urge your colleague to seek help or even pursue assistance on his or her behalf. In some instances, you may need to insist your peer allow you to take him or her to the nearest emergency room. Experts recommend aggressive and immediate treatment and hospitalization for physicians. Fortunately, physicians may be especially treatable.

At some point during your career, you may find yourself grappling with the suicide of a colleague. Suicide can result in a wide range of emotions including shock, anger, and despair. As a psychiatrist, you may feel a unique sense of responsibility or guilt that you were unable to intervene. It is crucial to remember you cannot predict the future or control another person's actions. Despite the fact that this is not the case, suicide often feels senseless and preventable in a way that deaths from other causes may not. How you feel in the wake of such a tragedy may be affected by how well you knew the deceased, but this is not always the case. Allow yourself to pay attention to your feelings. You may find you are more distressed than expected.

Remember, you are not alone. You are surrounded by a department of caring providers you can turn to for support. You may find yourself so overwhelmed by work that you have trouble processing your feelings, or you may find yourself so overcome by your feelings that you have difficulty at work. Talk to your chiefs and supervisors, who may be able to provide special accommodations. Try your best to work through your feelings now, rather than delay until later, when you may not have access to as much support.

Coping strategies in the face of tragedy take many different forms. Your program will likely set up support services. Take advantage of them. Process groups can also help – it is healing to hear that others sharing an experience are having similar emotions. Beyond your program, there may be local support groups for survivors of suicide. Visit afsp.org for listings of local support groups. Grieving is a personal process, and everyone grieves a little differently. Here are a few tips to help you focus on promoting your own healing:

- You may wish to reach out to family and friends, or to others at work. Not everyone will be able to help you. Find the people who are, and lean on them
- Take care of yourself physically as well as mentally. Make sure you rest, exercise, and obtain proper nutrition
- Many people find it comforting to take time to reflect and write about their feelings
- If spirituality is a part of your life, it may help to talk to a religious counselor, meditate, or pray
- It may provide closure to honor the deceased colleague, for example through a service or memorial in his or her honor
- Try to do things that you enjoy. Do not feel guilty about feeling good

Be aware that you may be vulnerable to emotional ups and downs, increased substance use, or unexpected reminders of the deceased peer. You may experience nightmares, difficulty sleeping, or intrusive thoughts about your colleague. If you find yourself overwhelmed with despair or functionally impaired, please, seek professional help. If you start having suicidal thoughts, it is especially vital to seek help immediately. You have the immense privilege of providing mental health service to those in need, so allow yourself the opportunity to receive services if necessary. Above all, remember **you cannot take care of others, if you do not take care of yourself first.**

35

Physician Impairment Due to Substance Use

Substance use among physicians and physicians-in-training has been documented since the 1800s. As a prominent example, in 1892 William Osler drew attention to William Halstead's cocaine addiction, which developed from self-experimentation while using the substance as an anesthetic for surgery. Specifically, Osler used Halstead's case to highlight the need to help colleagues impaired by substance use, for personal as well as professional reasons. Osler noted Halstead's achievements could have benefited society to an even greater extent had he not faced this "daily battle" with cocaine. Despite these insights, throughout the early 20th century it was estimated that 10-40% of physicians were impaired by substance use. In 1973, the American Medical Association (AMA) formally acknowledged substance use among physicians as problematic and impairing in their policy paper, "The Sick Physician: Impairment by Psychiatric Disorders, Including Alcoholism and Drug Abuse." The AMA further recognized that colleagues of impaired physicians have an "ethical responsibility to take cognizance of a colleague's inability to practice medicine adequately." This view has also been supported by the Federation of State Medical Boards in their "Policy on Physician Impairment," which adds that every physician has a duty to "protect the public" from impaired physicians.

The AMA defines physician impairment as being "unable to fulfill professional or personal responsibilities due to psychiatric illness, alcoholism or drug dependence." Though there are many causes of physician impairment, such as mental illness, physical illness, process addictions (e.g., gambling disorder), and burnout, here we focus on physician impairment due to substance use. The literature consistently finds that physician substance use is about equal to that of the general population, except for benzodiazepines and opioids, which physicians are more likely to use, and alcohol, which physicians are less likely to use. However, physicians are more likely to develop substance use disorders (SUDs) than the general population. While a dearth of systematic studies makes it difficult to determine the exact prevalence of physician substance use, it is estimated that the prevalence of SUDs may be 10-14% among residents and 6-15% among physicians who have completed training. Among psychiatrists in particular, it is estimated that up to 9.6% may be impaired due to substance use.

The prevalence of substance use in physicians may be high due to several factors inherent to the practice of medicine. These include greater access to and availability of substances, stress, long work hours, sleep deprivation, high demands of the profession, risk-taking behaviors, lack of social supports, and environmental exposures. Physicians’ development of a SUD does not appear random, as medical students as a group have been found to have a heightened vulnerability to developing SUDs due to inherent characteristics of those self-selected to become physicians. These include a history of insecure parental attachments during childhood, greater reliance on the defense mechanisms of altruism and reaction formation, as well as perfectionistic, narcissistic, and obsessive-compulsive personality traits. Of note, high levels of stress in medical students around examinations and subsequent post-examination parties have been associated with exceptionally high rates of hazardous binge drinking, which is a known risk factor for the development of an alcohol use disorder and comorbid psychiatric disorders. In residency, factors associated with substance use include perceived need for enhanced performance, prolonged vigilance, and self-treatment of conditions perceived as stigmatizing, including psychiatric illness and pain. Indeed, it has been shown that SUDs among physicians usually begin while in medical school or residency. These vulnerabilities to substance use are in addition to those found in the general population, such as a family history of SUDs, male gender, psychiatric illness, and childhood abuse, amongst others.

Identification of Impairment

The same residency characteristics that serve as susceptibilities for substance use, including self-diagnosis and treatment, highly ingrained defense mechanisms, perfectionism, and perseverance through stress, also make physicians skilled at concealing problematic substance use. To this effect, three symptom domains, outlined below, have been found to reliably indicate impairment due to substance use. These symptoms tend to become evident in sequential order as the severity of a SUD increases.

Domain	Signs and Symptoms
1. Personal and Behavioral	<ul style="list-style-type: none"> ▪ Familial conflict ▪ Marital discord ▪ Inability to maintain relationships with friends ▪ Neglecting social and familial obligations ▪ Emotional lability

	<ul style="list-style-type: none"> ▪ Financial instability ▪ Erratic behaviors ▪ Legal issues
2. Physical	<ul style="list-style-type: none"> ▪ Weight loss/gain ▪ Poor hygiene ▪ Unkempt appearance ▪ Tremors ▪ Slurred speech ▪ Sleep disturbance ▪ Frequent medical complaints ▪ Jaw clenching ▪ Dilated/constricted pupils ▪ Diaphoresis ▪ Odors (e.g., alcohol, cannabis, tobacco)
3. Professional	<ul style="list-style-type: none"> ▪ Diminished accessibility to co-residents, supervisors, staff, and patients ▪ Arguments with co-workers ▪ Frequent absences ▪ Mismanagement of patients ▪ Decreased concern for patient well-being ▪ Patient complaints ▪ Frequent mistakes in documentation and orders ▪ Suspicious medication prescribing ▪ Inappropriate behaviors ▪ Arriving late for shifts/call ▪ Decreased productivity ▪ Slow or lack of response to pages or other forms of communication ▪ Excessive alcohol consumption at work-related social events ▪ Isolative behaviors

Reporting Impairment

After identifying problematic substance use in oneself or colleagues, reporting this suspicion to program directors is crucial. In addition to our ethical responsibility as physicians to report suspected impairment in a colleague, it may also be legally mandated in certain states for the health and

well-being of patients. It is important to consult your state medical board regarding their policy on reporting physician impairment. Despite these collective responsibilities and most physicians' agreement that they should report impaired colleagues, many physicians do not actually report and, as a result, a significant number of program directors are unaware of their residents' substance use and impairment. Under-reporting and delays in reporting impairment appear to occur for several reasons, which vary between residents and attending physicians:

1. Under-reporting impaired co-residents or oneself:

- Concerns about getting in trouble
- Concerns about jeopardizing career
- Belief that others have already reported the impaired resident
- Conflicting emotions about reporting a colleague/friend
- Non-specific signs and symptoms of substance use
- Increased independence as residents progress through residency (i.e., hospital-based clinical care to outpatient care with decreased direct supervision and less contact with co-residents may make consequences of use less apparent)
- Isolation from colleagues
- Denial
- Avoidance of confrontation
- Fear of stigmatization

2. Under-reporting of impaired attending physicians

- Fear of retaliation impacting one's training or career
- Fear of damaging someone's reputation
- Fear of litigation for damaging someone's reputation
- Belief that accusations will not be taken seriously
- Belief that accusations will reflect poorly on the reporter
- Belief that others have already reported the impaired physician
- Lack of an easily accessible reporting system

In view of these barriers to reporting, the Association of Program Directors in Internal Medicine issued the following recommendations for residency program directors: **1.** Develop a protocol to address substance use; **2.** Provide education to resident and attending physicians on institutional policies regarding use; **3.** Educate residents about the problem of substance use among physicians; **4.** Outline the process for identifying and reporting

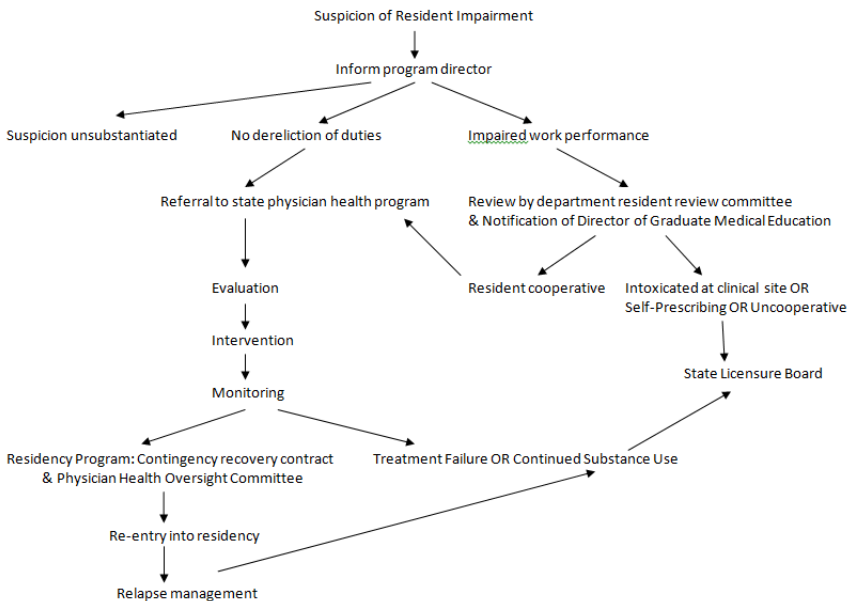
one's own or others' use; and 5. Outline the process of referral for treatment and subsequent expectations for re-integration into one's residency program. It is essential that you feel comfortable and empowered to approach your program director about institutional substance use and impairment policies, resources available to residents and their families, and how to obtain treatment if these elements are not already incorporated into the residency program's curriculum.

This can be a daunting task for many residents who have conflicting feelings about or fear repercussions for reporting their colleagues. In these situations, residents may consider approaching impaired colleagues individually in a non-judgmental, supportive way to discuss their concerns and empower them to seek treatment. If this strategy is unsuccessful or not feasible, concerned residents may then want to involve their chief residents, who can approach the resident and interface with the program directors for more concerted intervention. For residents with conflicting emotions about reporting a colleague, it is important to realize that early identification of problematic substance use will actually help facilitate treatment, enhance odds of recovery, and prevent their colleagues from further damaging their careers, causing harm to patients, and advancing to more severe stages of SUDs that are associated with higher mortality rates. Moreover, identifying impaired colleagues has not been shown to adversely affect their careers, since the majority of impaired physicians who enter treatment and monitoring programs do return to residency training and the practice of medicine.

As a first step, the impaired resident should consent to an evaluation and, if applicable, accept and complete treatment according to their institution's physician impairment policy or program, or enter a state-based physician health program (PHP). Entering treatment should be the goal of the residency program's intervention instead of purely punitive actions. PHPs provide impaired physicians with evaluation, intervention, and monitoring services or referrals, and offer an alternative to punitive disciplinary actions. PHPs exist in many states and serve to develop individualized protocols for intervention, monitoring, relapse prevention, and follow-up over a period of five years. These protocols usually involve a combination of residential or partial hospitalization, substance abuse treatment programs, individual and/or group psychotherapy, 12-step recovery programs, weekly peer recovery meetings, and urine toxicology screening. In addition to services provided by state-based PHPs, or in the absence of such programs, residency program directors should be able to refer impaired residents for treatment and establish recovery

contingency contracts upon completion of treatment. These contracts should include clearly defined repercussions for non-adherence to the treatment team’s recommendations and monitoring. Additionally, establishment of a physician health or wellness committee within a resident’s home institution, if one does not already exist, may aid in subsequent monitoring and provision of support. If an impaired physician is unable or unwilling to comply with treatment and continues to practice medicine, the state medical licensing board, which has disciplinary authority, should then become involved. This can be facilitated by residency program directors, institutional committees on physician impairment or patient safety, or institutional risk management/legal departments.

Management Algorithm



Outcomes

Once referred for treatment through PHPs or similar programs, outcomes are generally quite favorable for physicians. A study of impaired medical students and residents revealed a 92% treatment rate, 67% of whom were able to complete medical training without relapse or further difficulty. Of the remaining trainees who completed treatment, 8% were able to finish training

with minor difficulty, another 8% dropped out of training, and 17% died secondary to their substance use. This mortality rate highlights the importance of early intervention and referral of impaired trainees.

Many state medical societies and sub-specialty professional societies, including the American Psychiatric Association, maintain that SUDs are treatable illnesses and advocacy and support should be emphasized for identifying impaired residents and attending physicians with prompt referral to treatment. Programs where impaired physicians are compliant with treatment and subsequent monitoring, including urine toxicology screens and continued therapy, usually reinforce and aid re-entry into residency programs and the practice of medicine.

Substance use disorders are common among resident and attending physicians, especially those in psychiatry and emergency medicine. Identification of impaired physicians and prompt interventions are essential to preserve the health and welfare of both patients and physicians. If concerted interventions and monitoring are implemented in a supportive manner, particularly through PHPs, successful treatment outcomes and re-integration into medicine are highly likely for physicians.

Resources

- American Academy of Addiction Psychiatry – aaap.org
- American Society of Addiction Medicine – asam.org
- Association for Medical Education and Research in Substance Abuse – amersa.org
- Federation of State Physician Health Programs – fsphp.org
- National Institute on Alcohol Abuse & Alcoholism – niaaa.nih.gov
- National Institute on Drug Abuse – drugabuse.gov
- Substance Abuse and Mental Health Services Administration – samhsa.gov

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When Attending Physicians Appear Impaired

When residents' behavior signals mental illness, attendings and peers should, and do, intervene to ensure the resident gets the psychiatric evaluation and treatment needed. However, when an attending physician's behavior suggests mental illness, intervention may not take place for a variety of reasons. Physicians may deny or minimize their symptoms for a number of reasons, including, fear of what their symptoms mean, concerns over the impact on their own practice, and difficulty entrusting one's care to colleagues.

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, or appears unable to concentrate? What do you do if your supervisor tells you about problems with significant others, talks about suicide, or you see them pocket medication samples? These situations present difficult dilemmas for residents. The imbalance of power between the resident and the attending, as well as the transference to this "parental figure," must be acknowledged immediately so action can be taken and tragedy avoided.

1. **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.
2. **If 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.
3. **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 risk far worse outcomes for both the attending and their patients.

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Sexual Harassment: Don't be a Victim!

Sexual harassment is unpleasant and frightening, but not an uncommon occurrence in the residency workplace. No one should have to endure sexual harassment, however it often remains unrecognized and underreported.

What is Sexual Harassment?

While federal and state law protects workers from sexual harassment, the AMA Code of Medical Ethics also defines the term for physicians. Sexual harassment includes 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
- Such conduct is sufficiently severe or pervasive as to alter the conditions of an individual's employment and create an abusive working environment

Notice, some phrases are not entirely clear. "Unreasonably interfering," "sufficiently severe or pervasive," and "abusive working environment" are open to interpretation. The important point is that if someone's behavior makes you uncomfortable, you should discuss it with a trusted supervisor.

Examples of Sexual Harassment in Residency Training

Sexual harassment often involves a power differential that makes it difficult for victims to assert that the advances are unwelcome. It is important to understand what constitutes sexual harassment so you can take action if it happens to you. Here are a few examples that might occur in the context of residency training:

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. As a result, you find yourself avoiding them 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 for fear of receiving a poor evaluation.

Steps to Take if you Experience Sexual Harassment

Usually, **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 policy that indicates to whom you can report sexual harassment. 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 appropriately. **You can file a complaint with the equal employment officer from the hospital and/or university with which your residency is affiliated.** They are obligated to investigate the situation and can provide guidance on additional actions you should take. If the sexual harassment is severe or you believe that you might be in physical danger, file a police report and consider obtaining a temporary restraining order.

The process can be overwhelming and traumatic, so it is important to **identify individuals who will support you.** 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," "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, 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. A friend, individual psychotherapy, or some time off from work can be helpful and may be necessary in order to regain optimal functioning. Seeking help early can often ameliorate the situation quickly so that you can focus on your training.

Women in psychiatry have more opportunities than ever to advance in the profession, but still face challenges when it comes to “having it all.” Here are some tips and recommended reading to help women thrive through psychiatric training:

1. **Stand up for yourself.** As Eleanor Roosevelt said, “No one can make you feel inferior without your permission.” 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. Calmly remind the patient or coworker of your name and role. For example, “It’s actually Dr. Smith, now let’s talk more about your treatment plan...”
2. **Speak up.** You may sometimes feel ignored or overlooked even when making contributions to a meeting or discussion. Men tend to be confrontational and interrupt each other and are less likely to become emotional. Watch successful women, both in their voice and body language to see how they make themselves heard. Don’t let interruptions fly, even if it’s another speaker. Try phrases like “Please, let me finish,” and “I’d like to hear what Jess was saying.”
3. **Learn the rules of the game.** It’s sometimes difficult for women to understand how men can be at each other’s throats at work but be drinking buddies at night. Learn how to be a team player without becoming overly invested in workplace interpersonal dynamics. For further training, check out the American Association of Medical Colleges’ Early- and Mid-Career Women Faculty Professional Development Seminars.
4. **Keep your emotions in check.** Pick your battles. When situations become tense, try to first react calmly. While exhibiting the same behavior as men, women are more likely to be labeled as bossy, obnoxious, overbearing, ambitious, and bitchy. Acting like a man will not work. Pat Heim notes in her book *Hardball for Women*, Women have to “operate within a narrow band of acceptable behavior” and know “how far to go without overstepping the bounds.” Learn to withstand and quickly

"If we can find cures to cancer and understand the human genome, why should it be hard to believe that we can fix the culture of our profession?"
-Nancy Andrews, MD, PhD

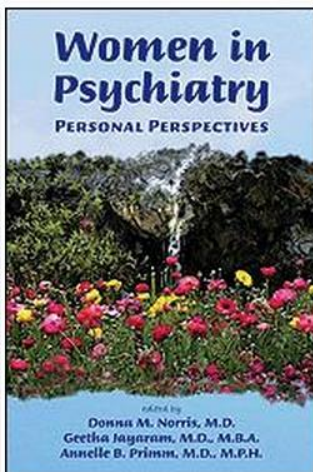
move on from criticism.

5. **Keep your radar on.** Unsolicited comments about your appearance and sex life are unacceptable. If behavior seems out of line, speak up – but consider the consequences so you can properly frame your actions. In many cases, a firm statement will suffice. For example, “Dr. Smith, perhaps you meant no harm by your comments about my appearance, but I don’t think such comments are appropriate. Let’s focus on my work and education.”
6. **Network and look for mentors.** What people of both genders, including peers, do you admire? Observe and try to develop good working relationships with them. Male authority figures may be accustomed to advising and promoting men. As a woman, you might have to work harder to connect with people in power who can help guide your career path. Think about having several mentors, both men and women.
7. **Look to the future.** 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. Remember to frequently reflect and develop strategies to achieve your larger career goals. Mentors can help you develop a roadmap for achieving them.
8. **Stretch yourself.** As Pat Heim states, “Don’t back away from leadership positions.” If you are offered an opportunity that seems overwhelming, stop, take a deep breath, and consider it carefully. Career progression often depends upon taking risks. 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. 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. **Toot your own horn.** Sometimes you’ll have to prove yourself before being taken seriously. If you have done something well, be your own public relations department and make sure your supervisors know. Do not be afraid to be a self-promoter, within reason.
10. **Be cautious.** Many women are interested in 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. Consider supplementing your expertise in women’s issues with other endeavors to get the recognition you deserve.

11. **Seek support.** Associations for women can provide opportunities for networking, troubleshooting, and friendship. Sharing war stories is a way of bonding and connecting. Play to your strength. Women tend to be better listeners and to work collaboratively.
12. **Take Care Of Yourself.** Last but not least, make time for yourself! Too much stress can limit your performance. Find a hobby, maybe exercise, reading, art – whatever it is, make time for it. Remember you can't take care of others well unless you take care of yourself first.

Suggested Reading

- **Hardball for Women: Winning at the Game of Business.** P Golant Heim (1993). New York: Plume
- **Lean In: Women, Work and the Will to Lead.** Sheryl Sandberg (2013). New York, Random House
- **Wonder Women: Sex, Power, and the Quest for Perfection.** Deborah L. Spar (2013), New York, Farrar and Giroux
- **Women in Psychiatry: Personal Perspectives** . Donna M Norris MD, Geetha Jayaram MD MBA, Annelle B Primm MD MPH (Eds) (2012). Washington DC: American Psychiatric Publishing



Women in Psychiatry: Personal Perspectives is available at a discount to APA Resident and Fellow Members. Visit APPI.org to purchase as a paperback or eBook.

39 Professional Relationships with Supervisors

Celebrate! You are finally getting paid for the hard work you put into taking care of others. While most residents have had some sort of previous employment, residency is a unique form of work that comes with entitlements and responsibilities. Through your training you find many ways that your professional relationships with supervisors are different from past jobs. Use the following *Do's*, *Don'ts*, and *Consider's* to navigate the new terrain.



The Do's:

1. **Understand you are part of a team** – Your university or hospital will have a code of conduct with expectations for all employees. Be familiar with it on day one. Sit down with each new supervisor and clarify expectations. It can take as little as five minutes and demonstrates you care about doing a good job.
2. **Communicate your Plans and Rationale** – Mental health is team-based care. You'll need to communicate with nurses, patients, other providers, patients, families, and more. Your supervisor is an important part of this team. Keep them abreast of discussion with other team members. This doesn't diminish your autonomy, it demonstrates your initiative and ability to manage a case while keeping the supervisor, who is ultimately responsible for the patient, in the loop.
3. **Make "Yes" Easy** – Prevent conflict by thinking through your patient care plan and anticipating follow-up questions. You'll demonstrate pro-activeness and reach consensus more quickly.
4. **Solicit Feedback** – Attendings who may not be as comfortable giving feedback often appreciate you bringing it up first. Don't be surprised by end of rotation feedback – ask for it throughout.



The Don't's:

1. **Forget Hierarch** – Psychiatry is unique in that there is still an “art” to practice where basic science is still not well-established. Practice is often guided by clinical experience when choosing among multiple reasonable treatment plans. This can be a source of contention. Understand that, while it’s important you present a well-reasoned treatment plan, your supervisor ultimately has the final say.
2. **Do Without Understanding Why** – Even though your attending will make the ultimate decision, always understand the underlying rationale. Turn it into a learning moment by asking, “Why in this situation did you decide this was the right course of action?” It helps foster your understanding and improves patient safety by ensuring the care team is on the same page.
3. **Romantic/Financial Relationships** – As aspiring masters of transference, boundaries, and consent, psychiatrists specifically should be aware of the conscious and unconscious motivations that can result from romantic and financial attachments.

The Consider's:

1. **Find Sponsors** – While it’s important to have a few long-term mentors, it’s also helpful to find sponsors – short-term, task-specific relationships. It may be gaining knowledge on a certain topic area, or assistance publishing an article or poster. There’s no expectation of continuing involvement in your development, just a helpful consult when the need arises.
2. **Professional Involvement** – You’re a member of a profession now. Professional organizations, including the APA, exist for your benefit and can help expose you to other professionals.

40 Ethical Leadership

Almost from birth, we are taught to do the right thing, to understand our parents' words: "No, don't do that, it's not nice." Through decades of school, sports, friends and books, we learn about good behavior. Though we may not use the word "ethics" until college or medical school, from a young age we understand the concepts of lying and cheating.

As a physician, you are mindful of ethical behavior in your professional as well as personal life. The question of ethics must frame every thought and action. Leah J. Dickstein, M.D., an original Guide editor created the following formula as a rule to live by:

$$\left[\text{REGE} = A_7VE_2M_2B \right]$$

Racial, Ethnic, and Gender Equality depend on MY 7 A's:

- **Attitude**
- **Awareness**
- **Actions**
- **Assertiveness**
- **Assumptions**
- **Abilities**
- **Adaptability**

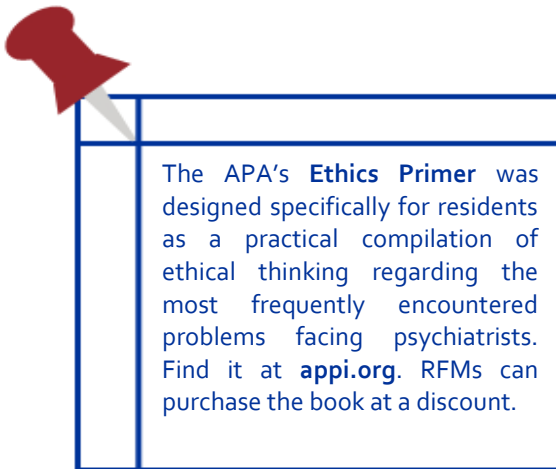
...my **VALUE** system. What I hear with my **EARS** and see with my **EYES**, think with my **MIND**, what comes out of my **MOUTH**, all of which results in my **BEHAVIORS**.

Stereotypes should have no place in your decision making. As diarist and Holocaust victim Anne Frank wrote, "Human greatness does not lie in wealth or power; but in character and goodness." Ethical leadership does not take more time; it can take less because these rules provide guidance for our decisions and team deliberations. Gloria Steinem's adage, "The political is personal & the personal is political" is a useful guide. Recalling your role models and their approach to leadership, keep their lessons as part of your adopted skills.

"Whom can you trust?" must begin with your own definition of ethical leadership. "What's the risk?" Those three words should also be part of your

decision scale, as you weigh the ethics of an impending decision and are offered and seek new professional leadership opportunities. As in the lives of all too many known leaders, the absence of personal ethics may be hidden and known only by a few. Quickly assuming the best in apparently successful professional leaders can be dangerous. Responding to a professional work opportunity with the response, "I'll let you know Tuesday," can perhaps enable you to offer your wise decision based on seeking and discovering more information. Sharing leadership roles can also enable you to see more examples and accept your growing abilities as an ethical leader at current & future levels.

Living only for the future is misguided. Living the risky, ethical life 24/7 is what life can and should be about. A French proverb is relevant here: "only he (or she) who does nothing makes no mistakes." Promoting yourself based on earned self-respect is another gold key.



41 Professionalism

As a resident, you are now a professional with responsibilities to your patients and colleagues. This transition in roles is emotionally and intellectually challenging for all new medical school graduates. As you labor to fulfill patient care responsibilities while developing your clinical acumen, remember that professional reputation comprises a key part of a physician's identity. The way you present yourself and interact with others can have unforeseen downstream effects on your career, your colleagues, and your department. This chapter is meant as an introductory guide to developing professionalism as a psychiatry resident.

Timeliness

Timeliness demonstrates reliability and respect for others. The simplest way to cultivate goodwill with colleagues is to arrive to work on time, answer pages quickly, and finish tasks efficiently. The number of emails, pages, notes, and questions that require attention on a daily basis will seem overwhelming at times. Most often, addressing small issues as they emerge saves time and energy in the end. Doing so also minimizes the likelihood of forgetting any individual task. Of course, situations that interfere with timeliness will occur (e.g., unexpected illness, weather delays, technical difficulties). In such scenarios, honesty, timely notice, and a sincere apology leave more of an impression than the unexpected circumstance.

Dress to Impress

Attire conveys a great deal of information, which is why the mental status exam begins with a description of appearance and clothing. In your varied professional contexts, you must consider the message that your dress delivers to patients and colleagues. First impressions are made quickly and are difficult to undo. Furthermore, psychiatry is a specialty in which persuasion plays a role, so managing perceptions increases the likelihood of a good clinical outcome. At the same time, modesty is important, and appearance should not be so strong as to distract from the task or clinical relationship at hand.



General Tips for Professional Attire

1. Even though you might think “dressing down” would make for a more comfortable patient-physician interaction, most patients prefer professional attire.
2. Make your photographic identification badge clear and visible at all times.
3. Scrubs should be worn only when on call or on duty in the emergency department.
4. Be aware that religious jewelry or head coverings may prompt questions from patients. Decide how you want to address these questions before they arise.
5. Avoid casual clothing including T-shirts, tank tops, denim, mini-skirts, athletic apparel, shorts, sneakers, and hiking boots. Athletic shoes may be acceptable when worn with scrubs, but they should be clean and well-maintained.
6. Avoid loose jewelry and other accessories that could potentially be used violently against the wearer.
7. Consider context before wearing a necktie. For example, avoid wearing it when assessing a highly agitated, psychotic patient.
8. Clogs, sandals, and high-heeled shoes may pose a safety risk. Avoid any footwear that encumbers your movement.
9. Pull back long hair before dealing with a potentially dangerous patient.
10. Avoid any clothing that could be construed as sexually provocative. Err on the side of conservatism...this is not the time to show off your black leather pants!

For men, dress pants and button-down shirts are appropriate. Not all button-down shirts are the same: plaids and flannels send a different message than paisleys and solid colors. Formal dress shoes are not essential, but sneakers should be avoided. Traditional neckties are a subject of controversy, seen by some as convenient objects for agitated patients to grab. Bowties are an alternative. A fair amount of leeway exists for style of hair and beards.

For women, options are varied. Balance individuality with conservativeness. Dresses and skirts should not be too short and blouses and pants should not be too tight. If your garment is shorter than knee length,

consider tights, leggings or pantyhose. When in doubt, dressing more conservatively allows your clinical acumen, rather than your physique, to be the center of attention. For the same reasons some men avoid neckties, some women minimize earrings, necklaces, and other grabbable accessories.

Reliability, Responsibility & Trust

All patients and health care teams want a reliable, responsible, and trustworthy physician. Always be prepared for rounds and efficiently complete daily tasks without excessive reminders. Learn to obtain collateral information and write notes quickly to expedite daily workflow. Also, keep family members and outpatient providers up to date and be on time for provider meetings. A finer point to develop is patient communication. It is extremely important to be honest with patients, even if you know your response will disappoint them. Only make promises you can keep. Finding less specific ways to address patients' concerns goes a long way.

<p>Example... I promise you'll be discharged this week.</p> <p>Try instead... We hope you'll be discharged by the end of this week, but we can't promise this will happen because we'd hate to disappoint you if something pops up.</p>	<p>Rationale... Sometimes, an emergency or logistical snafu will arise. Some patients may understand these situations, but others may interpret such change as a violation of trust, which can cause distress or taint the therapeutic alliance.</p>
<p>Example... I'll stop by again before the end of the day.</p> <p>Try instead... I will try to stop by and see you by the end of the day, but if I'm unable to make it then I'll see you tomorrow.</p>	<p>Rationale... It is not hard to imagine a lonely, scared, vulnerable patient being disappointed and feeling forgotten when a resident is unable to fulfill this promise. Although these may seem like trivial details on paper, such promises, broken or fulfilled, have a strong impact on alliance.</p>

Lastly, please don't forget that how you communicate with patients and colleagues is just as important as the dialogue itself.

Teamwork

Part of developing your professional identity involves learning your role on the team. This will change by service and as you proceed through residency. No matter your particular role, good manners and respect for other disciplines is vital. This includes learning how to politely, but firmly, stand up for yourself or your patients in certain situations. This can be uncomfortable, especially with superiors. Remember that team members in nursing, social work, pharmacy, and insurance have unique areas of expertise. Actively listening to their contributions on rounds, seeking out their thoughts on patient care, and asking for clarification about unfamiliar topics fosters collegiality, improves patient outcomes, and develops your skills as a physician. Team members will be more open to sharing their knowledge and proactively helping when the relationship with you is one of mutual respect. Furthermore, learning to navigate team dynamics at the beginning of residency will help your transition into leadership roles, when your responsibilities only increase.

A Word on Interacting with Other Services...

Whether it's the day team critiquing the night crew, the consult service griping about the primary team, or the residents dissatisfied with the attending, there's always potential for disharmony among teams. "The most frequent mistake I see when people get irritated at the hospital," counsels one attending, "is assuming bad intentions." She elaborates, "Say the day team gets an admission that they don't like, they complain the overnight admitting people have bad judgment. Or the consult service feels overworked and thinks the consult question isn't valid, the primary team is just afraid to manage the chronically mentally ill." Even if these assumptions are true, she warns, "Being bitter is a distraction. Plus, you may be wrong anyway. You miss the story when you rush to judgment like that." Of course, sometimes being charitable is easier said than done. "I have embarrassed myself by being curt more than once," says one former chief resident. "We have a shorter fuse when we're tired or stressed. Especially when notes are piling up and the pager keeps going off." One thing to keep in mind: "Apologizing solves a lot of problems, and it never hurts. When in doubt, just apologize. People always appreciate if you appear sincere and you acknowledge what they wanted."

Leadership & Advocacy

Psychiatric patients are a vulnerable population, often stigmatized if not victims of outright discrimination. Research shows that mentally ill patients do not receive the same medical care as non-psychiatric patients on the basis of

mental illness alone. As such, it is imperative for psychiatrists to focus on developing leadership and advocacy skills as part of their professional identity. All physicians are called upon to lead, whether in a family meeting as a resident or working as medical director of an inpatient unit. Teaching medical students and leading by example are excellent ways to develop these skills. Many residency programs have leadership development programs incorporated into training. Advocacy similarly comes in many different forms. Protecting patients' access to social services and medical care are critical ways to advocate. On a broader scale, advocacy may include getting involved with mental health policy efforts or public psychiatry projects.

Boundaries

Boundaries are critical in psychiatry. Of course, you should always maintain professional boundaries by never exchanging personal contact information or entering into platonic or romantic relationships with current or former patients. When living in the same community, you may run into patients in a non-professional setting, such as a grocery store, restaurant, or community event. To protect the privacy of your patients, you should not engage with them before they engage you. Saying hello to a patient at a party, for instance, could violate their privacy if others in attendance correctly assume that you are their mental health provider. However, if the patient initiates conversation with you, then it is perfectly acceptable to interact in public, with appropriate boundaries. To avoid feelings of dismissal, some outpatient clinicians inform patients at the start that if they see them outside of the office, they will not engage in a conversation unless the patient initiates.

It is also important to have clear boundaries with your colleagues. For example, when beginning a new rotation, immediately ask your attending or supervisor their expectations for your performance. This will help delineate job expectations so you don't mistakenly leave tasks incomplete or do all the work yourself instead of delegating.

Maintaining a healthy work-life balance by leaving work at work is also critical to your overall well-being. This is sometimes difficult, such as signing out an active patient when your shift ends. In such scenarios, it is helpful to remember that you are part of a larger team and that taking care of your own needs will make you a better physician in the end.

Consistency

A key component of medical professionalism is the notion that doctors are professionals inside and outside of the office. Maintaining a consistent professional appearance across all areas of your life is vital to your overall reputation. The credibility of your work is called into question when social lapses in judgment, such as drinking to excess or gossiping about coworkers, come to the attention of others. Seriously unprofessional behavior, such as breaking the law, could threaten your career and professional license. Maintaining a professional presence on the internet is also important in today's world. Do a thorough internet search and try to eliminate any photos, videos and other content you wouldn't want your patients, colleagues, or program director to see.

Mental Toughness & Positive Outlook

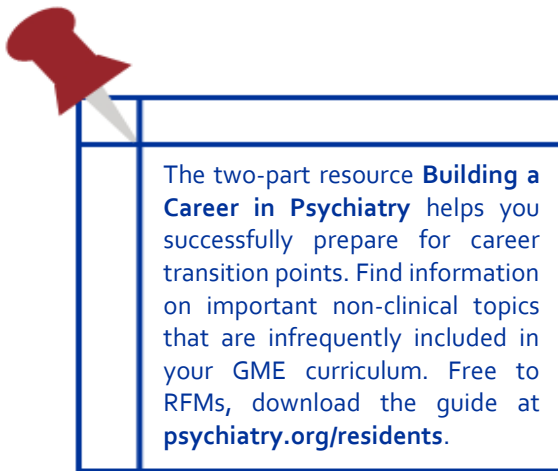
Show up ready to do your best work every day and don't take the rest personally! Whenever someone snaps at you or misinterprets your intentions, try to remind yourself that such behavior reveals more about their internal state than your medical competence. We all have our bad days. Try to stay calm under pressure and remember to be the bigger person.

Additionally, residency will be difficult at times, but complaining about it only makes it worse. No one wants to be around negativity. Many aspects of medicine are out of our control, but we can always control our attitudes. Although some days or rotations will be harder than others, try to maintain a positive outlook and savor life's small pleasures, like free lunch at noon conference. Everyone finds joy differently, so be mindful of what makes you happy. Try incorporating such activities into your daily routine, whether it's exercise, taking a walk outside, mindfulness and meditation, cooking, or watching your favorite TV show when you get home from work. You have to find ways to maintain balance during residency. Staying sane will prevent burn out and not only make you a better doctor, but a better colleague and person.

Supervision

There will be days when you're physically exhausted, emotionally drained or both. If you've moved for your program, learning to navigate a new hospital system, let alone a new city, can be overwhelming. Tolerating negative affect from your patients and their families (and, let's face it, sometimes from your colleagues) is a unique skill unto itself. Witnessing distressing situations with patients can be devastating and encountering flaws within our healthcare

system is often infuriating. Residency will be hard on many levels and it is never too early to seek supervision. Supervision comes in many forms, such as site supervisors assigned to work with you on specific rotations or peer supervision, where you process events in real time with fellow residents. It is not uncommon for residents to enter long-term individual therapy (or even psychoanalysis), discovering that doing so enhances their personal and professional lives. Your residency program may be able to recommend clinicians who offer reduced fees for residents. Processing difficult scenarios and learning why you feel the way you do about such situations is vital to developing your proficiency as a psychiatrist.



42 Professionalism and Social Media

Given the rootless existence of residents, social networking can serve as a convenient way to connect with friends and family miles away. For many residents, these tools are vital to maintaining a personal identity outside of medicine. Unfortunately, residents must also contend with the possibility that their Facebook posts, tweets, and Instagram photos may be seen by patients, administrators, and colleagues all over the world. This is especially true since these services may have confusing privacy settings. Furthermore, even private postings can be screen-grabbed and redistributed, and forgotten acquaintances on social media may one day become colleagues or superiors. As a result, remaining connected while communicating professionally requires careful attention to your online behavior. Since social media platforms multiply and change constantly, it is difficult to provide a comprehensive list of rules to remain professional online. Some guidelines, however, may minimize the likelihood of harm or embarrassment.

Choose Postings Wisely

Do you want your name to indicate that you are a physician or a psychiatrist? If *@psychdocjohnwang* extols his love for a particular product or service, some may construe this as a medical endorsement. Likewise, any joke, status update, shared article, or political expression may be seen as a reflection of your professionalism, or lack thereof. This is especially important in light of the expectation that psychiatrists maintain therapeutic neutrality. Postings are easily misinterpreted outside their original contexts. Even on clearly personal pages, the risk of unintended exposure of private material remains, and residents must consider the risk-reward ratio involved in any potential postings. As the saying goes, "If you're explaining, you're losing."

Your profile picture is likely the first image your social media network will associate with your name and is often publically accessible, even on private profiles. Some people anonymize their name in order to avoid being searchable (e.g., change Gina Jenkins to "Gn Jkn" or something similarly unlikely to be revealed via auto-complete, but recognizable to people who know you already). Adding a non-descript profile picture (landscape, building, food) further decreases the likelihood that you will be identified via search.

Limit Your Viewership

Determining the ideal breadth of your social network can be a difficult balancing act. A good initial limit is to keep your profile and posts visible only to people you know. As you approach fellowship and job application time, limiting your profile visibility or removing it altogether may be a good option. Indeed, searching yourself occasionally on various engines and social networks is a good way to assess how potential colleagues and hiring managers may see you. As your career progresses, cultivating a wider public persona may eventually become part of your professional identity.

Be Vigilant Regarding Information Exposure—including Hidden Data

As smartphone technology advances, the opportunity to post compromising time-stamped and geo-tagged pictures increase. You don't want everyone working in clinic asking, "Why is @psychdocnealkumar at the beach at 2:34pm on a Monday?" More concerning, a party photo tagged with your home location compromises your safety. This can be posted publicly by well-meaning friends unaware of privacy concerns faced by psychiatrists. Even when not tagged, photos retain easily accessible metadata such as owner's name, device identifying data, time, and location. And since information provided to professional organizations may be publicly accessible, always use your departmental address and phone number when registering (e.g., for your NPI).

Resist the Urge to Post Revealing or Controversial Items

Deciding what content to post is usually done in the heat of the moment. And even removed posts sometimes remain searchable long after being deleted. Limiting your readership to people you know is helpful, but not all-encompassing protection. Newspaper op-eds are a better place for controversial opinions where you can professionally present your argument. Ask yourself, "Could I explain this post to my boss? Would I want to?"

Most Importantly: Keep Patients Out of It

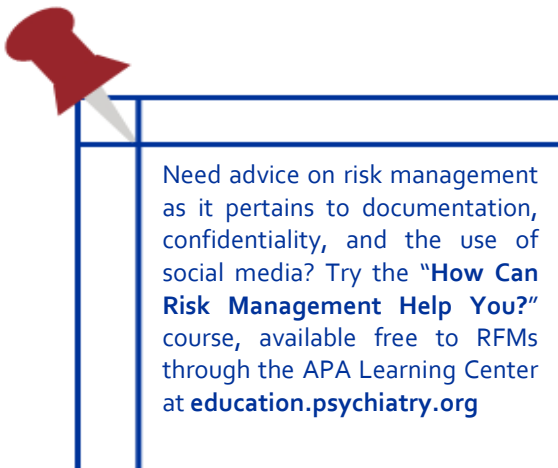
Funny and unbelievable things happen in psychiatry every day. The field is replete with stranger-than-fiction anecdotes. Although well concealed references might avoid a HIPAA violation, representing patient scenarios out of context risks misrepresenting psychiatry, already a misunderstood and wrongly-maligned field, in a very public way. Process groups, resident happy hours, and private conversations are better options for decompressing and

sharing the delights and challenges of work. Residents are professional ambassadors and patient advocates, especially on the internet.

The Role of the Internet in Gathering Collateral

Gathering collateral information is a key part of the psychiatric evaluation, whether in child psychiatry, consultation-liaison, or the emergency room. Considering this, to what extent should clinicians search for collateral on the internet? One resident tells the story, "In the emergency room, I was evaluating a potentially manic patient who described a series of weird jobs that supposedly brought her financial success and minor acclaim. She also said she could access the minds of all world religious deities. I did a search, and the first part was true."

Other times, needless fishing for trivia can lead to regret. An intern shares, "I had a patient around my age while I was at clinic in medical school. I realized while he was talking that we may have crossed paths with similar groups in the past. I checked discreetly, and one of the social networks showed we had a mutual acquaintance. But I'm not sure the information ended up being meaningful, and I'm not sure it felt appropriate to come across it like that." Still, searching thoughtfully can yield useful general information, according to one attending. She shares, "Sometimes when I want a better grip on a person's environment, I'll bring up public pictures of their neighborhood. What kind of cars do people drive there? What are the stores like? The houses? Take it with a grain of salt, but it's the same as reading into their appearance and speech. Sometimes we need more data to get a good picture."



Need advice on risk management as it pertains to documentation, confidentiality, and the use of social media? Try the **"How Can Risk Management Help You?"** course, available free to RFMs through the APA Learning Center at education.psychiatry.org

43 How to be a Chief Resident

Most chief residents enter their position 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. A few simple tactics can help you approach the role of chief resident with more confidence.

Define Your Role

Chiefs sit in a “boundary position,” midway between residents and faculty. In administrative functions, their role is akin to faculty. In their everyday work, they still act as residents. This boundary position isolates chiefs, but also provides them with an understanding of how to manage complex systems.

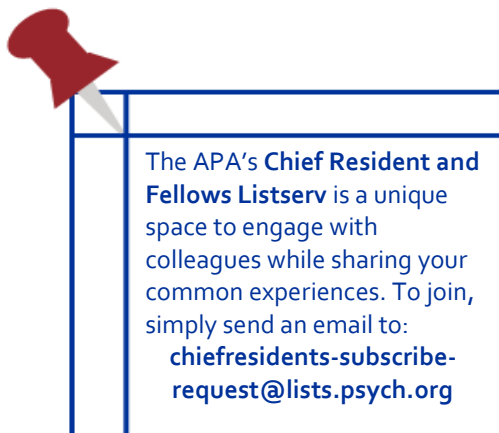
Residents and faculty may view chiefs in simplistic ways – either as ally or opponent. As a result, you may feel unsupported in your work as chief. The job of chief resident isn’t a popularity contest. There will be situations, such as dealing with non-performing residents or taking a stand for residents’ rights, that will require you to be decisive and confrontational, sometimes in a very public way. 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 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 parts of the job on which you would like to concentrate. It is also important to consult the outgoing chief to get their advice on how to handle ongoing conflicts in the program and a sense of progress made under their 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 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 help establish your role.

Quick Tips for New Chiefs

- **Organization is key** – It is important to complete your own administrative duties in a timely manner. Schedule an hour each day to do these tasks. If your program doesn't take this time into account when budgeting your hours, insist that they do.
- **Communicate...constantly** – Always be conveying information from faculty to residents and vice-versa. This will help you build consensus among the residents and establish your role as mediator within the program. Consider sending periodic updates or scheduling drop-in office hours for residents.
- **Be a teacher by being a role model** – your residents are looking to you as an example of model professional behavior. Provide feedback on how to manage a caseload, arrange a schedule, and teach medical students – while also making sure your own activities are in order.
- **Treat your residents how you'd want to be treated** – it's the golden rule! Be straightforward, compassionate, respectful of confidences, patient, 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.
- **Be your residents' staunchest advocate** – 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.



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Getting Involved: Participating in Professional Organizations

It takes effort, energy, and time to participate in professional organizations, and some don't see this kind of involvement as worth their while. However, for those who choose to become involved, the benefits can certainly outweigh the time invested. Below we consider the implications of participating in professional medical organizations and how it may benefit three areas of your professional life:

- Gaining a broader perspective of the residency training experience
- Supplementing residency education
- Establishing a network of colleagues with similar interest

Residents as Advocates

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 and clinical experiences provides encouragement and a new type of vigor, which you can bring home to your institution. Open discussions about rotations, didactics, supervision, call, and important issues facing our specialty can help us better understand our profession. By learning about the strengths and weaknesses at other programs we can become catalysts for improving our own programs.

Whether it is through a local or national medical society, learning about psychiatric trends in both a specific region of the country or nationally can be 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, nationally, and even internationally. Further, actively participating in an organization allows residents to learn about political trends that directly affect the way mental health care is delivered and provides avenues to advocate for change that are beneficial to our patients and our profession.



Learn more about current psychiatric advocacy efforts:
psychiatry.org/advocacy

In my experience...

My involvement in the APA through the APA Leadership Fellowship is really just beginning. However, I have already found it to be a place of great inspiration, both in the sense that our twice annual meetings serve as a catalyst, re-igniting your sense of purpose as psychiatrists. Additionally, as APL fellows we are given the unique opportunity to both give and receive advice and mentorship from senior psychiatrists and leaders in the community. Further, perhaps the greatest rewards of the fellowship are the relationships we make and networks we build with peers from around the country, who are all phenomenally accomplished.

-Aparna Atluru, M.D.

Enriching Your Residency Educational Experience

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

Establishing Your Professional Network

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 and obtaining mentorship from more senior psychiatrists, to simply enjoying social events with 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, the American Psychiatric Association, and the Group for Advancement of Psychiatry, provide much needed support to unique populations of trainees.

Participation in organized medicine 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 trainees and early career psychiatrists. Volunteering for small or oft neglected positions in organizations will get you noticed. This, in turn, can lead to additional responsibilities and integration into an organization. Over time, this can greatly enhance your professional identity in the field of psychiatry.

Get Started!

The APA and American Psychiatric Association Foundation offer a variety of fellowships to advance your training in leadership, government affairs, public and community psychiatry, and more. Most are completed simultaneously with your training. Find application instructions and deadlines at psychiatry.org/residents.

Leadership and Public Affairs

- American Psychiatric Leadership Fellowship
- Jeanne Spurlock, M.D. Congressional Fellowship
- Public Psychiatry Fellowship

Minority Fellowships

- APA/SAMHSA Fellowship
- Diversity Leadership Fellowship
- APA/SAMHSA Substance Abuse Fellowship

Research and Sub-Specialty

- Psychiatric Research Fellowship
- Resident Psychiatric Research Scholars
- Child & Adolescent Psychiatry Fellowship



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Being Assertive in Your Professional Roles

Becoming assertive in your professional roles is an important transition in residency. Medical students are expected to be compliant learners, but residents are expected to accept leadership roles. As you transition from trainee to independent physician, you will learn to be assertive to advance your own career, and to advocate for what is best for your patients.

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. For some women and minorities, being assertive may not be part of your earlier life messages from home and society. However, in your future role as a physician, you will be expected to be assertive to fulfill your responsibilities in several capacities, including...

In Your Residency

As an intern, try to learn by observing 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. Volunteer when special leadership opportunities arise in your training program. You should be prepared to justify 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.

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. These are suggestions the patient may not want to hear, though are in their best interest. Recommending additional treatments and goals for patients is also appropriate. Learn to set limits with patients if they begin to cross appropriate boundaries with you, other patients, or staff. Patients may initially react negatively when boundaries are set,

With Patients

providing an excellent discussion topic with your supervisors. If a patient is emailing you inappropriately, for example, consider copying the attending on your responses so they can see exactly what is being said and offer advice. Being a resident offers the rare opportunity of having an attending who can advise or intervene if things get out of control, so take advantage of it. Try new approaches. Trust yourself. It is better to learn now, during training, than the hard way when alone in practice.

With Attendings 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. You can also ask other residents, particularly the chief resident, what to expect and how to advocate for what you believe is lacking in your program without antagonizing faculty.

On inpatient psychiatry rotations, you may need to consult different medical specialties to evaluate your patient. It is perhaps not surprising that you will get push-back at times, and the services may try to decline the consultation or defer it to outpatient. Keep in mind that your ultimate duty is to the patient, and if he or she really needs the evaluation, stand firm in requesting the consulting service to see the patient. If you come to an impasse, ask to speak to a senior resident or refer the discussion up the chain to your own chief resident or attending.

With Consulting Services

With Insurance Providers

You may be required to speak with a physician from an insurance provider to justify continuing your patient's admission. This interaction doesn't need to be antagonistic; this is a reasonable and common request to ensure that finite medical resources are being allocated appropriately. However, do be firm with your recommendations and be prepared to justify your assessment.

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

In Professional Organizations

opportunity to meet leaders in the field, future colleagues, and friends. Furthermore, such involvement can offer healthy, creative opportunities to balance the stresses of residency. 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.” 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.). Remember, “cocktail hours” are not just for relaxation. They are also important times to network. Approach them with a goal-oriented mindset.

Consider Seeking a Career Adviser

Your program may be able to match you with a faculty member or psychiatrist in the community to serve as a career adviser, if requested. A career mentor can be invaluable in helping you clarify your career goals, such as whether to pursue certain fellowships or what type of job to seek after residency (private practice versus academic versus hospital-based, etc). When you do meet with your adviser, an effective technique to employ is called “leading from below.” Your adviser likely wants to be as helpful to you as possible, but only you know exactly how they can help. Come to meetings with an agenda to guide the session in the direction you want. Although this seems quite forward, it is typically well-received by the adviser, because he or she has the satisfaction of knowing they are being helpful in precisely the way you need it.

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 in the end you will feel if you do not receive credit for your work.

A Possible Scenario

Joe Intern is pulled aside by an attending after rounds. The attending says, "I noticed you seem interested in autoimmune etiologies of psychosis when discussing our last patient. I happen to be working on a research project about just that. How would you feel about helping out with my research? It would be low commitment, just a few hours a week. Unfortunately I won't be able to make you an author but I can promise a good evaluation on this rotation."

One response...

If this is research you are in fact interested in, by all means consider the invitation. However, you would want to politely but firmly make clear that you want, at the very least, to be considered for authorship, dependent on your level of commitment. A response might be: "Thanks, I appreciate your offer. That is actually something I'm very interested in. I would also like to get more experience with research, and I am especially interested in getting more experience publishing academic papers. Perhaps we could discuss how much commitment you would expect in order to consider including me as an author."

On the other hand...

If this is not research you are interested in, do not feel pressured to accept. Keep in mind that the attending's offer to provide a good evaluation based on outside work that you are doing for him is ethically dubious. If you fear that you are facing repercussions by not accepting, you may need to discuss the situation with other supervisors, your chief resident or possibly your program director. This is yet another opportunity to practice being assertive.

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.

46 How to Advocate for Yourself

Residency can be tremendously challenging at times, especially when a resident feels less-than-supported. Working many hours without a break, can often cause one to feel miserable and inadequate, with serious emotional toil. Thus, one of the most important aspects of having a well-balanced, healthy life during difficult times, is skillful negotiation with peers, superiors, and residency leadership, in order to improve the residency experience.

Know Your Rights

Sometimes, an institution's culture can make discussing duty hour issues difficult. But these are your rights, and both you and your patients deserve protection. **Be aware of the ACGME's specific stipulations regarding work hours, time free of duty and supervision requirements.**

Speak Up! Communicate Your Needs

Oftentimes, residents get a new rotation every month. It can be very hard to adapt to a new environment quickly while providing optimal patient care. **It's very important to ask for help when a new rotation starts.** Asking senior residents and attending physicians about specific expectations can help reduce anxiety and provide concrete guideline as to your role on the team. For example, the expectations and hours as an intern on medicine can be very different than psychiatry. On medicine months, ask how work is typically divided among residents and interns, so time is used efficiently and without redundancy. Alternatively, on psychiatry, identify your role in coordinating care and responsibilities for patients. Social workers are often responsible for finding placement and directing family meetings, whereas residents can offer advice regarding family meetings. Clearly understand roles within teams, and how you can best serve on the team, so workflow is optimized.

Identify the Problem

Even if you speak up, there may be logistical, administrative, or supervision elements which can make a rotation uncomfortable or of poor educational value. If this happens, take time to reflect so you can clearly point out what needs to change. If you find yourself in a situation where duty hours requirements are being violated, it's paramount to report this to

administrators, including chiefs and/or program directors to promote change. Sometimes it's not an issue of duty hours, but instead a rotation with very little educational value or poor supervision. Feeling alone and unsure in making decisions can put patients at risk. If you feel uncomfortable making a decision about medications or evaluating patients for safety, ask for help. **Sometimes it's hard to ask for help, but it's much harder to deal with bad patient outcomes.** If no help is available, then the issue may be a systems-level problem. Participating in a hospital-based quality improvement team may prove helpful. Change may seem unlikely. But if several residents feel the same way, taking an active role in raising awareness could be the spark needed.

Find Help

If you feel overworked with minimal supervision, your institution should have pathways for expressing concerns. Some programs offer residency councils and work groups as portals to make program directors and senior leadership aware of problems. Alternatively, contacting or meeting with site directors or offsite supervisors regarding stressful situations, can help address problems within rotations in real-time. **Feeling personally overwhelmed and overworked can be tremendously detrimental to personal well-being and also to patient care.** Making sure that your voice is heard regarding poor or mediocre experiences can help current and future residents. Most rotations will have feedback forms and verbal feedback sessions during and after a rotation. Residency directors should be willing and open to receive feedback about specific resident challenges and help coordinate/resolve them.

Advocate for Your Future

Residency is a time to explore. It is worth your while to develop a good foundation for your future practice by advocating for yourself during residency. This might include negotiating research funding if you're interested in academics. The best place to start is by talking with colleagues and mentors. Ask residency directors and peers about who within the department shares similar research interests. In addition, look through the department website and newsletter for opportunities to participate in research, committees, and other activities within the university. Additionally, many professional organizations, including the APA, offer resident-only awards to encourage research and travel money to attend conferences.

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How to Make Your University Work for You

Psychiatric residency is rewarding in and of itself. That doesn't mean you shouldn't also take advantage of the benefits and perks available to you. 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 they offer, so the following might not be available at all programs. Nor should this be considered an exhaustive list of benefits you might have at your program. Start with your local GME office, Program Coordinator, and other residents for program-specific information.

Health, Dental and Vision 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 while others will offer cost-sharing programs or subsidies. The same applies to spouses and children. Depending on your institution, insurance benefits might be available to significant others or same-sex partners in states without same-sex marriage. Be aware of open-enrollment deadlines. These are the times of 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 period. These time periods will vary among insurance companies, so check your policy packet or contact your GME office for details.

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

Mental Health 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. A successful transition from student to resident to graduated expert in psychiatry can take a toll on your mental well-being. Some programs require their residents to obtain individual therapy, and

may offer resources such as greatly discounted therapy referrals. Most programs offer counseling services. It is also important to check whether Behavioral Health services are included in your health insurance – fortunately a more common occurrence nowadays. Don't neglect your own mental health!

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. Usually these types of insurance provide some percentage of your monthly salary until you are able to return to employment. If your program covers these for you, it will most likely be a group policy for all of the residents. Utilize any financial planning services offered at your medical school or residency program to determine if obtaining individual disability insurance during residency may be advantageous for you, as insurance rates usually jump significantly if you start insurance once you've graduated from residency.

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.

Step 3, Licensing, and the DEA

These fees are quite expensive, especially for a resident on a limited budget. Some programs will pay for some or all of these fees, while others may offer alternate ways to pay, such as using funds set aside for academic purposes.

Loans and Student Loan Forgiveness

Some programs offer loans to residents at comparatively low or zero interest rates. These funds may help especially when starting residency, before your first paycheck kicks in. Before or when beginning residency, particularly if you have a heavy debt burden, look into the various loan repayment plans. Income-Based Repayment and Pay As You Earn are particularly popular among residents on a tight budget. Also consider whether you will aim for a particular kind of loan forgiveness option in the future, and plan ahead.

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 offered. Recent changes in regulations of pharmaceutical interactions with physicians have decreased the availability of some free meals, but food is often still available at educational conferences, journal clubs, and other meetings.

Relocation and Housing

Programs that are located in attractive but expensive locations, such as New York, San Francisco, and Los Angeles, may offer financial assistance to help with residents' standard of living. Some programs offer subsidized housing units, while others provide a financial stipend to help with housing costs, and yet others provide relocation funds.

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 or university 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. Many universities offer daycare for a reduced fee for the children of residents and fellows. Some programs also offer adoption assistance by covering some of the expenses of adoption.

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. All residency programs offer paid vacation time for residents, usually 3-4 weeks/year. 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.

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:** Many programs offer or mandate 401k retirement plans in which you deposit a certain percentage of your stipend; sometimes programs will match these contributions 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.

- **Rollover:** It will inevitably happen that you will change universities or employers, whether during residency or afterwards. It almost always makes financial sense to rollover your 401k into a Roth IRA, which you have hopefully started during or before residency, given the promise of higher salaries (and income tax brackets) later in life. Consult with your GME office for any forms or instructions you need for this.

Mentoring and Networking

Residency is a good opportunity to gain mentorship and start building peer, supervisorial, and professional networks with your colleagues and university-affiliated faculty and community providers. Your program may have started a Big Sib/Little Sib program, or you might inquire about starting one. There may also be program-sponsored or resident-driven events in which to meet more faculty and community providers.

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 the benefits at your university. 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 program's resources to save money and enhance your quality of life.



Is your program part of the APA Residents Circle – the exclusive club for psychiatry training programs? Check out [psychiatry.org/residents](https://www.psychiatry.org/residents) for more information and a list of benefits.

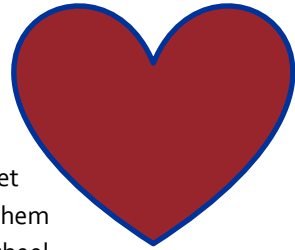
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Romance, Relationships, and Residency: A Practical Guide

As residents we can be busy. What does that suggest about our personal lives, about our relationships? Might they suffer? Might they even end? Are we doomed to be alone forever, or at least for the duration of residency? What, in short, about *love*? Put your worries at ease. Love and psychiatry residency are compatible. I've seen and even experienced it. Here's some of the advice I've gleaned.

For the Single

Congratulations! You struggled through the thicket of medical school and came out the other side only to find yourself surrounded by married co-residents. You'll befriend these people and meet their spouses, and when you spend time with them you'll have fun yet also feel awkwardly like a third wheel.



You'll tell yourself it's clearly too late for you to enter a relationship because look, all your married co-residents are about your age. They obviously had the foresight to get this taken care of already, and now each of them is half of a happy couple. And anyway, how are you supposed to meet people if you're at the hospital twelve hours a day? What are you supposed to do?

Consider that people, because they are different, hit different life milestones at different times. If that's too trite for you, consider also that your married friends are almost certainly less happy than you think they are.

Perhaps being single has its advantages. You don't have to answer to anybody. You have control over your destiny. You can date whomever you want, for however long you want. You are free.

Yes, maybe your job makes it harder to meet people than it would be otherwise, but it's not impossible. If you're a resident at an academic center, there are probably places where grad students hang out. There are organizations to join, events to attend.

There's the Internet, too. Online dating has its own frustrations, but it can lead to positive results. Actual research data suggests that you'll be particularly successful if your screen name starts "with a letter in the top half of the alphabet," if your profile features "an attractive still picture," and if your self-

description employs "simple language with humor added."¹ Seems straightforward enough.

If all else fails, remember that there's no shame in just staying single. Embrace your inner schizoid, if you want, or spend time with friends. Or just spend time with your cat. Cats are much easier. I speak from experience.

For the Committed

Congratulations! You've chosen the medical specialty with the statistically highest incidence of divorce. But the news isn't all bad. Doctors as a group are, contrary to conventional wisdom, pretty good at keeping their marriages intact – substantially better at it, in fact, than other professionals, such as attorneys.



Yet some level of interpersonal conflict is inevitable, particularly given the stresses of residency training. You'll work long and sometimes odd hours. You'll find yourself seeing little of your significant other. When you do have time together, you're exhausted. What are you supposed to do?

See what you can do to lighten your schedule. Take a look at your moonlighting habits. Money is a wonderful thing, but maybe you don't need to go work in the ER every week. Maybe the gain of together time is worth the loss of income. Take a look at work-related projects. You might have over-committed yourself. There's nothing wrong with scaling back.

But perhaps you're an intern, and the craziness of your schedule is unavoidable, or perhaps you're on a particularly busy rotation, and will be for several months. In that case, try to make the time you have count. Be creative. Run errands together if you can. It's not particularly sexy, but it is time with your significant other. It's better than nothing, and it keeps you connected.

Sometimes the stress of residency training manifests as tension, as relational friction. Remind yourself that you probably aren't the only one who's stressed out. Your partner will appreciate that acknowledgement.

Consider couples therapy. It works, and as a psychiatry trainee you might even find it weirdly educational. Maintaining a relationship always, on some level, involves navigating and reconciling differences, and those differences may seem even starker when you're under stress. Therapy can help with that. Your relationship may even be stronger as a result.

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Moonlighting for Residents

Despite the demands of residency, some residents choose to moonlight to broaden their clinical experiences and, of course, make some extra money! Deciding to moonlight is personal, and should address your individual, family, and financial obligations. Moonlighting is not for everyone. First check your training program's policies to find out whether moonlighting is even allowed. If it is, 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 evaluate your performance to ensure 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. 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 advise on moonlighting opportunities, malpractice insurance, working conditions, etc., and give you the scoop on selecting a plum moonlighting job and avoiding the lemons.
3. **Be resourceful.** Some moonlighting opportunities are highly desirable, and your co-residents may be unwilling to share their resources. 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.
4. **Ask whether your training institution allows its residents to moonlight in the facility after hours.** Though some medical centers consider this “double dipping,” if it is allowed you have the advantage of already being familiar with procedures and expectations.
5. **Be informed.** Generally, you need to interview to secure a moonlighting job. Ask specific questions! Ask 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 by making 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 work-time cutoffs. It is easy to get carried away once you start getting those extra paychecks. Moonlight in moderation and allow yourself sufficient time for rest and relaxation to prevent burnout. Remember, you still have to get to that long-awaited graduation day!

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Debt Management: Avoidance Equals Interest Accrual

The cost of graduate medical education is soaring, with the average student owing more than \$100,000. Borrowing money is the only means for many individuals to pursue a career in medicine. It is essential that students and graduates remain informed and organized about their loan portfolios. Avoidance behavior in regard to keeping accurate records and managing debt 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.

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 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 incurred if you make several consecutive payments on

time. Finally, inquire about the terms for paying off loans early and any associated fees.

Deferment and Forbearance

If there is no room in your current budget for payments, you may 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 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 over time. For many loans, you must reapply annually or semiannually for deferment or forbearance. This makes it essential for you to keep up with important dates to ensure 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 repayment amount exceeds 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. Find a qualified financial advisor if you have difficulty organizing your loans or 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). The Association of American Medical Colleges' MEDLOANS program offers a variety of services for managing student loans available at aamc.org.

51 Subspecialty Training in Psychiatry

As you progress through residency, people will ask what you're planning to do afterwards. "Are you thinking about fellowship?" If your response is "I'm doing geriatric psychiatry. Isn't it obvious? I've known it was my calling to treat elderly individuals with psychiatric illness since I was nine years old," this chapter will not be particularly helpful. For everyone else, it offers an overview of the types of fellowship training you might pursue.

Fellowships typically last one year and begin after you complete four years of adult residency. Child and adolescent psychiatry is an exception: this fellowship lasts two years, but can potentially begin after three years of adult training. A fellowship in any of these areas allows you to sit for the relevant ABPN subspecialty exam. If you pass, you can call yourself board certified in that area (note that you must first be board certified in general psychiatry before sitting for the subspecialty exam).

There are good and bad reasons to pursue fellowship training. Bad reasons would be because you want to postpone your entry into the "real world" by another year, or because you aren't really sure what kind of psychiatry you want to practice. Good reasons include a desire to focus on a particular patient population, type of practice, or to study something in greater depth.

Fellowship training has some tangible advantages. It could give you a competitive edge in the job market and make it possible for you to negotiate a higher salary. Keep in mind, however, there may be financial pitfalls as well. Accepting a fellowship means at least one additional year of training at a substantially lower salary than you'd make as an attending. This is worth consideration. If you accept a salary of \$50,000 rather than \$100,000, then your future salary must increase by \$4,000 to 6,000 per year for twenty years for you to earn back the value of the missed earnings. If your subspecialty qualifications get you the exact same starting salary, or the same salary in five years, it will have cost you financially.

It's also worth considering whether you need a formal fellowship for what you plan to do. 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 your child fellowship, particularly if you let faculty know your interests. On the other hand, if you want to perform competency evaluations on incarcerated juveniles, a forensic fellowship makes sense. If

you like emergency psychiatry and there's an emergency room job available, you may want to pursue that rather than an emergency psychiatry fellowship, depending on how much on-the-job training you will receive.

There are ten ABPN recognized psychiatric subspecialties and a number of non-recognized fellowships. Here is a brief introduction to each:

Addiction Psychiatry

- **Description:** This subspecialty focuses on treating patients with substance use disorders. Areas studied might include biopsychosocial assessment of patients with addictions, motivational interviewing, psychopharmacological treatment of withdrawal, detoxification, psychopharmacological treatment of drug craving, and treatment modalities for "dual diagnosis" patients. Psychiatrists who pursued addiction training comment that the fellowship helped them feel "more confident about setting boundaries and limits with patients," and "more comfortable managing addiction pharmacologically."
- **Length:** Typically one-year, some offer an additional research year.
- **More information:** The American Association of Addiction Psychiatry (AAAP) – aaap.org

Forensic Psychiatry

- **Description:** Forensic psychiatrists are knowledgeable about the intersection of psychiatry and the law, and they are trained to perform a variety of specialized examinations. They can evaluate an accused person's competence to stand trial and their ability to understand the legal process. Forensic psychiatrists also serve as expert witnesses on defendants' mental state at the time of a crime and perform third-party evaluations of worker's compensation claims.
- **Length:** One year
- **More information:** To apply, contact the programs directly. The American Academy for Psychiatry and the Law's provides a list of training programs – aapl.org.

Child and Adolescent Psychiatry

- **Description:** A child and adolescent psychiatrist's training might include pediatric psychopharmacology, behavioral interventions, family therapy, and play therapy. Child and adolescent psychiatrists have experience working with schools and juvenile justice systems, and with pediatrics to provide psychiatric care to hospitalized

children. A current child and adolescent psychiatry fellow notes that training has helped her appreciate “the importance and complexity of family dynamics” as they pertain to children’s mental health. Some feel that fellowship training has given them more flexibility to practice, as they are able to see both children and adults.

- **Length:** Two-year fellowship that can begin either after the third or fourth year of general psychiatry training.
- **More information:** Fellows apply through ERAS and go through the NRMP match. American Academy of Child and Adolescent Psychiatry – aacap.org.

Geriatric Psychiatry

- **Description:** Geriatric psychiatrists, by virtue of their patient population, must manage the psychiatric symptoms of many medical disorders. That makes this 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. Psychopharmacological knowledge is crucial, as is the ability to assess dementia and delirium, evaluate competency and functional skills, and work with families. Geriatric psychiatrists are in particular demand given the aging population.
- **Length:** One-year fellowship
- **More information:** American Association of Geriatric Psychiatry – aagponline.org.

Clinical Neurophysiology

- **Description:** For those who like neurology as well as psychiatry, this fellowship may be of interest. Clinical neurophysiologists are knowledgeable about seizures and their effects on psychiatric disorders, and are skilled at interpreting electroencephalograms, electromyograms, and nerve conduction studies.
- **More information:** American Clinical Neurophysiology Society – acns.org.

Psychosomatic Medicine

- **Description:** Formerly known as consultation/liason psychiatry, psychosomatic medicine deals with the interface between psychiatry

and other medical specialties. Fellows diagnose and recommend treatments for psychiatric illnesses in medically complicated patients. They may help manage chronic medical, obstetric, surgical, or infectious processes that can lead to, or that are comorbid with, psychiatric symptoms. Specific areas of focus include HIV, organ transplantation, psycho-oncology, and neurological illnesses such as multiple sclerosis. Psychosomatic specialists most often work as consultants within general hospital inpatient units, but in some cases they may see patients in an outpatient clinic (for example, an HIV psychiatry clinic embedded in an infectious disease clinic). One psychosomatic medicine specialist notes that fellowship training made her a more competitive candidate for academic jobs, and that it exposed her to new patient populations

- **Length:** One-year fellowship
- **More information:** Academy of Psychosomatic Medicine – apm.org.

Pain Medicine

- **Description:** This subspecialty is open to psychiatrists, neurologists, anesthesiologists, and other qualified specialists. An interdisciplinary field, it 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:** American Board of Anesthesiology – theaba.org – or American Board of Pain Medicine – abpm.org.

Sleep Medicine

- **Description:** This subspecialty is open to psychiatrists, neurologists, pulmonologists, and other specialists. Psychiatrists in this field help diagnose and treat sleep-related disorders such as insomnias, hypersomnias, parasomnias, sleep-related breathing disorders, circadian rhythm disorders, and sleep-related movement disorders.
- **More information:** American Board of Sleep Medicine – absm.org.

Hospice and Palliative Medicine

- **Description:** This subspecialty is open to psychiatrists, neurologists, internists, family medicine practitioners, and others. Fellows become experienced in dealing with hospice and end-of-life issues.

- **More information:** The American Academy of Hospice and Palliative Medicine – aahpm.org – provides a list of programs.

Brain Injury Medicine

- **Description:** Also called a neurorehabilitation fellowship, it offers advanced training in managing traumatic brain injury and stroke.
- **More information:** ABPN – abpn.com/cert_bim.html.

Non-Accredited Psychiatric Fellowships

There are some fellowships available that are not accredited by the ABPN, but are worth pursuing for the educational experience.

- **Emergency psychiatry:** one-year fellowship focused on the acute management of mentally ill persons.
- **Public psychiatry (community psychiatry):** Focused on community-based mental health. The American Association for Community Psychiatrists, communitypsychiatry.org, provides a list of fellowships.
- **Behavioral neurology & neuropsychiatry:** Although not ABPN accredited, completion allows you to take the United Council of Neurologic Subspecialties special certification exam – ucns.org.
- **Research fellowship:** 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, nimh.nih.gov, offers intramural programs in Bethesda, Maryland. Your program may have extramural training opportunities (ex: T32 training grants), so inquire with your research mentor. Typically, at least two years is dedicated toward preparing a solid "K" career development grant application. K awards often cover material in a specific area, such as affective and anxiety disorders, addiction, cognitive disorders, or schizophrenia. NIH offers loan repayment awards to certain qualified trainees.

If you want to continue training after residency, you've got plenty of options, depending on your interests. This chapter offers a taste of what those options are. To really know what it's like pursuing a particular fellowship, ask around. People will usually be happy to share their experiences in subspecialty training. Their advice will be invaluable in helping you decide what, if any, fellowship to pursue. Good luck!

52 Negotiating for Your First Job

You've finished residency and it's time to "hold your feet to the fire." It's time to get a J-O-B! While this chapter has been written by experts who have recruited psychiatrists for many years, former residents have also shared their advice, which is summed up by three pitfalls to avoid:

DO NOT SIGN a contract without understanding the responsibilities, the salary, and the legal jargon.	This sounds intuitive, but many have signed contracts prematurely, based on what was promised or "said" in negotiations, rather than what was actually in writing.
DO NOT be afraid to negotiate.	Salary is not the only item that can be negotiated. Depending on the job, you can negotiate protected time, lab space, clinical hours, loan repayment, instruments, etc.
DO KNOW your priorities.	There is no such thing as a perfect job. Take time to understand what's important to you.

A successful job negotiation begins well before the offer is on the table. First steps: The first few months of your final year in adult residency training is a good time to think about your next career step. Usually, the first decision is whether training is complete or if you want to consider a fellowship. For those residents who clearly would like to pursue additional training – either subspecialty training in an ACGME accredited fellowship, research, or other specialized skills – attending salaries will be postponed for another year or two (depending on the program selected). Fellowship training does have advantages, however, like allowing someone to evaluate the options within an academic center in a chosen geographic area before pursuing a more permanent position.



Nervous for negotiating? The APA course and workbook, "**Negotiating your First Physician Contract**" can help. Available free for RFMs at education.psychiatry.org

If a fellowship has been ruled out, it's time to consider the type of position you'd like to pursue. It's helpful to start with the basic elements of a position and personal preferences. These include job-related preferences such as:

- **Institution type:** academic, state funded, private not-for-profit, private for-profit, Veterans Affairs or Department of Defense
- **Work setting:** inpatient, outpatient, clinic, hospital, or private-practice based
- **Type of work:** full time, part time, call
- **Colleagues:** (solitary, psychiatrist colleagues, multidisciplinary colleagues, other physician colleagues)
- **The position:** front-line, administrative, supervisory, consultative

It is helpful to have some sense of the relative importance of these aspects before even applying for jobs, although flexibility is always important. At this point, it is better to include options than prematurely narrow your possibilities. While still in the early stages of thinking about your desired position, also consider the non-job related factors that can influence job satisfaction including geography, urban vs. rural, distance to family, and cost of living.

Searching for Jobs

In searching for jobs, it is important to go beyond merely checking posted or advertised job listings or using search firms. Many jobs are not formally posted until late in the process, when candidates have already been identified through word of mouth or other informal contacts. Be active in your search strategy. It can be very worthwhile to meet with residency coordinators about positions they have heard about and potential contacts in searching for positions in a certain geographic area or discipline. This is not a time to be shy. In fact, taking a moment to think about who you might know (other residents or faculty), who could provide you with potential leads, can be very useful. Don't wait for the formal job application stage to get your resume in order, as it is important to have one ready for distribution, since it may be requested at any one of these points during the job search process.

Interviewing

The importance of preparing for the interview cannot be stressed enough. Jobs are won or lost during the interview. Preparing for an interview includes thinking of answers to anticipated questions and researching the position, interviewers, and practice. Consider arranging a mock interview conducted by a faculty member or friend. Interviews may be one-on-one, or conducted in a group format. Be prepared for either type. Common mistakes that convey you have not taken the interview process seriously include inappropriate and

casual dress, inability to articulate answers to standard questions and lack of knowledge of the position, the institution, or other aspects of the job.

Negotiating

The negotiation, despite the anxiety it may produce, is actually the fun part. There is a job offer on the table, and you have to decide whether to accept it or not. While there are many elements, there are several that deserve specific scrutiny. There is the overall type of job (see above), salary, benefits, working conditions, contract issues, and non-job related aspects.

The first thing to understand is the relationship between the person negotiating with you and the person who actually makes the decisions about salary and other benefits. Usually, negotiations are with the direct supervisor of the position or the director of the program (i.e. service chief, head of the practice, chairman of a department). In a practice, the person who is negotiating may have the ability to affect benefits and salary, but in institutional settings, including academic settings, hospitals, and large healthcare organizations, salary and benefits are likely determined by the larger parent institution. It is helpful to have some understanding of the working of the institution so the negotiation goes smoothly. This sets the stage for good working relationships.

Generally, salaries for entry-level positions are usually not truly negotiable. Frequently, the way to earn more money is through productivity measures such as call, seeing more patients, or other duties such as inpatient vs. outpatient work (inpatient usually is worth more). It is worth asking if there is flexibility in the quoted figure, but don't expect much. Benefits are important, but their importance is often very specific to your individual circumstances. Good factors to consider include:

- Health benefits: do you need individual or family coverage?
- Disability/life coverage
- loan repayment programs
- Retirement savings options –
- Vacation policies
- Support for education
- Tuition support for you or family members
- What about relocation?
- Immigration status issues

Working conditions can also vary greatly between positions. Is this a full-time (and exactly what does that mean) or a part-time position? How variable will the amount of time be? How flexible is the work schedule? Who gets to decide? What are the incentives for working more? Is there a way you could end up making less than the quoted figure? How, exactly, will your time be

spent? How much call is there? How does that change over time? Can you do more call (for more money) or could you do less? What do your future employers think of you opening a private practice?

What does the contract look like (a sample Yale contract for junior faculty is reproduced below)? What conditions are spelled out and which ones are modifiable? Who can modify the terms and when? Is there a non-compete clause in the contract (usually not). How long is the contract in force?

The things that are the most negotiable are the smaller factors, which can actually make a big difference when starting out. For instance, the start date is one in which there is often more flexibility than you might think. Even if the stated start date is immediate and the employer is eager to fill, this is an area for negotiation. If there are extenuating circumstances that require a later start (wedding, family event etc.), be upfront about it and employers are likely to be very accommodating. However, don't misrepresent your reasons for the later start date. If you would like a long anticipated vacation after residency, say so. Your ability to negotiate may depend on the field of candidates for the position. Most employers would rather get a good employee a few months later than expected, than fill with a less desirable candidate. This may only be problematic if there are many equally qualified candidates. In that case, you may have to be prepared to choose between the vacation or the position.

Getting Help

Identify knowledgeable people who can help you think through job proposals. These may include faculty, other residents, family members or even a lawyer. If you do retain a lawyer, ask for a fixed fee rather than being billed by the hour. Sometimes the most useful people will be those in similar jobs. Sometimes, this is easy (many VA jobs are very similar), sometimes it isn't. It is entirely appropriate for you to ask your potential employers to connect you with other psychiatrists in their organization. A visit is usually a good idea (including significant others can help preemptively address concerns).

Lastly, there are some observations that we have made over our combined 40 years of recruiting psychiatrists to work at Yale. Do not lie. Be enthusiastic, but you don't have to misrepresent your interest in the job offer. This is a relatively efficient market—if something sounds too good to be true, it probably is. Things never turn out exactly the way you thought they were going to. You will have to determine whether it's a red flag or a misunderstanding. The best way to minimize that chance is to have learned as much as you can before you get to your first day.

Sample Offer Letter – Position at Connecticut Mental Health Center

(Date)

(Applicant)

RE: RFP (number)

Dear Dr. (X):

I am pleased to offer you a position as Assistant Professor of Psychiatry at Yale University School of Medicine. This letter sets forth the specific terms and conditions of this offer of employment and supersedes any previous correspondence or discussion between you and the School or Department; it also explains the documentation required and the process for making your appointment official. Please note that this offer is contingent upon the successful completion of a background check.

Faculty Appointment: The Department of Psychiatry is recommending your appointment as an Assistant Professor for an initial three year term, effective July 1, (X) to June 30, (X). Your appointment is contingent upon completion of the normal University review process including approval by the School of Medicine and the Yale Corporation. This review is well underway, and I will notify you when it has been completed. In the meantime, I will be glad to answer any questions you may have regarding faculty appointments, reappointments and promotions.

Policies for faculty, including a description of ranks and tracks are set forth in the Faculty Handbook, which can be found on-line. Because these policies represent essential employment understandings between you and the University, you are urged to read the Faculty Handbook with care, including revisions that are made periodically and become part of these understandings. If you have specific questions, please contact Monica Doyle at Monica.Doyle@yale.edu.

Salary: This position will correspond to 100% of your effort. Your salary will be (X) on an annual basis for the academic year July 1, (X) through June 30, (X) and will be comprised of a base of \$XX,XXX and a supplement of (X). Your salary will be funded by (X). At the School of Medicine, faculty salaries are determined in accordance with School and departmental guidelines and are reviewed annually, with adjustments based on the faculty member's overall contribution to the School and the department.

Benefits: If you wish to enroll in Yale benefits including a Yale insurance plan, you must do so within 30 days of your appointment start date. Please use your NetID and password to log onto yale.edu/portal, and click on "My Benefits" to begin the enrollment process. Note that if your appointment start date is the first of the month, your health coverage will be effective as of your start date.

For appointments that begin on any day other than the first of the month, health coverage begins on the first day of the subsequent month. Please note that upon hire you are automatically enrolled in Yale University's Retirement and Planning program (YURAP) with a 5% employee contribution rate and defaulted to TIAA-CREF as the 403(b) vendor. Attached to this offer is a notice that provides instructions on how to change your contribution rate and/or 403(b) vendor on the My Benefits site. If you need further information or assistance with enrolling in benefits, please contact the Employee Service Center at 203-432-5552 or employee.services@yale.edu.

Space: Your office will be located in the Connecticut Mental Health Center.

Responsibilities: As an Assistant Professor in the Department of Psychiatry, you will be responsible to (X). In this position, your responsibilities will include: (X)

Please note that you must be credentialed by the Connecticut Mental Health Center (CMHC). Since CMHC is a state institution, the State of Connecticut is responsible for billing payers for non-research clinical services provided by you to CMHC patients. You must complete any necessary billing credentialing for the State and must possess and maintain eligibility for participation in federal health care programs such as Medicare. Upon acceptance of this offer you will be contacted by the CMHC Medical Staff office to begin these processes.

You are eligible to participate in the department's clinical incentive plan under which you may earn additional compensation for clinical activities outside your assigned duties. ALL income from these clinical activities must be turned over to the Department. You will be responsible for billing, payer or other institutional credentialing and HIPAA and other regulatory compliance for this activity. Information detailing the plan is enclosed.

Reappointment after your initial term will be dependent on the continued budgetary authorization of the position, the needs of the department, and evidence of success as a researcher, teacher, and scholar and on favorable action by appointment committees. In the event that you wish to resign, you agree to give the Department written notice four months in advance of the proposed date of your leaving.

By accepting this faculty position, you agree to abide by these requirements as well as all other University policies and procedures.

Please review this letter and all attachments thoroughly and do not hesitate to contact me should you have any questions. This offer is valid for 30 days after it has been received. Please indicate your acceptance by signing and dating both copies, return one copy to me, Attn: Monica Doyle, by that date, and keep the other for your records.

My colleagues and I in the Department of Psychiatry look forward to having you join the ladder faculty.

Sincerely,

John H. Krystal, M.D.
Robert L. McNeil Jr. Professor of
Translational Research
Chair, Department of Psychiatry

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Directory of Organizations

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 groups. The names and websites are subject to change.

Organization	Website
Academy for Eating Disorders	aedweb.org
Academy of Organizational & Occupational Psychiatry	aoop.org
Academy of Psychosomatic Medicine	apm.org
Administrators in Academic Psychiatry	adminpsych.org
Alzheimer's Association	alz.org
American Academy of Addiction Psychiatry	aaap.org
American Academy of Child and Adolescent Psychiatry	aacap.org
American Academy of Clinical Psychiatrists	aacp.com
American Academy of Hospice and Palliative Medicine	aahpm.org
American Academy of Psychiatry and the Law	aapl.org
American Academy of Psychoanalysis and Dynamic Psychiatry	aapdp.org
American Association for Emergency Psychiatry	emergencypsychiatry.org
American Association for Geriatric Psychiatry	aagponline.org
American Association for Technology in Psychiatry	techpsych.org
American Association of Chairs of Departments of Psychiatry	aacdp.org
American Association of Community Psychiatrists	communitypsychiatry.org
American Association of Directors of Psychiatric Residency Training	aadprt.org
American Association of Suicidology	suicidology.org
American Board of Addiction Medicine	abam.net
American Board of Pain Medicine	abpm.org
American Board of Psychiatry and	abpn.com

Neurology	
American Board of Sleep Medicine	absm.org
American Brain Coalition	americanbraincoalition.org
American College of Neuropsychopharmacology	acnp.org
American College of Psychiatrists	acpsych.org
American Foundation for Suicide Prevention	afsp.org
American Group Psychotherapy Association	groupsinc.org
American Neuropsychiatric Association	anpaonline.org
American Orthopsychiatric Association	amerortho.org
American Pain Society	ampainsoc.org
American Psychiatric Association (APA)	psychiatry.org
American Psychiatric Association Alliance	apaalliance.org
American Psychiatric Foundation	psychfoundation.org
American Psychoanalytical Association	apsa.org
American Psychological Association	apa.org
American Psychopathological Association	appasn.org
American Psychosomatic Society	psychosomatic.org
American Psychotherapy Association	americanpsychotherapy.com
American Society for Adolescent Psychiatry	adolpsych.org
American Society of Addiction Medicine	asam.org
American Society of Clinical Psychopharmacology	ascpp.org
Anxiety and Depression Association of America (ADAA)	adaa.org
Association for Academic Psychiatry	academicpsychiatry.org
Association for Behavioral and Cognitive Therapies	abct.org
Association for Medical Education and Research in Substance Abuse	amersa.org
Association for Psychoanalytic Medicine	theapm.org
Association for Women Psychiatrists	associationofwomenpsychiatrists.com
Association of Directors of Medical Student Education in Psychiatry	admsep.org
Association of Gay and Lesbian Psychiatrists	aglp.org
Association of Medicine and Psychiatry	assocmedpsych.org
Autism Society of America	autism-society.org
Brain and Behavior Research Foundation	bbrfoundation.org
Canadian College of Neuropsychopharmacology	ccnp.ca
Canadian Psychiatric Association	cpa-apc.org
Center for the Study of Traumatic Stress	centerforthestudyoftraumaticstress.org
Children and Adults With Attention-Deficit/Hyperactivity Disorder	chadd.org
Collegium Internationale Neuro-	cinp.org

Psychopharmacologicum (CINP)	
Depression and Bipolar Support Alliance	dbsalliance.org
Disaster Psychiatry Outreach	disasterpsych.org
European College of Neuropsychopharmacology	ecnp.eu/emc.asp
Families for Depression Awareness	familyaware.org
Freedom from Fear	freedomfromfear.org
Group for the Advancement of Psychiatry	ourgap.org
International College of Psychosomatic Medicine	icpm.org
International OCD Foundation	iocdf.org
International Psychogeriatric Association	ipa-online.org
International Society for Affective Disorders	isad.org.uk
International Society for Bipolar Disorders	isbd.org
International Society for Neuroimaging in Psychiatry	isnip.org
International Society for the Study of Personality Disorders	isspd.com
International Society for the Study of Trauma & Dissociation	isst-d.org
International Society for Traumatic Stress Studies	istss.org
International Society of Psychoneuroendocrinology	ispne.org
Mental Health America	nmha.org
National Alliance for the Mentally Ill (NAMI)	nami.org
National Center for PTSD	ptsd.va.gov
National Institute of Mental Health (NIMH)	nimh.nih.gov
National Institute on Alcohol Abuse and Alcoholism	niaaa.nih.gov
National Institute on Drug Abuse	nida.nih.gov
National Sleep Foundation	sleepfoundation.org
ParentsMedGuide	parentsmedguide.org
Royal College of Psychiatrists	rcpsych.ac.uk
Schizophrenia International Research Society	schizophreniaresearchsociety.org
Society for Neuroscience	sfn.org
Society of Biological Psychiatry	sobp.org
Substance Abuse and Mental Health Services Administration (SAMHSA)	samhsa.gov
The Neuroscience Education Institute	neiglobal.com
The Stanley Medical Research Institute	stanleyresearch.org
US Psychiatric Rehabilitation Association	uspra.org
World Psychiatric Association	wpanet.org

Non-Psychiatric Organizations

Organization	Website
Accreditation Council for Graduate Medical Education	acgme.org
American Academy of Neurology	aan.com
American Association for the Advancement of Science	aaas.org
American Board of Medical Specialties	abms.org
American Medical Association (AMA)	ama-assn.org
American Neurological Association	aneuroa.org
Association of American Medical Colleges	aamc.org
Centers for Disease Control and Prevention	cdc.gov
Drug Enforcement Administration (DEA)	usdoj.gov/dea
Educational Commission for Foreign Medical Graduates	ecfmg.org
Electronic Residency Application Service (ERAS)	aamc.org/eras
Federation of State Medical Boards	fsmb.org
Fellowship and Residency Electronic Interactive Database (FREIDA)	ama-assn.org
Food & Drug Administration (FDA)	fda.gov
Institute of Medicine	iom.edu
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)	jcaho.org
National Institutes of Health (NIH)	nih.gov
National Library of Medicine	nlm.nih.gov
National Resident Matching Program	nrmp.org
New York Academy of Medicine	nyam.org
Physicians for Human Rights	physiciansforhumanrig hts.org
Sigma Xi, The Scientific Research Society	sigmaxi.org
United States Medical Licensing Examination	usmle.org
World Health Organization	who.int
National Institute on Aging	nih.gov/nia

About the Authors

Editors:

Leah J. Dickstein, M.D., M.A., is Professor Emerita and former Associate Chair for Academic Affairs of the Division of Attitudinal and Behavioral Sciences and former Associate Dean for Faculty and Student Advocacy at the University of Louisville School of Medicine.

Tonya A. Foreman, M.D., completed general psychiatry residency at Vanderbilt in 1997 and child psychiatry training at the University of Florida in 1999. She also completed a Forensic Psychiatry fellowship at Yale University in 2000. Currently, Dr. Foreman has a private practice in Indianapolis, IN, specializing in forensic psychiatry, child/adolescent psychiatry, and women's issues.

Amir Garakani, M.D., completed general psychiatry residency and a research fellowship at the Mood and Anxiety Disorders Program at Mount Sinai Medical Center in New York, NY, in 2006 and 2007, respectively. Dr. Garakani also completed a fellowship in Forensic Psychiatry at New York University Medical Center. Currently, Dr. Garakani is an attending psychiatrist at Silver Hill Hospital in New Canaan, CT, where he also maintains a private practice.

Ayana Jordan, M.D., Ph.D., completed a combined MD/PhD program at the Albert Einstein College of Medicine of Yeshiva University in New York, NY in 2011. She finished her general adult psychiatry residency at Yale University in 2015, where she served as Chief Resident and is currently completing an addiction psychiatry fellowship. Dr. Jordan has a special interest in the advancement of access and excellent mental health care for minority populations.

Misty Richards, M.D., M.S., is a first year Child Fellow at the University of California, Los Angeles, where she also completed her general psychiatry training. She is a Fulbright Scholar and completed her graduate fellowship as part of her master's degree in Tokyo, Japan. Dr. Richards also served as the 2014-2015 Editor-in-Chief of the *American Journal of Psychiatry – Residents' Journal*. She is a 2014-2015 Laughlin Fellow, the 2015-2016 APA/APL Fellowship President, and sits on the APA Board of Directors as a non-voting member. She has a special interest in global mental health.

Since 1999, *A Resident's Guide to Surviving Psychiatric Training* has been a collaborative gift of wisdom from current psychiatric residents and fellows to their successors. The editors would like to acknowledge all of the authors who contributed to the Guide's current and previous editions.

Authors Contributing to the Current Edition:

Miguel Alampay, M.D. J.D.
Frank S.K. Appah, Jr., M.D., Ph.D.
Aparna Atluru, M.D.
Kara Bagot, M.D.
Stuart Downie, M.D., MRCPsych
Katrina Furey, M.D.
Garo Ghazarian, M.D.
Michael Hann, M.D., M.B.A., M.S.
Amanda Paige Harris, M.D.
Jonathan Heldt, M.D.
Marilise Hyacinth, M.D.
Kevin K Johnson, M.D.
R. Scott Johnson, M.D., J.D., L.L.M.
Renz Juaneza, M.D.
Seth Judd, D.O.
Amandeep Jutla, M.D.
Jeremy Kidd, M.D., M.P.H.
Karen Lai, M.D., M.P.H.
Luming Li, M.D.
Michael M. Mirbaba, M.D., M.A., Ph.D.
Tua-Elizabeth Mulligan, M.D.
Ismene L. Petrakis, M.D.
Siddarth Puri, M.D.
Arjune Rama, M.D.
Misty Richards, M.D., M.S.
Hannah Roggenkamp, M.D.
Brandon D. Schneider, M.D.
Dale Sebastian, M.D.
Michael J. Sernyak, M.D.
Kyle P. Smith, M.D.
Guillermo Valdes-Montemayor, M.D.
Tobias Wasser, M.D.
Rachel Wurmser, M.D.

Authors Contributing to Previous Editions:

Khleber Chapman Attwell, M.D., M.P.H.
John Barker, M.D.
Cathy K. Bell, M.D.
Beth Boyarksy, M.D.
Todd S. Cox, M.D.
Laura Davies, M.D.
Nancy Delanoche, M.S.
Margaret Wu Fang, M.D.
Caroline Fisher, M.D., Ph.D.
Leslie Hartley Gise, M.D.
Melva Green, M.D., M.B.A., M.P.H.
Monica Radford Green, M.D.
E. David Hjellen, D.O.
Leslie Hulvershorn, M.D., M.Sc.
Lisa Kotler, M.D.
Brian Kubacak, M.D.
Maria Leonido-Yee, M.D.
Daniel Bonifacio Martinez, M.D.
Daniel O. Rippetoe, D.O.
Joshua Roffman, M.D.
Gregory M. Singleton, M.D.
Amanda G. Smith, M.D.
Susan Watrous, M.D.
Ashley Wazana, M.D.
Jason Wuttke, M.D., M.P.H.

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