

Newsletter

MEDICAL STUDENT



A Publication of the American Psychiatric Association

Committee on Medical Student Education

Greetings from the Chair!

By: Linda Pessar, M.D.

A meta-analysis of studies of long-term psychodynamic psychotherapy that have a prospective design and reliable outcome measures concludes that this treatment is effective for patients with personality disorders, multiple mental disorders, and chronic mental disorders, reports Leichsenring and Rabung in the October 1, 2008 JAMA. Thus long-term psychoanalytic psychotherapy can be added to the growing list of psychotherapies, that includes cognitive behavioral therapy, dialectic behavioral therapy, and interpersonal therapy, which have evidence-based support for their indications and efficacy.

I point this out for a number of reasons. Perhaps the most important is Justin Chen's and Iman Parhami's enthusiastic report about a PsychSIGN regional conference devoted to psychother-

apy. For many psychiatrists, psychotherapy offers an intimate, challenging, sometimes exhilarating, or frustrating collaborative venture we undertake with patients. It is guided by our understanding of and adherence to principles and techniques that define the type of psychotherapy in which we are engaged.

In my experience, medical students are very interested in psychotherapy. They are impressed by what psychiatrists learn about people through sophisticated interviewing, and how that knowledge makes a difference in treating them. Medical students are impressed that to some extent, psychiatrists "think outside the box."

When it comes to choosing specialties, some medical students who are attracted to psychiatry become preoccupied by the notion that "thinking outside the box" is "being outside the box" and choosing psy-

chiatry is loosening ties to medicine. The article in JAMA is the latest reminder that the efficacy of even that most uniquely psychiatric of treatments, psychotherapy, can stand up under the rigorous requirements of evidence-based medicine. I have come to think that psychiatry does not think outside the box. We simply have a bigger box.

Dr. Pessar is Professor of Psychiatry at University at Buffalo, SUNY, School of Medicine and Biomedical Sciences. She is also the Chair of the APA Corresponding Committee on Medical Student Education.

The First PsychSIGN Interactive Lecture Series: Psychotherapy

By: Justin Chen, MS4, Yale School of Medicine, Region 1 Chair & Iman Parhami, MS4, St. George's University, Region 2 Chair

On Saturday September 13, 2008, PsychSIGN held a combined Regions 1 & 2 regional conference on the topic of psychotherapy at the New York Psychoanalytic Society and Institute. This was the first PsychSIGN meeting ever to be centered around a single topic. The idea of organizing a conference on psychotherapy for medical students was originally suggested to Iman Parhami (MS4 at St. George's and Region 2 Chair) by Dr. Ronald Rieder, Director of Psychiatry Residency Training at Mt. Sinai. Iman was quickly sold on the idea of such a conference, given the relative lack of attention that psychotherapy receives in most medical school cur-

ricula. Additionally, a recent article in *Archives of General Psychiatry* highlighting the shrinking role of psychotherapy in psychiatric practices nationwide made this idea for a conference even more timely. [1] Justin Chen (MS4 at Yale and Region 1 Chair) suggested the potential benefit a collaboration to organize a combined regional conference, especially given the geographical proximity of Region 1 (New England) and Region 2 (New York), and soon joined Iman as a co-organizer.

The NY Psychoanalytic Society and Institute (NYPSI) generously agreed to host the PsychSIGN event in their auditorium. Founded in 1911, NYPSI is the oldest psychoanalytic organization in the

United States. The APA also graciously agreed to provide a budget for food with the help of the ever-supportive Nancy Delanoche. On the day of the conference, 61 students were in attendance hailing from a wide range of medical schools, including Albany Medical College, Albert Einstein, American University of the Caribbean, Columbia, Cornell, SUNY Downstate, Duke, Philadelphia COM, Harvard, McMaster University in Canada, Mount Sinai, NYCOM, NY Medical College, NYU, St. George's, Temple, Touro COM, UCONN, Yale, and the Yale School

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Psychiatrist Profile—Dr. Elizabeth Childs**Shaping your Own Career in Psychiatry: A Life in Public Service”****By: Cristina Gioioso, MS4**

I was given the opportunity to interview Dr. Elizabeth Childs, a child psychiatrist currently on the National Advisory Mental Health Council of the National Institutes of Mental Health and former Commissioner of Mental Health for the Commonwealth of Massachusetts. My conversation with Dr. Childs enabled me to see how psychiatrists can create unique careers involving private practice and public service while living a full family life.

Dr. Childs knew early in her life that she wanted to become a physician when, at the age of twelve, she found herself the primary care giver to her terminally ill parents in a rural area of Ohio. After receiving an A.B. degree from Mount Holyoke College in Massachusetts, Dr. Childs pursued a medical degree from the University of Cincinnati College of Medicine. During her medical training, she was strongly influenced by her psychiatry professors to become a psychiatrist. She felt that “these were people she understood, and she would want to call her colleagues.” She also began to see a psychiatrist herself to help cope with the deaths of her parents and realized the great utility of therapy in people’s lives. During her clinical rotations, she realized that she was most interested in the psychosocial aspects of her patients’ care rather than other medical issues, and therefore, decided to apply for residency in psychiatry.

In choosing a residency program, she sought a program that would be the best fit for her and did not make her decision based on a “program’s cache.” She was drawn to Massachusetts Mental Health Center and began her residency in adult psychiatry in 1986.

She did not intend to become a child psychiatrist. However, the encouragement and advice of her mentors and certain experiences helped dictate her next steps in life. While she was a chief resident, someone told her that she was very

talented and that she would find it invaluable to work with children. Additionally, she had always felt an incredible pull to help children, and one rotation in particular with a child psychiatrist impressed upon her the pain and suffering that children can experience. After listening to the advice of trusted mentors, she went on to complete her training in Child Psychiatry at Massachusetts Mental Health Center and the Gaebler Children’s Center in 1992. According to Dr. Childs, “I always listened to my mentors, to the people I trusted and that walked down before me. My mentors opened up many doors that I might not have walked through without a little nudge, and by listening to them, I was able to avoid making many mistakes.”

Since her residency, Dr. Childs has taken on many different roles as educator, clinician, patient advocate, and public officer. In addition to her private practice, she became the Chief and Director of Psychiatry at the Carney Hospital in Dorchester, MA in 1996. She served as a consultant in child psychiatry at the Dana Farber Institute and Children’s Hospital, and worked as a child psychiatrist at the Massachusetts Institute of Technology Health Plan. Dr. Childs held academic appointments at the MA Institute of Technology, Harvard University, and the University of Cincinnati. Dr. Childs has also sought leadership positions within the psychiatry community serving as the president of the Massachusetts Psychiatric Society and as chair of its Legislative Committee. In 2003, she was appointed Commissioner of the Department of Mental Health in Massachusetts.

In addition, Dr. Childs enthusiastically describes her private practice as including all kinds of patients from young children through to the elderly. Her general approach to treating patients is to reach people wherever they are to help solve their unique problems and

employ various modalities such as psychodynamic therapy, cognitive behavioral therapy, and medication. She asserted that in psychiatry, “you have to be willing to see the most complicated individuals... if these people are not important to you as a psychiatrist then who else would be willing to care for them?” Her patients tend to be those with serious mental illnesses who require ongoing, pharmacologically-complicated regimens, such as bipolar patients, and those with multiple co-morbid issues such as addiction, familial problems, and learning and developmental disabilities. She sometimes employs complementary and alternative medicine in her practice and is also interested in what hypnosis can do for patients, and has referred people to acupuncture therapy. She finds learning about CAM is helpful to patients as many of them will approach her with various alternative treatments.

When treating children, engaging the entire family in the therapy and addressing parental concerns are paramount to successful outcomes. She said, “it can be difficult for parents to decide to use medication for their children, and this decision requires a great deal of thought.” She has the deepest respect for parents who want to do an empiric trial of another therapy when the current interventions are not enough to treat the child. She adds, “when you see these children - how much they are suffering - your heart goes out to them and you try to weigh all of the risk profiles and unknowns against what the child is going through. I find that the biggest problem in child psychiatry is not that we over medicate them, but that we do not provide continuous access of services. It is not sufficient to treat children with medication alone, you have to bring to the table anything that could help alleviate that suffering.”

Preparing for Your Residency Interview? Advice from Chief Residents

We get some of our most useful information from the Residency Education office staff. People should NOT "let their hair down" just because the residents or faculty are not in the room.

*Joshua Bess, MD
University of Michigan Health System*

Don't email the same list of 17 open-ended questions to EVERY resident whose contact information you have, expecting them to take 1.5 hrs out of their day to answer them. I offered to speak with this applicant on the phone, and answer her most important questions, but got no response. Don't do things just to "show interest" in the program.

Matthew J Ehrlich, MD, Cambridge Hospital

I think every residency has a certain culture which is usually apparent during lunch and observed interactions. I think the candidate fairs better when they see that culture and is able to adapt. Don't dress down: dress appropriately. Some may judge on the basis of this. Don't hog the question session yet don't be completely quiet either. Don't harp on questions that focus on the weaknesses of the program

*Geena Athappilly, MD
University of Illinois-Chicago*

What I tell applicants is something I learned while applying. Much like real estate, it's all about "location, location, location." You want to be in a town or city you're comfortable living in. It makes no sense to go to the "best program" if you hate the location. Residents will work enough hours a week; consequently, they need time for R&R. It should be spent in an environment the resident can enjoy!

Also, applicants should pay attention to the residents they meet. Consider this: the applicants will be working with this year's current interns. If they can't get along at an applicant dinner, then perhaps they won't be able to get

along while on call. I would also advise applicants to beware of programs where they don't meet many residents. Residents shouldn't be "hidden" from applicants. A program that needs to "hide" people might have more to hide as well.

Kurt Miceli, MD, University of Virginia

Medical students should be conscientious of their attire. Also I have heard that too much cologne or perfume has been an issue in some cases and is very distracting, especially to interviewers that may be sensitive or even allergic to strong perfumes.

Also, medical students should research the hospitals before going on interviews and if at all possible, try to get a roster of interviewing faculty on that day and research them as well. If you are knowledgeable about the program and faculty, it shows that you are very interested in the program and might give you a better shot at securing a high position on the rank list.

Nora San Diego, MD, UMDNJ-Robert Wood Johnson MS (Camden)

Be yourself above all. Try to find a balance between sensible self-disclosure when appropriate, and boundary awareness. A little "quirky" may be fine, but stay away from "weird." You want to be remembered but not that way. You'll have your personal story down pat after a few rounds of interviews. Be careful of falling into lazy patterns. Keep the interviewer engaged. You're not expected to have planned out your entire career by now. It's ok (and may be a sign of strength) to admit uncertainty.

*Christopher J. Oleskey MD MPH
Yale University School of Medicine*

I'd recommend that the applicants always be positive. The old adage that if you don't have something nice to say, then you shouldn't say anything at all. Hearing people bad talk their

school, other programs and the like makes me wonder about them as individuals.

I'd also recommend that applicants come prepared: This means knowing about the program, the city and the like. I understand that it can be a whirlwind few months, but knowing those pieces is important.

I'd recommend that applicants be themselves. Rather than trying to guess what side of themselves they should present, I'd advise applicants to relax and be comfortable and confident.

Don't be defensive. Certainly the interviews for residency have the reputation of being more benign, but if there's something in your application that needs to be clarified, expect that it will be fair game. Anticipate the question about your year off, any remediation, your transfer from one service to the next and the like and answer with poise as honestly and succinctly as possible. As an applicant, the invitation to interview is a showing of significant interest by the program in the applicant. At times, the interviews serve to just make sure the person will fit in and isn't a potential "problem child." As such, assume that what was in your application was strong, and continue in that regard.

*Jason Edward Rock, MD, MPH
Western Psychiatric Institute and Clinic*

Sincerity is key to effective communication, but don't ramble on with sincerity. Short, concise answers are often more sincere and convey conviction to your beliefs without apologizing or qualifying too much.

Nick Pejic, MD, LSU New Orleans

Candidates should inquire about creature comforts offered by the program, but should not focus on it as if it were the most important aspect of their decision making process.

Regine Bruny, MD North Shore HS

The First PsychSIGN Interactive Lecture Series: Psychotherapy, *continued*

of Nursing. Iman and Justin were lent a huge helping hand by Hope Cohen-Webb, a student at the New York College of Osteopathic Medicine whose voluntary assistance throughout the day proved invaluable to the two conference organizers!

The program opened with an enthusiastic introduction by Elizabeth Auchincloss MD, Director of Psychiatry Residency Training at Weill-Cornell. She traced psychotherapy's roots to its origins in exorcism, mesmerism, and hypnosis. She then discussed some of the struggles facing psychotherapy, including cost cutting by managed care and pressures to decrease exposure during residency training. However, she also included the good news that psychotherapy is becoming more of an evidence-based science, with growing support from increasingly sophisticated neuroimaging and other techniques. More good news included the ACGME mandate that residency programs provide adequate training for the different types of psychotherapy. Lastly, she discussed the vital importance of the physician-patient alliance, which comprises the very basis of psychotherapeutic practice.

The next speaker was Dr. Helen Verdeli, PhD from Columbia, who discussed her own research as it pertains to new trends in psychotherapy. She shared some of the fascinating work she has done in Africa on adapting psychotherapeutic practices to resource-poor nations, based on the "overwhelming demand for training and testing of evidence-based psychotherapies by NGOs and academic centers in other areas of the world." Dr. Verdeli was joined by Michael Devlin MD of Columbia for a panel discussion on cognitive behavioral therapy (CBT) and interpersonal therapy (IPT). To help illustrate CBT, Dr. Devlin used a case scenario of a college student with an eating disorder, then discussed how a CBT-trained therapist might approach such a patient. His talk about the history and theoretical basis for CBT was both entertaining and informative. Following

Dr. Devlin, Dr. Verdeli gave a presentation on IPT, after which the speakers took questions together.

Just before lunch, the students were treated to a surprise appearance by Deborah Cabaniss MD, Director of Psychotherapy Training at Columbia. She delivered a powerful missive on the importance of psychotherapy training and the joys of practicing psychotherapy. Afterwards, students were invited to have lunch (provided by the APA) and network with the speakers and their fellow conference participants.

Directly following lunch, Justin Chen gave a PowerPoint presentation about PsychSIGN's history, mission statement, membership, structure, and goals. He urged students to invigorate their own schools' psychiatry student interest groups and to get involved in PsychSIGN's national leadership. Subsequently, Panel 2 began with discussions of traditional psychoanalysis and supportive psychotherapy by Peter Dunn MD and Richard Rosenthal MD, respectively. Dr. Dunn gave an entertaining and free-form discussion of some of his psychoanalytic encounters with patients. Dr. Rosenthal chose a PowerPoint-based approach that was both engaging and incredibly informative, and which helped to stir many in the audience from their post-prandial slumber. With the time remaining, both speakers fielded questions from students, including to what extent different psychotherapeutic modalities can be combined or modified when working with patients in a clinical setting.

The program concluded with a joint talk by Drs. Rieder and Thakur (PGY-1 at Mount Sinai) regarding psychotherapy training in residency programs. Dr. Rieder spoke of the continuing role of psychotherapy in psychiatric practice, and gave practical suggestions regarding how medical students can evaluate which residency programs are supportive of psychotherapy training. Many students felt that this session was the most helpful of the day.

Based on preliminary analysis of the conference evaluations, the vast majority of students had positive responses to this program and were very interested in attending similar conferences in the future. The average rating given to the conference as a whole was 4.3/5. Suggestions by participants for future themes included forensic psychiatry, health care policy as it relates to psychiatry, stress reduction in medical school, psychoneuroimmunology, addiction psychiatry, and incorporating behavioral medicine into a non-psychiatric practice. With such a strong showing of medical students on a beautiful Saturday morning in September, the future appears to hold much promise for PsychSIGN in tackling some of these exciting topics and hopefully continuing to expand medical student interest in the field of psychiatry.

1. Mojtabi and Olfson. "National trends in psychotherapy by office-based psychiatrists" *Arch Gen Psychiatry*. 2008;65(8):962-970.

Psych Clerkship Pocket Cards

Available for free download from the APA website are **Psych Pockets Cards** covering the following topics useful during your clerkship:

- Mental Status Examination
- Management of Overdose
- Emergency Room Psychiatry
- Laboratory Screen
- DSM-IV-TR
- Psychiatric Interview

The 10 page PDF file can be downloaded from www.psych.org/students

Dr. Elizabeth Childs interview, *continued*

For this interview, I had specific questions about how she became involved in the public sector and organized psychiatry. For someone already so accomplished, I wanted to know what else she had planned for her career and her advice for medical students.

How did you transition from private medicine to the public service? “I always thought of myself as working in the public service. My residency was in a public service setting, and there was never a distinction in my career. When I left from my residency, I went to a private hospital (Carney) in a complex, multicultural community in Boston. Most of the patients that were served by this hospital were those using the public access insurance.” She always maintained a private practice that varied in size depending on the intensity of other aspects of her career. At one time, she had a practice where people would come to her home, patients who were more affluent, and had more resources. During this time, she realized the dichotomy of those who had access versus those that she saw in the public clinic. For the people without access, there was the need to intervene in different aspects of a person’s life, such as with special housing or school supports. Because of this, she always thought that part of her responsibility to the public is because the individuals in the public sector need so much more and that public service keeps you grounded in the real world.

What would you say are your greatest achievements as Commissioner for the Department of Mental Health?

- Building the first state psychiatric hospital in 50 years utilizing the finest examples of evidenced based architecture—that the success of interventions given to patients depends on the environment in which they are delivered.
- Seclusions: Enforced quality improvement mechanisms and more solid infrastructure across Massachu-

setts.

- Implemented an initiative in decreasing hospital readmission across public and private sector by advocating healthy lifestyles. Serious mental illness is one of the greatest health care disparities, and [patients with severe persistent mental illness] die 20 years younger than healthy individuals.
- Improved access and decreased the fragmentation of community mental health
- Improved child psychiatry access programs by implementing 24-hour telephonic access.
- Empowering clients and families to have a strong voice. Programs were established for training peer specialists and the first class graduated in 2007. These are individuals who are in recovery working in the mental health system who will work in peer driven organizations that provide support across the state.

What are some of the barriers in implementing the DMH Strategic Plan to improve the MA mental health care system? “Change is very challenging. However, you cannot stand still. It is hard to take risks, but if you don’t take them you will move backwards. Therefore, helping to manage change is the biggest barrier. The second major barrier is funding and as such, the need to employ broad stakeholder management.” She has been successful because of the tremendous mental health community in MA and by creating a strategic plan that many people were willing to implement.

What incentives did you use to engage community members and public figures in improving mental health in MA? “The most influential tactic is educating community members, especially by helping people to understand the cost. People are not surprised that if you don’t have access to effective outpatient mental health services, patients who are under-treated or untreated, soon find

themselves in mental health emergencies such as in emergency rooms and in jails.”

What led you to run for president of the Massachusetts Psychiatric Society in 2002? “[My] colleagues are very important to me - for support and good sounding boards. I used organized psychiatry for advocacy for patients and ourselves. I am on the most solid ground when keeping the patients’ best interests in the heart of the argument.

“People who are committed to the public and clinical care must be willing to take leadership positions. You need to be willing to make something better, and can’t wait for someone else to make it better. This is a responsibility that we all share.”

During your experience in leadership positions, what challenges did you encounter and how did you overcome them? “I am accustomed to being in leadership positions that have few women, both in state and the hospital and have not run into any major challenges, most likely because of the women who have come before who have paved the road.” She admits to having run into the occasional person who thinks that if you are a woman you are more emotional or less capable of doing your job.

How do you balance your career with two young children ages 7 & 5 years old? Does being a child psychiatrist influence your decision-making process as a mother and vice versa? “I am very fortunate to have a wonderful husband who is retired and can be at home with the children. I could not do my work without



Dr. Elizabeth Childs



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Dr. Elizabeth Childs interview, continued

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my whole family's support." However, her husband's and children's needs always come first, and although she can feel torn between career and family at times, there is no conflict. "But they know that what I do is to help people, and they help by being a little more flexible."

"I want to give my children a childhood, and I see so many children who don't. I have learned that children don't develop resiliency by everything being perfect but by learning about challenging situations. [My] goal is to have my children grow up being resilient."

In turn, being a mother influences her career, especially when evaluating a new program. She asks herself if such a program would be good enough for her husband or her children, and "if not then something about it has to change."

What are your future goals? "You do not have to be the Commissioner to do public service, whether in communities

or calling up the town government to say that you can be an emergency response physician. It is possible to do anything. The work does not change for me, only the titles." After resigning as Commissioner for the Department of Mental Health in Massachusetts, Dr. Childs will be serving on the National Advisory of Mental Health Council of the National Institutes of Mental Health. She will also be attending the Harvard University Kennedy School of Government to receive a Masters degree in public administration. She looks forward to continuing her work in public service. She is also looking forward to having more time with her children.

What is your advice for medical students looking to pursue a career in psychiatry? "Psychiatry is an incredibly exciting career and I would encourage everyone into psychiatry. This is not a career to make you rich in money but in spirit. If you think you are interested in psychiatry then get to know some col-

leagues from psychiatry, and you will get support."

What is a medical student's role in organized psychiatry? She would like to see more medical students involved in social issues. Not only are you helping the community, but this is also "how you are able to discover what psychiatry is all about."

Cristina Gioioso is a MS4 from the University of Massachusetts Medical School.

Attention Readers!

This is the final paper version of this newsletter. Future issues will solely be available as an e-newsletter and distributed by email and online. To receive the e-newsletter, send your request to education@psych.org.