

Newsletter

MEDICAL STUDENT



A Publication of the American Psychiatric Association

Committee on Medical Student Education

Finding your "Home"—Is Psychiatry for You?

By: **Brenda Roman, M.D.**

I entered medical school with the conviction that I would some day be a pediatrician, and that conviction was unchallenged until my third year, when I discovered that for me, outpatient pediatrics offered little excitement. The inpatient part was better, although I realized that I was more fascinated by all the social and family aspects of the infant I cared for who had one of the first liver transplants, than by the machines, calculating I/O's and reading about the pathophysiology of his liver failure. After that initial rotation, I felt lost....and that feeling continued in the psychiatry clerkship. I just didn't enjoy working with the severe behaviorally disturbed children on the child and adolescent unit, plus I felt little connectedness to the residents or attendings. Although I enjoyed surgery, I couldn't see myself as a surgeon many years later. Then I finally fell in love with internal medicine, under the leadership of a wonderful chief resident and a kind attending. I was so relieved to have found my home in medicine, and planned my fourth year accordingly. I began searching residency programs, and planning for my rotations in Tanzania after interviewing would end.

Life was going along smoothly as I did my cardiology rotation, infectious disease rotation, and then my junior internship in internal medicine. And then, on a Sunday afternoon, while talking with my patient who was dying of cancer, I was drawn to his life stories and the various complications that his death would bring, in a way that I had never been before. Although the psychiatry consult team had been involved for several weeks, I had only glanced at their notes, more interested in what the oncologist recommended. My patient was sharing his wisdom about "go after a career with passion, no matter what others might think of you." For the first time, I began confronting my own stigma of mental illness and psychiatry. "You are too smart to consider psychia-

try....psychiatry isn't a real field of medicine....all the patient's are hopeless and crazy." I sought out the consultation/liaison psychiatrist at the university, and began to see psychiatry in a different light, and most importantly realized that maybe that area was truly my "home". I completed a psychiatry elective, but I was still waging an internal battle about the direction I wanted to take. Although I interviewed in both psychiatry and internal medicine programs, ranked a psychiatry residency as my number one choice, and internal medicine program as my second, the passion for the field of psychiatry was growing. In the end I was thrilled to get my top choice, and completed a psychiatry residency with no regrets about my chosen field.

My journey is not unique—most students decide to enter psychiatry as a result of their clerkship experience, never dreaming that they would join the ranks of psychiatry. Psychiatry is exciting, as one can tailor a career to one's interests. Described in this newsletter are several areas of "subspecialty psychiatry"...and even most 'sub-specialists" end up involved in multiple areas of psychiatry. This list is not complete, as geriatric psychiatry is also a much needed area of expertise, especially as our population ages. Rather than provide you with an exhaustive list of career options within psychiatry, I asked psychiatrists to share their passion in psychiatry. The goal is to "tweak" your interest, to encourage you to find that area of medicine that excites you, to seek out mentors in the field, and to enter this fascinating area of medicine!

I now identify myself as an academic psychiatrist, since my primary responsibility is Director of Medical Student

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Education in Psychiatry. My clinical interest is in psychotherapy, women's mental health and trauma. I am branching out in some areas of clinical research with an infertility specialist, so there is always more to explore. And thus far, I feel I maintain a reasonable balance in my life, working four days a week, so that I can make family time for my surgeon husband and two sons.

I am glad I listened to my patient long ago, and that a consultation/liaison psychiatrist who barely knew me took time to offer solid advice. Thanks to them I found my home in medicine. It is an exciting career!

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It's not the couch—The Art of Psychotherapy

By: Brenda Roman, M.D.

Can a psychiatrist do psychotherapy? Absolutely! Most students seem surprised by the answer, but even with my “pharmacological management” patients, I engage in basic psychotherapy techniques. My primary practice, however, is focused on patients on weekly or twice weekly psychotherapy.

What exactly is psychotherapy? In broad terms, psychotherapy involves a therapist (healing agent), a patient (sufferer) and a healing or therapeutic relationship. Psychotherapy is the systematic use of a human relationship for therapeutic purposes of alleviating emotional distress by effecting enduring changes in a patient’s thinking, feelings and behaviors.¹ For effective psychotherapeutic work, both patient and therapist must be highly motivated and engaged.²

There are many different types of psychotherapy; common to all forms is the fact that the therapist must engage with the patient by accepting the subjective experience of the patient’s emotional pain and conflict. This can only be done through the establishment of an empathic and non-judgmental therapeutic rapport.³ As the therapist listens, he/she will develop an understanding of the intricacies of the patient’s life. In psychodynamic therapy, sharing an understanding of the patient in an interpretive mode sets the stage for insight and changes in the patient’s life. Cognitive behavioral therapy (CBT) and interpersonal therapy (IPT), have solid research efficacy in the treatment of various depressive and anxiety disorders at rates that rival medication. Imaging studies have shown that the same areas of the brain activated by medication for certain disorders is also activated by psychotherapy – so this whole field is not just hocus-pocus! Psychotherapy also positively affects the immune system; indeed the neurobiology of psychotherapy is fascinating.

What excites me the most about engaging in psychotherapy is the tremendous opportunity I have to get to know my patients in a way few physicians ever do—I am privileged to learn and understand their pain, fears, hopes, and dreams! Since psychotherapy can be a long term relationship (I’ve had several patients for over 10 years) I marvel at the impact that I can have on the lives of many through the life of my patient – spouse, parents, children, and co-workers. For example, in helping a patient understand the consequences of childhood sexual and physical abuse, the patient felt she was able to mother far more effectively, stopping the cycle of abuse that had been a part of her own history. Likewise, struggling with the hopelessness of a suicidal patient can be emotionally draining, yet the satisfaction of literally saving a life is enormous. Most rewarding is noticing a pattern in a patient’s behaviors, which generally is rooted in the unconscious mind, offering a well-timed interpretation that provides an “ah-ha” experience for the patient, enabling a process of self-reflection and tremendous change.

Additionally, the excitement comes from the fact that each case is unique – I may end up treating with same antidepressant, but everybody’s story is different, and everyone responds uniquely based on their life experiences. Lastly, I learn from my patients. If similarities exist between their story and mine, I may be more challenged to remain objective, due to my countertransference (feelings that I have towards the patient), but through exploration of their issues and feelings, I may have a better understanding of my own. Likewise, I have come to understand the emotional pain of human life in a way never imagined – from working with a woman who committed infanticide to impaired physicians to men who have committed acts of domestic violence. I don’t judge, but seek to understand, which

ultimately enables me to help my patients understand their emotional pain, setting the stage for long lasting change.

Psychotherapy is an “art” in the “practice” of medicine. For this reason, training to be a highly skilled therapist requires much supervision, evaluation of skills via direct observation and a willingness for self-observation, including the therapist’s own experience of being in psychotherapy. One can become a competent therapist through training in a residency program that emphasizes psychotherapy education. However it is a skill that is not simply learned in residency – it involves lifelong development of skills. This can be attained through formal programs, such as analytic training or advanced psychotherapy certificate programs, or informal training through continued case supervision, course work, reading literature on the subject, and, of course, being open to learn in daily practice from your patients.

Indeed, for me, psychotherapy is the most exciting and rewarding aspect of my psychiatric practice. My patients have sought out a psychiatrist to provide the psychotherapy often in addition to medications, because they were dissatisfied with the “split model of care” in which a psychiatrist only provides pharmacologic management. I am truly honored that I have been able to help patients through the “art of psychotherapy.”

1. Frank JD and Frank JB (1991) *Persuasion and Healing: A comparative Study of Psychotherapy*, 3rd ed. Johns Hopkins University Press, Baltimore.

2. Strupp HH (1986) *The nonspecific hypothesis of therapeutic effectiveness: A current assessment*. *Am J Orthopsychiatry* 56, 513-552.

3. Kay J and Kay RL (2003) *Individual Psychoanalytic Psychotherapy*. In: *Psychiatry*, 2nd ed, volume 2, pages 1699-1718.

Not Guilty by Reason of Insanity: How Forensic Psychiatry Works

By: Carl Greiner, M.D.

The standard version of forensic psychiatry is based on headline-grabbing cases where there has been a vicious murder and the defendant is claiming to be “not guilty by reason of insanity.” Battling psychiatric experts will provide opinions to a jury regarding the presence or absence of mental illness in the defendant. A relevant question would be whether or not the defendant was malingering mental illness in an attempt to escape going to prison. This image is exciting and consistent with the Crime Scene Investigation (CSI) fascination of current culture.

Although forensic psychiatrists are involved with high profile cases as mentioned above, the bulk of the work is important but not high profile. It is helpful to remember that the root of forensic is the Roman “forum”; that is, dealing with public and legal matters.

Three major tracks exist for the practice of a forensic psychiatrist. One may choose to work in a forensic setting such as a hospital for those who have been found to be “not guilty by reason of insanity.” The psychiatrist’s work would be similar to general hospital work in providing psychiatric care to improve the patient’s mental health. Here the psychiatrist would be functioning in a doctor-patient relationship. The forensic training would assist in understanding the legal context of the patient’s being placed into mandatory hospitalization. Release from the hospital is based on the patient’s resolution of dangerousness. The patient in a forensic hospital typically spends more time than if he were found guilty of the crime.

The second track involves a doctor-patient relationship. Psychiatrists who work with the chronically mentally ill may need to commit patients for

“dangerousness to self or others.” These psychiatrists benefit by having an expanded sense of the law. A stronger legal sensibility is helpful in dealing with problems such as right to accept and refuse psychiatric treatment.

The third track is to work as a consultant to an attorney or the courts. The typical work of a forensic psychiatrist is in assisting more complex matters of competency to stand trial, making of a will, or ability to manage medical affairs. In each case, the psychiatrist needs to clearly define the question that needs to be answered. For example, an elderly individual with moderate dementia might easily make a decision whether or not to spend \$250 to buy a gift for a granddaughter but not be able to decide how to divide a business that has multiple sites and complex operations. In each case, the forensic psychiatrist will provide an opinion. The psychiatrist does not make the ultimate decision regarding competency. The judge will make the final decision if the defendant/patient is competent to manage his affairs.

In the consulting role, the forensic psychiatrist examines the patient, reviews prior medical and social history, discusses with family (if the patient has given consent), and asks for additional psychological screening if necessary. One way to imagine the forensic psychiatrist’s work is as providing an objective viewpoint that synthesizes an extensive number of facts. Unlike the role of a treating psychiatrist to heal in the context of a doctor-patient relationship, the forensic psychiatric provides an opinion on a specific question such as mental illness. The forensic psychiatrist is a consultant with the consumer of the information being the court.

To become a forensic psychiatrist, the physician must first com-

plete a general psychiatry-training program. A one-year forensic fellowship allows the physician to gain experience with both civil cases (such as injury cases where the penalties are financial) and criminal cases (where the penalties may be both financial and imprisonment). A rigorous reading program of “landmark legal cases” in the United States is required. The willingness to present one’s opinion in court and be cross-examined is essential; the experience is not for the faint hearted. The American Board of Psychiatry and Neurology provide board certification examinations.

Being a forensic psychiatrist is intellectually rewarding. Translating psychiatric concepts for the judge and jury is a major task. Addressing the specific issues of a particular mental illness and how it might impair judgment requires a balanced perspective and a willingness to write carefully. Reviewing legal traditions requires some knowledge of history. Interest in political science, law, or ethics will provide additional incentive to study forensic psychiatry. The student who enjoys interdisciplinary work could feel comfortable with the challenges.

A more detailed review of competency and “not guilty by reason of insanity” can be found in most standard psychiatry textbooks. This author particularly enjoys Paul S. Appelbaum and Thomas G. Gutheil’s text, *Clinical Handbook of Psychiatry and the Law, Second Edition*. The American Academy of Psychiatry and Law has lively annual meetings where newer issues in forensic psychiatry are addressed. The APA has regular presentations, including the Manfred S. Guttmacher lecture, at the annual meeting.

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Psychiatrists...may need to commit patients for "dangerousness to self or others" ...

Addiction Psychiatry: Is It For Me?

By: Justin Trevino, MD

As you consider career choices in medicine, remember these points: use of substances (broadly defined to include all substances of abuse including alcohol and nicotine) is associated with a great deal of morbidity and mortality (deaths attributed to cigarette smoking and alcohol use are 400,000 per year and 100,000 per year respectively), substance use disorders are high frequency disorders, and numerous prescription medications (narcotic analgesics, benzodiazepines, stimulants, etc.) have the potential for misuse and abuse. Experience in addiction psychiatry places you in a position of knowledge that few of your colleagues will possess. While most will know of substance use and misuse as common problems and complicating factors in illness states, they do not typically possess in-depth knowledge of the specific actions of substances, the medical and psychiatric conditions associated with their use, and the strategies used to address substance use issues in short and long-term treatment settings. Addiction psychiatry skills are needed in a wide variety of medical and psychiatric settings. Addiction psychiatry is a field in which the knowledge base is expanding greatly. Both medical and psychosocial aspects of treating addiction have undergone a great deal of refinement in the last decade. Yet, there remain a myriad of issues in the field that require more study, from basic science issues (drug activities, drug effects on the central nervous system) to issues important in the clinical care of substance-using patients (how best to engage them and deliver treatment, as well as new pharmacotherapies to promote abstinence). Addiction psychiatry training is pursued following completion of residency training in general psychiatry. A fellowship experience of one year is required to sit for the initial American

Board of Psychiatry and Neurology (ABPN) certification examination (a written exam). The fellowship typically includes a mixture of supervised clinical experiences in a variety of settings as well as some research experiences.

Certification in addiction psychiatry provides a physician with increased work opportunities. As an example, a large percentage of patients with persistent mental illness have involvement with substances, and community mental health agencies greatly value the input of a psychiatrist with specific training and experience in addictions. In general medical settings, the opportunities to work with internist and family practice colleagues in the care of substance-using patients provide the addiction psychiatrist a chance to bring the increasingly specific knowledge of both psychiatric and substance use disorder treatment to physicians who may view these disorders as frustrating and not treatable. Certainly, many addiction treatment agencies value the input of a psychiatrist equipped with the knowledge to sort out the effects of differing combinations of mental illness and substance use and the experience to utilize psychotropic medications judiciously and effectively.

The virtue of patience is probably one that is necessary to work in the field of addiction psychiatry. Addiction issues are typically chronic and progress often occurs slowly over extended time periods. Relapse to substance use is a typical occurrence in the course of treatment and the ability to continue to impart hope and assist patients in strengthening motivation and problem-solving are core skills needed by the addiction psychiatrist. I found that I entered this field with hopes

of leading patients toward change with abstinence in a linear and timely manner as the marker of treatment success. As I worked with these patients, I had to confront my views on the nature of chemical dependency as a valid and significant medical condition, a true “brain disease” versus that of voluntary, willful behavior engaged in to relieve the stresses of life. I continued to listen closely to the stories of substances ruining marriages, family relationships, work careers, health and well-being, and becoming the only focus of life for some patients. I came to recognize the power of addiction to “hijack” the brain’s motivational and reward circuitry to the extent that substances become the preferred reinforcers for substance dependent individuals, replacing meaningful relationships and activities in this regard. Becoming more familiar with new models of treating substance use problems, particularly the Stages of

Change model, have assisted me in viewing addiction as a problem faced by an individual that can be addressed once the individual is ready to address the issue. This model proposes that the role of a clinician is to assist a person in developing motivation for change, that change occurs in stages with identifiable behavioral and cognitive markers, and that regression to earlier stages of change is a natural occurrence in any meaningful change process. I have found working

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APA Annual Meeting in Atlanta May 21-26, 2005 Free for Medical Students

Are you considering psychiatry as a career choice or just a little curious about the field? One of the best ways to learn about the latest in the diagnosis and treatment of mental health disorders and meet the leaders in the psychiatric field is to attend the American Psychiatric Association Annual Meeting—the premiere psychiatry meeting in the world!

Held this year in Atlanta, the meeting hosts upwards to twenty thousand attendees for 5 days of fun and education. The theme for this year is “Psychosomatic Medicine: Integrating Psychiatry and Medicine.”

As a medical student, your registration to the meeting is free! Visit the meeting webpage at www.psych.org/edu/ann_mtgs/am/05/index.cfm for more information on various events going on at the meeting, housing, etc.

Whether you come to meet your future residency training directors, network with residents and your future colleagues, or to just learn what new in the field, the APA Annual Meeting is the perfect place to do all these and much more. We hope to see you there!



Committee on Medical Student Education

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Nancy Delanoche (Staff Liaison)

Addiction Psychiatry, continued

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with patients to motivate change a much more meaningful and realistic process than struggling with a person to enact change when she/he is not motivated to do so. Celebrating small successes patients have made in feeling better, functioning better, and possibly, in reducing substance use has given me more satisfaction as a helping professional than viewing anything short of a commitment to total substance abstinence on the part of a patient as a failing of the treatment process.

To gain awareness of the field of addiction psychiatry, I would suggest the following steps:

1. Arrange learning experiences with an addiction psychiatrist.
2. Gain access to one or more comprehensive textbooks in the field.
3. Take advantage of the impressive array of resources on substance use problems available on the Internet,

including NIDA (National Institute of Drug Abuse), NIAAA (National Institute on Alcohol Abuse and Alcoholism), and SAMHSA (Substance Abuse and Mental Health Services Administration).

Consider joining an organization devoted to members of the subspecialty such as AAAP (American Academy of Addiction Psychiatry, an organization of psychiatrists only) or ASAM (American Society of Addiction Medicine, an organization open to any medical specialist interested in addictions).

Addiction psychiatry is an exciting, rapidly developing field. Opportunities abound in the area at this time in both research and patient care settings. Given the impact of substances on the health of our nation's population and the need for more clinicians who are knowledgeable in this area of medicine, an interest in addiction psychiatry will be enthusiastically sup-

ported and encouraged by those you contact in the field. I would certainly encourage your consideration and investigation— you may be quite surprised at the level of sophistication of the field, the need for such services in medical settings, and the impact you could potentially make on patient care and the health of a community.

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WEBSITES:

AAAP—www.aaap.org
ASAM—www.asam.org
NIDA—www.nida.nih.gov
NIAAA—www.niaaa.nih.gov
SAMHSA—www.samhsa.gov

The Community Psychiatrist as a Healer

By: Ann Morrison, M.D.

The idea of caring for people affected by the most severe and disabling psychiatric illnesses such as schizophrenia may seem depressing and draining, but my work with these individuals and their families is inspiring. My patients suffer from devastating illnesses, but the ability to help them reclaim their lives and recover from serious mental disorders is the reward that awaits the community psychiatrist. Ironically, illnesses that at times cause my patients to lose the ability to think clearly, to suffer tremendous fear and alienation, to endure melancholic depression or manic excitement also offer opportunities for displays of strength and survival that equal any battle against life threatening medical disorders. Indeed for many of my patients they are in a life and death struggle.

While the day to day work of the community psychiatrist may not have the surface excitement and drama of the emergency room or operating suite, it is the development of relationships with patients and the provision of effective psychiatric treatments that can help patients survive this struggle and recover from their illnesses. There are no flashing lights and sirens, no fancy machinery to master and wield in the community mental health center, where patients with schizophrenia often present in a frantic, frightened, mistrustful state; rather, the emergency treatments and techniques needed are one's calm caring presence and persuasive powers. Forming alliances with patients and families to see them through these worst of times as well as cope with the lingering battle with chronic symptoms is key.

In addition to the core challenge and rewards of developing these therapeutic relationships, community psychiatry also offers one the oppor-

tunity to work with a team. Nurses, case managers, therapists, housing providers, vocational specialists and others are all needed to help people with schizophrenia and other serious mental illnesses reclaim their lives in the community. Community psychiatry is not for the isolationist or the autocrat, but if one is able and willing to both provide leadership and accept assistance from others, community mental health centers are a great place to work. Being part of a hardworking, competent, compassionate team helps keep one's own morale high.

Community psychiatry will also allow you to take psychiatry out of the office, to homes, schools, shelters, and jails. Getting out from behind the desk gives one a more complete appreciation of patients strengths and skills and allows you to see the whole person, not simply the symptoms described in the office. It can also highlight those areas in which the person needs more assistance.

Community psychiatry also offers other roles and tasks for physicians, including administrative duties such as clinical supervision, program and service development, implementing policy and procedures, and budget decisions.

In "The Community Psychiatrist: Skills and Personal Characteristics,"¹ Leonard Stein reviews his experience in community psychiatry spanning three decades. He lists the skills needed as that of: 1) general physician, 2) excellent, broad clinical skills, 3) knowledge of psychodynamics, 4) crisis resolution, 5) administrative skills, 6) knowledge about systems and being a team player, and 7) knowledge and sensitivity about ethical issues. The personal characteristics he feels are essential are: 1) ability to effectively cope with illness, 2) the

ability to be a dreamer and pragmatist, 3) an egalitarian approach, and 4) a social conscience. In short, it requires one to use not only scientific knowledge but also social skills and humanistic values effectively.

Not a day goes by in my clinics when someone doesn't say how happy they are to be able to work; how proud they are to have been able to live at home and stay out of the hospital or to have recognized that they needed to go to the

hospital; share pictures of their children, grandchildren, or wedding; talk with joy about ordering seeds for their garden or crocheting for their family. In short, one shares peoples' lives in times of strife and success and is able to provide effective treatments to help them overcome their trials. For me, this is the essence of a being a physician and healer.

Personal characteristics: ability to effectively cope with illness, ability to be a dreamer and a pragmatist, egalitarian approach, and a social conscience.

Reference:

Stein LI (1998) The community Psychiatrist: Skills and Personal Characteristics. Community Mental Health Journal 34(4), 437-445.

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The Rewards of Child and Adolescent Psychiatry

By: Jill Carley, M.D.

I love my job. Now, just how many physicians have you heard that from since the start of training? As a medical student, I noticed that I didn't seem to hear it enough and wondered why. I think I got at least part of the answer when I queried a psychiatry resident during my clerkship—but not just any psych resident. I chose to ask Greg, a resident who had been a practicing anesthesiologist for many years prior to returning to complete a general psychiatric residency. Basically, my question to Greg was, “How do I keep from making the mistake you did? How do I choose the right specialty for me?” He thought for a moment and then replied, “You have to go with what puts the fire in your belly. You can't base the decision on your innate talent alone, because even if you have talent, everybody else will catch up in a little bit. Then what do you have? But if you've got that fire in your gut about whatever it is you are doing, even when things change, you'll have the drive to move along with the flow.”

I took his words to heart and have passed them onto other students whom I taught in the years to come. It was his advice that helped me be able to say, enthusiastically, “I love my job” today.

As a child and adolescent psychiatrist (CAP), I have a busy schedule-- a schedule which also happens to demonstrate several of the varied opportunities available to those who chose to pursue a career in the field. For most of my time, I am the school psychiatrist for two public sector “learning centers.” These learning centers focus on care for children who have mental or behavioral challenges such as ADHD, depression, bipolar disorder, PTSD, etc. Appointments are usually attended by the child, a parent, the teacher and the child's school-based therapist, and sometimes the child's community case manager. In this way, information can be gathered from many areas of the child's life, in order to gauge general progress and functioning level. To do this, we as a

team delve into the child's developmental, school and social history. I am able to do classroom observations, as well, which helps guide treatment planning. Treating a child should never be just prescribing a medication, but also needs to involve consideration of other factors in a child's life that impact the child's clinical condition and overall functioning.

In addition to the school-based clinic, I also see patients at a community mental health clinic, as well as spending some time each week supervising and lecturing medical students and psychiatric residents. For a few hours a week, I can also be found at a crisis center, where children and adolescents who are in acute need of treatment can get evaluated quickly and treated for a short time while they get linked to community resources.

The process of getting a patient linked to these services can be quite challenging, as there simply are not enough child and adolescent psychiatrists to go around. According to the American Academy of Child and Adolescent Psychiatry (AACAP), there are about 7,000 practicing child and adolescent psychiatrists in the US currently, with an estimated need for over 33,000. This is a need expected to grow substantially in the next 20 years, as well, as almost 20% of children aged 9-17 years old have a diagnosable mental health condition.

In a practical sense, I see this everyday and experienced it all through my training. The need in the community is palpable, and it is not unusual for a child to wait for 3-4 months prior to an intake appointment. On the flipside, long before I graduated, eager administrators were asking me where I wanted to practice when I completed training.

The opportunities were dizzying. Aside from what was already mentioned, there are vast needs for child and adolescent psychiatrists to teach

and do research, to open private practices, to run inpatient or residential treatment centers, or do consults for children hospitalized for other medical needs.

Not that what I do is easy. To hear some of the worst stories of abuse or neglect while looking into the eyes of the child victim is anguishing. But I can take heart in that now, this child is able to get help. His presence in my office signifies that finally, someone has recognized and accepted the fact that the child is in dire need. This first step in accepting treatment, although difficult, is often a pivotal one for families. The child sitting in my office now has a chance to turn it around and make his life better from this point forward. And that is the part of my job that I love the most, to see a child return after several visits smiling and tell of his recent accomplishment, whether it is advancement to the Honor Roll or finally setting a goal for the future, for perhaps the first time ever daring to hope that there *is* a future.

Dr. Jill McCarley is currently an assistant professor of psychiatry at Wright State University, Division of Child & Adolescent Psychiatry.

ParentsMedGuide.org

A large coalition of medical and family/patient advocacy organizations launched ParentsMedGuide.org, a new resource center for parents of children and adolescents with depression. A focal point of the site is a fact sheet called “The Use of Medication in Treating Childhood and Adolescent Depression: Information for Patients and Families” – practical advice for parents endorsed by more than a dozen national organizations.

In addition, the site contains a fully footnoted Physicians Medication Guide, written for frontline physicians, who have joined with parents to seek more accurate information about pediatric depression, treatment alternatives, and the latest science and research findings.



Medical Student Newsletter

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Association of Academic Psychiatry

By: **Don Hilty MD, AAP President, UC Davis**

John Burruss MD, Chair, AAP Medical Student Section, Baylor

What is the Association for Academic Psychiatry (AAP) and why should I know about it? This article will describe the AAP, its activities, and items of interest for you as medical students.

As you consider psychiatry as a specialty, also consider academics and teaching as something you might want to be involved in, whether on a full or part time basis. The AAP is an international organization which focuses on teaching skills, mentoring, leadership, and technology. Its most special attribute, though, is the warm atmosphere of the Annual Meeting, characterized by trust, openness, sharing of ideas without pretense, support, energy, and collaboration. It is a conducive environment to learn and think about career development.

The Annual Meeting is based on interactive learning: developing skills in

workshops with practice; options to present works-in-progress (e.g., projects, ideas for new organizations, papers); and open-ended discussions. Only rarely is lecture allowed. One can learn independently, in pairs, and in groups. We also have a night out on the town for fun.

This year's Annual Meeting is entitled "*Maximizing Our Academic Capital: New Inroads from the Fields of Business, Social Anthropology, and Technology.*" It will be held September 28—October 1, 2005, in Chicago, Illinois. Dr. Michele Pato and the Program Committee will bring in speakers from all around North America and, as usual, AAP members will take the lead with workshops and other presentations.

The AAP Medical Student Section helps faculty, residents and students learn how to learn and teach, as

well as discussing contemporary issues in education. A mentor and/or role model can be assigned based on interests or future plans. This is particularly helpful for those thinking about an academic career in psychiatry or in medicine in general.

Please contact us with questions (dmhilty@ucdavis.edu or jburruss@bcm.tmc.edu), or visit our web site at www.academicpsychiatry.org for general information, to visit streaming video resources, or check out the Annual Meeting. Come share your creativity and interest in learning at AAP!