

## ATTACHMENT E

### GENERAL TRAINING OBJECTIVES FOR POSTGRADUATE YEAR 1

- A. The continuing postgraduate development of primary medical skills. Important elements of this training include:

Gaining experience in selected areas of primary care medicine.  
Gaining experience in the triage of medical patients with referral to appropriate subspecialty physicians.  
Further development of skills in treatment of medical emergencies.  
To develop an increasingly firm sense of the resident's identity as a physician.

- B. To gain increased skill in understanding and dealing with behavioral aspects of medical/surgical patient problems.

- C. To demonstrate, through clinical performance, the attainment of the following skills and knowledge:

Interviewing techniques, including how to obtain a complete biopsychosocial history from a patient in psychiatry, how to perform a complete mental status examination, and how to understand both verbal and nonverbal communication between doctors and patients.

Psychiatric diagnostic skills, including an understanding of the five axes DSM-IV classification of psychiatric diagnosis, how to form a differential diagnosis after initial evaluation of the patient, and how to organize, present, and write up their findings. Residents should be familiar with the diagnostic criteria for all mental disorders listed in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition.

Basic psychopharmacology, including an understanding of clinically relevant neurochemistry and neurophysiology, and a basic understanding of the pharmacology, indications, clinical usage, side-effects, and drug interactions of antipsychotics, antidepressants, antianxiety drugs, and mood stabilizers.

Emergency psychiatry, including an understanding of the emergency assessment of suicide potential, medication and medical clearance issues in an emergency room setting, legal issues including commitment procedures, chemical dependency issues in an emergency room setting, crisis intervention, intervention skills with potentially violent patients, and psychiatric manifestations of acute medical illnesses.

Issues in medical economics and managed care, including understanding of the financial, legal and ethical aspects involved in the current system of health care delivery and financing in the United States.

## GENERAL TRAINING OBJECTIVES FOR POSTGRADUATE YEAR II

A. Skills - by the end of the residents' second year of training we expect them to be able to demonstrate, through clinical performance, the ability to do the following:

To conduct comprehensive psychiatric interviews.

To make use of appropriate laboratory examinations, psychological testing, and other consultations as indicated in the work-up psychiatric disorders.

To make accurate psychiatric diagnoses and thorough evaluations of presenting problems.

To formulate treatment plans and to implement them while in close consultation with supervisors.

To gain knowledge and experience in the use of psychopharmacological agents.

To conduct supportive psychotherapy with growing awareness of psychodynamic issues.

To have some awareness of countertransference problems as they influence interactions with patients and to learn to deal with them constructively.

To work harmoniously within a milieu consisting of nurses, social workers, psychologists and other mental health personnel in information gathering, treatment planning and implementation of therapeutic meetings.

To take an active part in teaching third year medical students

Conduct and/or participate in inpatient group therapy meetings.

To begin to apply basic principles in the administration of electroconvulsive therapy.

To begin to apply principles of insight oriented psychotherapy to selected outpatient cases.

B. Knowledge - by the end of the residents' second year of training we expect them to be able to discuss the following:

The nature of psychiatric data, including phenomenology and frames of reference. Indications, values, and limitations of psychological testing including the Rorschach, WISC, MMPI, TAT, Goodenough Draw-a-Man test, and Bender-Gestalt.

Methods for distinguishing between organic and functional processes, as well as their interactions.

Etiological explanations for the psychoses

Basic concepts of psychoanalytic psychotherapies including Freud and those who split from him, Kohut, Sullivan, and ego-psychology.

Basic concepts of psychotherapy including the differences between psychodynamic, cognitive-behavioral, experiential and family systems paradigms, the difference between directive inquiry and collaborative exploration, how to track associations, dual reference in language, parameters of treatment, transference and countertransference, identification of conflictual themes, and how to evaluate the response to interventions.

Psychological concepts of personality growth and development

Selected aspects of neurobiological basic sciences including neurotransmitter receptor physiology, molecular genetics, and brain imaging.

How to critically evaluate the merits and limitations of scientific literature including an understanding of basic research design issues, the difference between descriptive statistical measures and inferential statistical measures, measures of association, and the concepts of sampling, independent and dependent variables, randomization, reliability and validity.”

Basic concepts in cultural psychiatry, including an introductory understanding of American cultures and subcultures, and of cultural differences among various ethnic groups.

Psychological aspects of physical diseases including epilepsy, respiratory disturbances, chronic pain, endocrine disorders; introductory understanding of psychoimmunology.

Growth and developmental processes of children and adolescents and the implications for adult psychological functioning.

Neuropsychiatric disorders including neurodiagnostic techniques, cortical and subcortical dementias, vascular dementias, neurotoxic syndrome, AIDS Neurobehavioral disorders, subcortical structures and neurobehavioral disorders, memory disorders, frontal systems dysfunction, and psychiatric aspects of traumatic brain injury.

## GENERAL TRAINING OBJECTIVES FOR POSTGRADUATE YEAR III

### Training Objectives for the Adult Outpatient Clinical Rotation:

To improve and practice clinical interviewing, diagnostic, and case formulation knowledge and skills in an outpatient setting.

To increase knowledge of basic psychotherapy theories and techniques. At the conclusion of the rotation, residents should be able to describe, compare, and contrast theories and techniques from psychodynamic, cognitive, behavioral, experiential, interpersonal, family systems, couples, short-term, and group psychotherapies. They should be able to make use of a wide variety of psychosocial interventions, tailored to the individual's psychopathology. They should exhibit an understanding of transference and countertransference phenomena. They should understand various psychotherapeutic approaches to severe personality disorders. They should demonstrate, through clinical performance on videotaped psychotherapy sessions, basic skill in the following types of psychotherapy: psychodynamic, cognitive-behavioral, brief, supportive, and combined psychotherapy with psychopharmacology.

To understand and administer pharmacotherapy in an outpatient setting. At the conclusion of the rotation, the resident should have gained experience and demonstrate competence in the longitudinal administration of a wide variety of pharmacological agents. Residents should be able to plan drug treatment with an understanding of the nature and time course expectations of both therapeutic effects and side effects of antidepressants, sedative-hypnotic agents, mood stabilizers, and antipsychotic medication. They should be able to monitor patients for adverse medication effects and manage drug-drug interactions. They should be skilled in techniques for improving patient compliance with drug therapy. They should be able to integrate pharmacotherapy and psychotherapy when indicated.

To demonstrate the ability to serve as pharmacotherapy consultants for non-medical therapists.

## GENERAL TRAINING OBJECTIVES FOR POSTGRADUATE YEAR IV

To encourage a systematic integration of the multiple training experiences into a rational, eclectic approach to mental health and mental disorders

Residents are to gain broader experiences in consultation to physicians, other health professionals and a variety of social agencies

The residents are to receive training in dealing with selected patient populations such as the elderly, the economically disadvantaged, and forensic patients

During the fourth year special emphasis is placed on further development of teaching skills, both with junior residents and medical students

The residents are encouraged to identify and pursue their own special interests within the broad field of psychiatry

Knowledge: by the end of the residents' fourth year of training, we expect them to be able to discuss the following:

Systems-based and community psychiatry, including historical and organizational perspectives, psychiatric services, organizational and administrative theory, leadership and training, facility management and budget, deinstitutionalization, the community mental health center, the changing role of the state hospital, and psychiatric aspects of homelessness.

Forensic psychiatry, including the ability to discuss ethics, civil commitment, medical malpractice, duty to third parties, patient rights, physicians as expert witnesses, confidentiality, informed consent, insanity and diminished capacity defenses in criminal proceedings, and court-ordered psychiatric examinations in criminal proceedings.

Clinical hypnosis, including history, theoretical background, indications and contraindications, induction techniques, and case management.

Geropsychiatry, including normal and abnormal aging phenomena, differences in manifestations of depression, paranoid syndromes, and organic mental disorders in geriatric populations, and community resources for geriatric patients.

Sexual dysfunctions and therapy, including classification, etiology and therapeutic techniques.

## NEUROLOGY OBJECTIVES

- A. Clinical Rotation Objectives are to learn:
1. To obtain a comprehensive neurological history.
  2. Perform a competent neurological examination.
  3. Gain experience with common neurological disorders.
  4. Recognize neurologic disorders that overlap with psychiatry.
- B. During the rotation residents will:
1. Care for the patients located at the VA Medical Center
  2. Be responsible for history and physicals, daily orders, notes and sign-outs.
  3. Work closely with the consult resident who will round with you, instruct you in the neurological exam, review your notes, provide practical advice and literature regarding your patients.
  4. You may be asked to see and/or follow additional patients in the ER and the Consult Service (patients with particularly interesting neurological findings).
  5. You will workup at least 4 new patients each week.
  6. One or more medical students may be assigned to the service as well.
  7. The attending will round at least three times a week.
  8. You should carry no more than 8 patients and no fewer than 5 patients at any given time.
  9. One or medical students may be assigned to the service as well.
  10. Each new patient should be staffed within 24 hours of admission.

11. During night call, you should obtain the history and examine the patient before calling the backup Neurology Resident, who will see the patient with you and go over your findings and formulation. Afterwards, should you discuss the case with the attending on call.
12. At the VAMC, the ward Neurology Resident will be available to teach and to help you with your patients.

## INTERNAL MEDICINE OBJECTIVES

TEACHING OBJECTIVE: The focus of the internship is two-fold:

1. Inpatient primary patient care and consultation and emphasis on acute diagnosis, intervention, and follow-up care of assigned patients
2. Attending daily didactics, including reading and conferences.

RESPONSIBILITIES:

1. Performance and documentation of a complete history and physical examination (utilizing old records), development of a differential diagnosis, implementation of a diagnostic and therapeutic plan. The completed H & P must be charted within 24 hours of admission.
2. The intern is expected to arrive at the hospital in time to evaluate all assigned patients prior to morning work/attending rounds. It is impossible to conduct effective work rounds if you have not seen your patients before rounds begin.
3. Follow-up of all laboratory, radiological, and other diagnostic test results in a results in a timely manner.
4. Performing Gram stains, microscopic urinalysis, reviewing blood smears and x-rays as directed by clinical and laboratory findings.
5. Timely communication with each patient regarding results of testing, plan of investigation or treatment, and other relative aspects of their care.
6. Maintain close communication with family members and guardians, especially regarding a change in condition or prognosis of a patient. Thorough documentation of all discussions with the patient and family is essential.
  - b. Ward
    1. Complete history and physical
    2. Write admission orders
    3. Reading the resident admission note and discussing the assessment and plan with the resident or attending prior to any major intervention.

4. Daily care of each patient on the service, including a daily assessment, progress note, and daily orders.
5. Same day discharge summary dictations (required at VA, strongly encouraged at other program hospital(s)).
6. Supervise and instruct medical students on the proper way to perform and document a history and physical examination. Supervise and teach invasive procedures to medical students. Read and correct medical student notes daily and write a 2-5 line addendum to demonstrate your understanding and command of the case. Supervise, teach the writing of, and sign medical student orders. Most importantly, the intern is expected to be a teacher for the students assigned to the service.

TRAINING OBJECTIVES  
VA Medical Center - Inpatient Psychiatry Service  
Rebecca Van Zandt, M.D.  
Ann Guthrie, M.D.

TEACHING OBJECTIVES:

1. To develop and gain experience in diagnosing and managing the acutely ill psychiatric patient in an inpatient setting.
2. Initiate clinical and laboratory workups to evaluate for medical disorders presenting as presenting as psychiatric and vice versa
3. Learn the use the Bio-Psych-Social model of assessing their patients and therefore to augment their clinical evaluation and treatment.
4. Learn the proper usage of psychotropic medications in an inpatient setting.
5. Learn and begin to employ other modalities of treatment i.e. psychotherapy, behavioral therapy, etc.
6. Learn to work as a team leader in an interdisciplinary approach to treating their patients i.e. work with psychologist, nurses, social worker, addiction therapists, recreation therapist, Pharm. D's.
7. Learn to assess the future need for inpatient hospitalization and to transfer or refer patients to less restrictive treatments i.e., mental health clinics, or to the community.
8. Recognize the potential for common medical, neurological, and surgical disorders and in the psychiatric population and be able to formulate a plan with appropriate referrals and consultations to the specialty services.
9. Learn proper medical record documentation such as H&P, progress notes, treatment plans, and discharge summaries.
10. Learn to teach and supervise medical students and other health staff.

## RESIDENT DUTIES:

1. Residents are expected to cover their inpatient service Monday through Friday from 8:00 A.M. to 4:30 P.M. or until all of their routine duties are complete.
2. Residents perform preliminary psychiatric evaluation on all newly admitted patient with a complete history and physical examination, and subsequently propose appropriate lab work and a preliminary treatment plan.
3. On weekdays, residents make daily rounds with the attending at times specified by the attending psychiatrist. Residents also round separately daily on weekdays, and attend the multidisciplinary treatment team meetings on Monday, Wednesday and Friday.
4. Residents write orders and daily progress notes.
5. Residents participate in discharge planning, making appropriate dispositions, writing prescriptions, giving instructions to the patient and family regarding medications, side effects, and follow-up treatment plans. Residents assess patients for possible transfer to the VA Partial Hospitalization program or the VA Partial/Lodging program.
6. On evenings and weekends, residents are assigned call and provide coverage for the VA Inpatient Program. They will be available by telephone in order to give admission orders on new patients and for other needed interventions as determined by the nursing staff in concert with the resident. On weekday evenings, residents do not ordinarily need to come in for the initial workup on newly admitted patients, but they may have to come in to handle any emergencies which can not be handled over the telephone. On weekends, residents will come in during the morning hours to do initial work-ups on any admissions that came in the previous night, and to handle any other pressings clinical needs of the patients on the wards. Frequency of call depends on the number of psychiatry residents assigned to the VA.
7. Residents should document their contact with patients in the residents' log book.
8. Residents instruct medical students assigned to the service in performance of histories, physicals, mental status examinations, and general psychiatry.
9. The patient load is generally 10 to 12 patients per resident.

TRAINING OBJECTIVES  
MEMPHIS MENTAL HEALTH INSTITUTE INPATIENT ROTATION

Director: Kelly M. Askins, M.D.

1. To gain experience in the inpatient diagnosis and treatment of the seriously mentally ill.
2. To learn the criteria used to assess the need for psychiatric hospitalization.
3. To be able to appropriately assess patients referred for psychiatric inpatient treatment, including diagnostic assessment, the assessment of concomitant medical conditions with consultation with other specialties when appropriate, and the assessment of the patient's social and family support structure.
4. To learn the use of psychotropic agents in an inpatient setting, including the use of medication for rapid stabilization of the patient and the initiation and administration of antipsychotic, antidepressant, anti-anxiety, and mood stabilizing medication up to the point in time when the patient is discharged to the next lower level of care.
5. To learn to work within a multidisciplinary treatment team concept in mental health services provision and to work with professionals from other disciplines including nursing, psychology, and social work.
6. To learn to take care of the routine medical needs of psychiatrically ill inpatients and to interact with other medical services in consultation.
7. To work on teaching skills with medical students and other health care staff.
8. To learn how to approach difficult patients, including those with severe personality disorders, multiple psychiatric complaints, or multiple physical complaints.
9. To learn to work with the families of psychiatric inpatients to mobilize social supports and reduce troublesome interactions between the patient and family members.
10. To gain experience in treatment of acute withdrawal from alcohol.
11. To learn the technique of a biopsychosocial case formulation in psychiatry.

12. To have an exposure to the role of psychiatry in the criminal justice system. To gain experience in the interface between psychiatry and the courts.
13. To increase understanding of health care financing and other aspects of our changing health care system and the requirements imposed by third party payors, including managed care constraints.
14. To learn the principles of aftercare planning prior to discharge to ensure continuity of care.
15. To gain an understanding and empathy for patients with chronic or rapidly recurring psychiatric illnesses.

#### RESIDENT DUTIES:

1. Residents perform preliminary psychiatric evaluation of all newly admitted patient and propose appropriate lab work and an initial treatment plan.
2. On weekdays, residents make daily rounds with the attending from 7:30 a.m. until all patients have been seen and multidisciplinary treatment teams as scheduled.
3. Residents write orders and daily progress notes.
4. Residents participate in discharge planning, making appropriate dispositions, writing prescriptions, giving instructions to the patient and family regarding medications, side effects, and follow-up treatment plans.
5. Residents should document their contact with patients in the residents' log book.
6. Residents instruct medical students assigned to the service in performance of histories, physicals, mental status examinations, and general psychiatry.
7. Residents should participate in discussions about the patient's legal admission status and testify in court when appropriate for cases involving the resident's patients.
8. The patient load is generally 8 to 12 patients per resident.

TRAINING OBJECTIVES  
PSYCHIATRIC EMERGENCY ROOM ROTATION  
Director: Kelly Askins, M.D.

TEACHING OBJECTIVES:

1. To be able to appropriately assess patients presenting with psychiatric emergencies, including history gathering from patient and additional sources, mental status assessment, and laboratory assessment.
2. To be able to identify situations which present imminent danger to the patient or others and make appropriate interventions. At the end of the rotation, residents should be able to evaluate patients for their potential for suicide and violence. They should understand techniques and procedures for dealing with threatening or acting-out patients.
3. To understand indications for, and principles of emergency psychopharmacological intervention including the use of anti-psychotics and benzodiazepines.
4. To understand and utilize the civil involuntary commitment process.
5. To consider possible general medical conditions which may present as psychiatric emergencies and utilize medical consultants appropriately.
6. To be able to recognize non-urgent psychiatric conditions and make appropriate referrals to available services.
7. To become aware of and learn to co-ordinate patient treatment with available community service agencies and resources for the chronically mentally ill.
8. To provide appropriate therapeutic intervention to resolve crises when possible, including family interventions, and mobilization of community resources.
9. To understand our changing health care system and the requirements imposed by third party payors.
10. To learn to work within a treatment team concept in mental health services provision, including working with professionals from other disciplines and their respective trainees.

## RESIDENT DUTIES:

1. Resident assigned to the Psychiatric Emergency Room rotation are responsible for assessing patients brought to the emergency between the hours of 8:00 a.m. to 5:00 p.m. Monday through Friday. A minimum of 32 hours per week must be spent on site. If other academic activities take more than 8 hours per week, the time must be made up by working after 5 PM.
2. The resident will ensure that all pertinent available information regarding the patient's care will be placed on the chart in an timely manner; including, but not limited to, Psych evaluation, complete physical exam, etc.
3. The resident will ensure that appropriate consult (Level 1, Neuro, Ortho, etc.) is made when medically indicated.
4. Residents should adequately document all emergency room psychiatric contacts; using standard emergency room forms and protocols, immediately after completing the evaluation.
5. The resident will ensure appropriate documentation supports the need for seclusion/restraint.
6. The resident will ensure appropriate documentation supports the need for medicating a patient in the ER.
7. The resident should document their contact with patients in the patient log book.
8. Discharges - the resident shall assure that the disposition of each patient is thorough and that appropriate outpatient follow-up is arranged, with written instructions to the patient. Appropriate documentation shall be produced for the patient transfers/603 commitment.
9. The resident will their pager at all times during the 8:00 a.m. - 5:00 p.m. shift.

TRAINING OBJECTIVES - VETERANS' ADMINISTRATION HOSPITAL  
ALCOHOL AND DRUG TREATMENT ROTATION

Director: Wesley Pitts, M.D.  
Lamar Bailey, M.D.

1. To become familiar with the principles of chemical dependency and chemical dependency treatment as a part of general psychiatry, including the physical and psychological effects of various substances, twelve step treatment models, aversion therapy, and pharmacotherapy.
2. To learn and implement the principles and protocols for detoxification of patients from various substances.
3. To learn to take care of the psychiatric and physical problems of dual diagnoses patients involved in drug or alcohol rehabilitation.
4. To learn the principles of aftercare treatment planning in patients with substance abuse problems.
5. To learn to teach and supervise medical students.
6. To learn to work within a multidisciplinary treatment team concept in the provision of substance abuse services, and to work with professionals from other disciplines including social workers, drug counselors, and case managers.
7. Research and elective opportunities are available.

Resident Duties:

1. Residents are expected to be present on weekdays starting at 7:30 A.M., and to participate in rounds on detoxification patients every weekday at 8:30 A.M.
2. Residents participate in all multidisciplinary treatment planning conferences. There are two such conferences daily on weekdays: one for detoxification patients and one for rehabilitation patients.
3. Residents sit in on twelve step group meetings.
4. Residents run a medication group for appropriate substance abusers twice a week.
5. Three times per week, residents participate in a teaching conference.

They may be asked to review cases or to present and discuss a topic related to substance abuse treatment.

6. Residents may occasionally meet individually with patients to discuss psychiatric, medical, or substance abuse issues.
7. Residents document interventions appropriately in the patients' charts.
8. Residents participate in discharge planning and help make appropriate dispositions.
9. Residents perform psychiatric consultations on patients who are suspected of having a dual diagnosis.
10. Residents should document their contact with patients in the residents' log book.
11. Residents instruct medical students assigned to the service in the performance of histories, physicals, mental status examinations, general psychiatry, alcohol and drug detoxification, and alcohol and drug treatment.

TRAINING OBJECTIVES  
CONSULTATION LIAISON PSYCHIATRY

Directors:

Robert Kores, M.D.

Kristin Beizai, M.D.

Marie Tobin, M.D.

I. Skills

A. Clinical

1. Evaluation

Identify the overt reasons for referral for consultation, preferably by talking directly to the referring physician. Identify any covert reasons for referral (e.g. systems issues)

Perform a full review of patients medical chart including obtaining up to date results of investigation (labs, CT-scans, EEG's)

Conduct a comprehensive psychiatric interview of a physically ill patient.

Liaison with other personnel involved in patients' treatment.

Contact patients' family and other persons relevant to patient's situation (e.g. previous therapist, relatives - being aware of confidentiality issues)

Compile a comprehensive formulation of the patients' problem with special attention to the life setting and specific circumstances leading to the illness and request for consultation, the significance and meaning of the illness to the patient, and psychosomatic and somato psychic interactions.

Evaluate the specific influences of the patients' personality on the manifestation of this illness and illness behavior.

## B. Treatment

### 1. Short-term

Formulate and then implement appropriate interventions using psychopharmacological, psychotherapeutic and social measures as appropriate (special attention to crisis intervention and brief, supportive therapy).

Communicate concise practical suggestions for management to referring physician and treatment team.

### 2. Long-Term

Interact with community services to set up appropriate outpatient psychiatric care. Pay particular attention to physical, psychological and social needs in designing such care.

Interface with referring team and facilitate transfers to inpatient psychiatric facilities in commitment cases.

Develop proficiency in performing crisis and family intervention and brief psychotherapeutic interventions with supervision.

Develop proficiency in dealing with patient populations who have specific needs (e.g. organ transplant patients, suicidal patients, or patients whose competency is in question).

## C. Teaching

Develop good working relationships with other disciplines and view every clinical interaction as a potential educational opportunity (Liaison).

Participate with supervisor in designing curriculum for medical student clerkship.

Supervise medical students, psychology interns and other affiliated staff.

Participate in interdisciplinary teaching conferences by presenting cases for review.

Engage actively with supervisor in becoming familiar with the consultation liaison body of literature.

D. Administrative

Integrate into consultation - liaison team.

Understand the "mechanics" of organizing and ensuring the working of consultation-liaison team.

Understand the complexities of provision of service in a changing health care system.

Engage in committee work (attend ethics committee a/o Quality Assurance Committee).

E. Research

Engage with supervisor in exploring research ideas and gain familiarity with writing protocols and critically reviewing papers.

F. Specific Duties

The Psychiatry Resident, while carrying the Med C/L pagers are expected to receive calls between 8:00 a.m. and 5:00 p.m. - Monday through Friday.

On call Residents cover the C/L Service on weekends between 5:00 p.m. Friday and 8:00 a.m. on Monday and 5:00 p.m. - 8:00 a.m. Monday through Friday.

As the M-3 students are expected to have conducted individual rounds on their assigned patients and be ready to report by 9:30 a.m.; the current C/L resident is also expected to be present for patient reviews.

The Med C/L Service also covers the UT Bowld Hospital during the 8 a.m. and 5 p.m. M-F hours. After hours and weekends at the Bowld, are covered by the on-call (weekly) psychiatry resident on schedule (pager #765-9709) with facility support .

**MENTAL HEALTH PRIMARY CARE CLINIC**  
VETERAN'S ADMINISTRATION HOSPITAL  
DIRECTOR: Lamar Bailey, M.D.  
Douglass Jones, M.D.

The Mental Health Primary Care Clinic in the Blue FIRM offers primary care for patients that have a primary psychiatric diagnosis, but who also have medical problems. It is our goal to give patients that have a variety of psychiatric problems a clinic where a holistic care program can be offered. The clinic is staffed by Dr. Jones, a nurse practitioner, and a physician's assistant.

The clinic staff is responsible for diagnosis and treatment of all medical and psychiatric problems within the scope of the clinic's abilities. If needed, the full array of medical services is available in the Veteran's Administration Hospital. The clinic is open 8:00 A.M. to 4:00 P.M. Monday through Friday.

First and second year residents in psychiatry are assigned to the clinic one half day each week. They see a full variety of patients, some of which are walk-ins and others that are follow ups post hospitalization. Whenever possible, residents are expected to follow appropriate patients they first treated on the VA inpatient psychiatry service.

Any change in schedules or vacations are to be authorized in advance so that patients are not scheduled during the resident's absence. In the case of unscheduled leave, the resident must notify the clinic clerk and the administrative assistant.

## **TRAINING OBJECTIVES FOR THE ADULT OUTPATIENT CLINICAL ROTATION**

### **Directors**

**David Allen, M.D.**

**Robert Kores, Ph.D.**

1. To improve and practice clinical interviewing, diagnostic, and case formulation knowledge and skills in an outpatient setting.

To increase knowledge of basic psychotherapy theories and techniques.

At the conclusion of the rotation, residents should be able to describe, compare, and contrast theories and techniques from psychodynamic, cognitive, behavioral, experiential, interpersonal, family systems, couples, short-term, and group psychotherapies. They should be able to make use of a wide variety of psychosocial interventions, tailored to the individual's psychopathology. They should exhibit an understanding of transference and countertransference phenomena. They should understand various psychotherapeutic approaches to severe personality disorders.

Specifically, the resident must demonstrate through performance on videotaped psychotherapy sessions the following skills and competencies:

### **A. GENERAL COMPETENCIES:**

- Ability to establish and maintain a treatment frame e.g., time, space, outside agencies/relationships, setting schedules and sticking to times).
- Ability to establish and maintain a professional relationship.
- Ability to understand and protect the patient from unnecessary intrusions into privacy and confidentiality.
- Ability to handle financial arrangements with patient in a manner appropriate to t
- Ability to establish rapport
- Ability to understand and develop a therapeutic alliance with the patient
- Ability to recognize a variety of forms of therapeutic alliances including negativistic ones
- Ability to enable the patient to actively participate in the treatment
- Ability to recognize and attempt to repair disturbances in the alliance
- Ability to establish a treatment focus
- Ability to set limits in an empathic way
- Ability to listen non-judgmentally and with openness
- **Ability to facilitate the patient talking openly and freely**
- Ability to recognize and specifically describe affects
- Ability to tolerate direct expressions of hostility, affection, sexually and other powerful emotions

- Ability to recognize and describe (to the supervisor) one's own affective response to the patient
- Ability to recognize and tolerate one's uncertainties as a trainee in psychotherapy
- Ability to empathize with the patient's feeling states
- Ability to convey empathic understanding
- Ability to identify problems in collaborating with the treatment/therapist
- Ability to recognize defenses in clinical phenomena
- Ability to recognize obstacles to change and an understanding of possible ways to address them
- Ability to maintain focus in treatment when appropriate
- Ability to confront
- Ability to assess readiness for and manage termination from treatment
- Ability to assess the patient's readiness for certain interventions
- Ability to assess the patient's response for certain interventions

**B. COMPETENCIES FOR BRIEF AND CRISIS INTERVENTION**

- Ability to rapidly establish a therapeutic alliance with the patient
- Ability to identify the precipitating event (stressor) and the patient's reactions to it
- Ability to identify a history of the patient's usual coping mechanism
- Ability to facilitate the patient's expression of emotions
- Ability to normalize the patient's emotional reactions to the event in the setting of crisis, when appropriate
- Ability to focus the therapy on the precipitating crisis
- Ability to provide support to the patient
- Ability to actively listen to the patient to enhance understanding
- Ability to provide psycho education about the crisis
- Ability to help the patient develop adaptive coping mechanisms and identify additional sources of support
- Ability to establish achievable therapeutic goals with the patient
- Ability to rapidly obtain collateral information where appropriate
- Knowledge of community resources and ability to make timely and safe dispositions

**C. COMPETENCIES FOR COMBINED PSYCHOPHARMACOLOGY & PSYCHOTHERAPY**

- Ability to establish and maintain a therapeutic alliance and to negotiate a treatment plan
- Ability to provide psychoeducation about DSM IV diagnoses and relevant psychotherapeutic, psychosocial, and psychopharmacologic treatment options
- Ability to assess patients beliefs about medications and to recognize how and when these beliefs can impact on efficacy and compliance
- Develop a basic understanding of medico-legal and psychotherapeutic issues in the context of one person prescribing medication and another person providing psychotherapy: confidentiality, informed consent and collaboration

- Ability to use the concepts of transference and counter-transference in prescribing medications in a therapeutic manner
- Recognize how prescribing medications might enhance or hinder psychotherapy and how providing psychotherapy might enhance or hinder the use of medications
- Identify psychological aspects of non-compliance
- Ability to integrate biological and psychological aspects of a patient's history

**D. COMPETENCIES FOR PSYCHODYNAMIC PSYCHOTHERAPY**

- Ability to identify and effectively begin treatment with a suitable patient for psychodynamic psychotherapy
- Ability to identify aspects of an ongoing case in terms of theories of drive and defense, and consideration of the patient's experience of self and others
- Ability to link present to past as demonstrated by understanding the patient's present pattern of thought, feeling, action and relationship in terms of his or her past personal experience
- Ability to identify and respond appropriately and flexibly to a variety of defenses in the clinical setting
- Ability to effectively confront, clarify and interpret previously preconscious and unconscious material in the therapeutic setting
- Ability to facilitate discovery of latent meaning of clinical material(e.g., dreams, associations, transference materials, etc.)
- Ability to recognize and make therapeutic use of transference
- Ability to recognize, contain and make therapeutic use of countertransference
- Ability to maintain a therapeutic alliance in the face of transference distortions, using concepts of neutrality, abstinence, empathy and support in an appropriate manner
- Ability to manage termination issues within the context of a psychodynamic psychotherapy

**E. COMPETENCIES FOR COGNITIVE/BEHAVIORAL PSYCHOTHERAPY**

- Ability to discuss cognitive models of psychopathology
- Ability to introduce the patient into the framework of cognitive therapy
- Ability to use structured cognitive behavioral model including mood check, bridging to prior session, agenda setting, and review of homework, capsule summaries and patient feedback
- Ability to identify and elicit automatic thoughts
- Ability to use self-recording tools in therapy
- Ability to use behavioral homework assignments as a tool in therapy
- Ability to identify common cognitive errors in thinking
- Ability to use behavioral techniques as a tool in therapy
- Ability to manage termination issues on a cognitive-behavioral context

**F. COMPETENCIES IN SUPPORTIVE PSYCHOTHERAPY**

- Ability to recognize regressive and adaptive shifts in ego functioning
- Ability to make interventions specifically in support of a patient's strengths

- Ability to deliberately take a non-interpretative stance in relation to a defensive operation in a patient
  - Ability to recognize internal conflict and help a patient prevent acting out without an emphasis on interpretation
  - Ability to be directive: give advice, set limits and educate when appropriate with a patient
2. To demonstrate competency through their clinical performance in administering pharmacotherapy in an outpatient setting. At the conclusion of the rotation, the resident should have gained experience in the longitudinal administration of a wide variety of pharmacological agents. Residents should be able to plan drug treatment with an understanding of the nature and time course expectations of both therapeutic effects and side effects of antidepressants, sedative-hypnotic agents, mood stabilizers, and antipsychotic medication. They should be able monitor patients for adverse medication effects and manage drug-drug interactions. They should be skilled in techniques for improving patient compliance with drug therapy.
  3. To demonstrate through clinical performance the ability to serve as pharmacotherapy consultants for non-medical therapists.

## **TRAINING OBJECTIVES FOR CHILD PSYCHIATRY**

**Director: Constance Durbin, M.D.**

- A. Skills - by the end of the residents' rotation in Child Psychiatry, we expect them to be able to do the following:

Conduct a thorough evaluation of children and their families, properly assessing the nature and significance of presenting problems including history taking from the child, family and collateral sources, laboratory finding and mental status examination.

Appropriately use psychological and physiological assessment techniques to augment the clinical evaluation.

Demonstrate the ability to work as a team with psychologists, social workers, and other professionals to obtain a complete evaluation and to formulate appropriate interventions.

Demonstrate the understanding of the dynamic and developmental aspects of disturbed behavior in children and adolescents and the extent to which those behaviors are responsive or refractory to environmental contingencies.

- B. Knowledge - by the end of the residents' rotation in Child Psychiatry, we expect them to be able demonstrate knowledge of the following by discussing the following in discussion with faculty in treatment planning for their patients:

Principles of the evaluation of children and their families.

Major theories of child development, including psychodynamic, cognitive, and biological issues.

Common psychiatric problems of childhood and current concepts in the classification of childhood disorders.

Mental retardation, including evaluation and treatment planning.

Adolescence, with a focus on personality development issues.

Principles of intervention in child and adolescent psychiatry including psychopharmacology and its appropriate uses in child and adolescent disorders.

Principles of structural family therapy.

### C. Resident Duties

PGY-III residents are assigned to the Child Division for ½ day weekly throughout their 3<sup>rd</sup> year of PGY3 training. They are participants in formal didactic sessions, individual and group supervision, and direct clinical care each week. Didactic sessions include psychopharmacology, child and adolescent diagnoses and classification, consultation and liaison psychiatry with children and adolescent, family therapy and trans-cultural seminar. They spend 1 hour weekly in didactic sessions. Group supervision occurs 1 hour weekly and includes case presentations prepared by the residents from their clinical contacts with supervision by faculty child psychiatrists, LCSW and clinical psychologist. There is also direct individual supervision of clinical cases seen in the outpatient clinic each week. Clinical contacts include psychiatric evaluations and short term therapy in the outpatient clinic with direct supervision.

PGY-IV residents spend 12 hours at Boys Town and 8 hours in the child clinic and covering consultations at LeBonheur Children's Hospital per week. They have a combination of individual supervision and direct observation by a faculty member of their clinical work. The residents are provided with direct supervision for all their evaluations and follow ups. At LeBonheur Children's Hospital, the resident learns to address the purpose of the consultation, to be able to provide a concise summary of the key pertinent historical data and findings, to do a complete psychiatric evaluation and to come up with a treatment plan. They also spend 1-2 hours per week in didactic discussions focusing on consultation-liaison, psychopharmacology, diagnostics and other issues. Teaching is ongoing and topics range from childhood psychopathology, substance abuse, physical and sexual abuse, psychopharmacology, child development, and administrative issues. The residents also learn to liaison with different disciplines - case managers, teachers, therapists and nurses - participating in an interdisciplinary staffing, conducted twice a month.

## **RESIDENT TRAINING OBJECTIVES IN GERIATRIC PSYCHIATRY**

**Sandra M. Baltz, M.D.**

### **OBJECTIVES:**

1. Learn and demonstrate understanding of current theories of aging, including normal effects of aging on human physiology with emphasis on altered pharmacokinetics, pharmacodynamics and sensory acuity in the elderly. Be able to distinguish differences in normal and abnormal age changes, with particular reference to areas of memory and cognition, affective stability, personality and behavioral patterns.
2. Demonstrate understanding of both successful and maladaptive responses to developmental milestones and stressors frequently encountered in older adults such as retirement, grandparenthood, widowhood, financial reverses, increased dependency and potential interpersonal and health status losses.
3. Recognize epidemiology, diagnosis, and treatment of all major psychiatric disorders seen in the elderly both alone and in combination such as delirium, dementia, late onset psychosis, affective disorders, sleep disorders, anxiety disorders, substance abuse disorders, personality disorders, sexual disorders as well as continuation of psychiatric illnesses that began earlier in life.
4. Learn and perform medical assessments, neurologic exam, mental status exam, community and environmental assessments, family and caregiver assessments and demonstrate proficiency in collecting, organizing, interpreting and communicating data from these multiple sources.
5. Assess medical disorders and clinical complications commonly seen in the elderly that can have neuropsychiatric manifestations.
6. Learn to select, utilize, and interpret in light of patient's symptomatology and functioning clinical laboratory tests, imaging procedures, EEG, sleep studies, and neuropsychological testing as well as consultations with other health-care specialists.
7. Learn to use the bio-psycho-social model of assessing geriatric patients and recognize how individual and family psychodynamics are relevant to patient's illness, treatment, and prognosis.
8. Demonstrate understanding of "ageism" and common transferences and countertransference issues which can influence doctor-patient relationship or treatment planning.
9. Learn relevance of cultural and ethnic differences and special problems of minority groups and disadvantaged as these bear on access and use of psychosocial and medical support.
10. Know community resources (adult daycare, assisted living, nursing homes with Alzheimer's units, local support groups) and be able to

- educate patients, families and care givers in detail about how to access these resources and at what stages they are appropriate.
11. Know and demonstrate how to utilize resources within an acute care hospital and nursing home which can benefit elderly patients (P.T., nutrition counseling, ethics committee, audiology assessment) and recognize individual limitations of acute hospital and nursing home milieu both in assessment and treatments.
  12. Learn to provide flexible guidance and treatment for elderly patients, with the need for ongoing monitoring of changes in mental and physical health.
  13. Recognize the stressful impact of psychiatric illness on caregivers and be able to assist in providing appropriate support, guidance, protection, as well as assessment of their ability to function as primary caregiver.
  14. Know and demonstrate awareness of indications, side effects (usual and unusual), therapeutic limitations, drug interactions, problems with compliance, specific monitoring needs with special attention to psychiatric manifestations of multiple medications (polypharmacy). Be able to propose and follow through with plan to reduce polypharmacy as appropriate for individual patients.
  15. Utilize and educate family and caregivers on nonpharmacologic approaches to patient's illness and behavior problems including but not limited to behavioral therapeutic strategies. Know appropriate use and application of electroconvulsive therapy in elderly.
  16. Be aware and demonstrate ability to educate patient and caregivers on ethical and legal issues especially pertinent to geriatric psychiatry including competence, power of attorney, guardianship, right to refuse treatment, wills, informed consent. OBRA, and elder abuse. Know pertinent community resources in regard to these matters (Aging Commission, State Guardianship Service, DHH-Elder Abuse).
  17. Understand current economic aspects of support services, including but not limited to Medicare, Medicaid, and Title III of Older Americans Act.
  18. Be able to discuss research methodologies related to geriatric psychiatry and apply critical review of current literature and clinical epidemiology.

### **RESIDENT DUTIES IN GERIATRIC PSYCHIATRY :**

1. Residents are expected to cover Geriatric Consult Service at VA Hospital Monday through Friday 8:00am to 4:30m pm or until all of their routine duties are complete.
2. Residents perform geriatric psychiatry evaluations on all new consults with a complete history and mental status examination and

- subsequently propose appropriate lab work and preliminary treatment plan and follow patient as indicated throughout their hospital course, documenting progress notes and writing orders.
3. Residents should document their contact with patients in the residents' log book.
  4. Residents instruct medical students assigned to the service in performance of histories, physicals, mental status examinations, and geriatric psychiatry.
  5. The patient load is generally 8 to 10 patients per resident.
  6. Residents see outpatient Geriatric patients one afternoon per week under supervision. They meet with home health care nurses, family and other care providers.
  7. Residents attend weekly Neuropsychology Conferences, Neuroradiology Conferences and Geriatric Medicine Conferences on patients followed on the inpatient consult service.
  8. Residents attend at least one community support group for Alzheimer's caregivers.
  9. Residents provide supervised assessment and treatment of nursing home patients for whom geriatric psychiatry consult has been requested.
  10. Residents follow geriatric patients transferred to inpatient psychiatry or Geriatric medicine unit from the general medicine service and participate in treatment planning.
  11. Residents visit at least one retirement community or Senior Center to gain exposure to successfully aged seniors.

TRAINING OBJECTIVES  
COMMUNITY MENTAL HEALTH ROTATION  
SOUTHEAST COMMUNITY MENTAL HEALTH CENTER  
Directors: Lalitha Vaddadi, M.D.

Teaching objectives:

1. To gain experience in, identify the principles of, and demonstrate proficiency in the community treatment for indigent, severely and persistently mentally ill patients in the public sector.
2. To demonstrate proficiency in the ongoing pharmacological management of the chronically mentally ill patient in a community mental health setting.
3. To gain experience with and demonstrate proficiency in corroborating with social workers in marshalling community resources to help community mental health patients obtain transportation to appointments, housing, financial assistance and health care.
4. To employ principles of community treatment planning with patients diagnosed with both substance abuse problems and chronic mental illness.
5. To participate in community outreach programs and observe chronically mentally ill patients in community settings such as board and care homes.
3. To gain further experience with and demonstrate proficiency in working with the police Crisis Intervention Team and the Mobile Crises Team.
4. To demonstrate proficiency in increasing patient compliance to medication through working with patients and the in-house pharmacy and by administering depot neuroleptics.

Resident Duties:

1. The rotation may be either 20 hours or 40 hours. Half time residents are expected to be on site from 1 P.M. to 5 P.M 4 days per week and 12:30 –3:30 PM one day per week. For full time residents, the respective hours are 8 A.M. to 5 P.M and 8 A.M to 3:30 P.M. In addition, the half time resident is expected to spend one evening per week or a half day on Saturday per week seeing patients; the full time

resident is expected to spend two evenings per week or a full day on Saturday per week seeing patients.

2. Residents will spend one hour on new patient evaluations and 15-30 minutes on follow up patients to review their response to treatment.
3. At some point during the rotation, the resident should participate in an outreach visit to see patients in board and care homes.
4. Since this is a fourth year rotation, residents are expected to demonstrate the ability to practice relatively independently. The resident will meet with the attending psychiatrist as needed and regularly at least weekly to discuss cases, review patient management and receive feedback.

## TRAINING OBJECTIVES - ELECTIVE ROTATIONS

Director: David M. Allen, M.D.

The elective rotations are open to the resident's choice and are determined by mutual agreement with the Director of Residency Training. They should be compatible with the educational goals of both the individual resident and the department, and must take place at a site with funding for a residency stipend.

One month before starting an elective experience, the resident must submit a written proposal for the elective, a supervisor, educational objectives, resident responsibilities, and a reading list. The elements of the elective must be acceptable to the supervisor. Electives are limited to a maximum of eight months.

**FOURTH YEAR RESIDENT  
ARLINGTON DEVELOPMENT CENTER ELECTIVE ROTATION**

We are please to welcome fourth year psychiatry residents to a special elective at Arlington Development Center, a long term facility for adults with mental retardation and other developmental disabilities. Arlington Developmental Center is located in Arlington, Tennessee, at the edge of Shelby County on Interstate 40. (Approximately 30 miles from the Regional Medical Center).

During the rotation residents will:

Receive orientation lectures about Arlington DC and mental retardation and psychiatry.

Read relevant book chapters and articles on mental retardation and psychiatry.

Round with the psychiatry attendings at Arlington Developmental Center.

Do consultations at ADC under the supervision of the attending psychiatrists.

Do initial evaluations and follow up appointments for outpatients at ADC.

Attend team meetings under the supervision of the attending psychiatrists.

Attend a lecture by the Chief Behavior Analyst on the principles of applied behavior analysis.

Work with behavior analysts to integrate psychiatric and behavioral health care.

Surf the web for web sites relevant to mental retardation and psychiatry.

Goals for fourth year resident elective rotation:

At the conclusion of the fourth year elective psychiatry rotation at Arlington Development Center the resident should be able to:

Demonstrate awareness of common etiologies of mental retardation and factors determining level of adaptive function.

Appreciate heterogeneity in the retarded population.

Distinguish myths from facts about mental retardation.

Know the criteria for autistic disorder and other pervasive developmental disorders.

Appreciate that when mental disorders or other psychopathology exists, symptoms may be modified by the patient's developmental level.

Demonstrate knowledge of the epidemiology and prevalence of mental retardation alone and with concurrent medical and psychiatric disorders.

Be able to perform a mental status exam of a person with mental retardation.

Be able to evaluate and diagnose psychiatric disorders in persons with mental retardation.

Appreciate the interdisciplinary team approach for optimal patient care.

Know the basics of behavior analysis and to understand how behavior analysis is useful in the practice of psychiatry with persons mental retardation.

Be able to do research using the internet and medline search.