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Points to Ponder Regarding Contemporary Psychiatric Training in Israel

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Abstract: In an era in which neuroscience is developing rapidly and different psychotherapeutic modalities are proliferating, psychiatric training encounters new difficulties. This article raises various issues that the authors feel are not adequately addressed in contemporary psychiatric residency programs in Israel. These include basic issues of doctor-patient relationship; different cultural trends such as the increase in popularity of CAM (complementary and alternative medicine), the increase in substance abuse, and the increasing popularity of different spiritual movements; transcultural aspects affecting the prevalence and understanding of different psychopathologies in various sectors of the population; ethical issues particular to psychiatric research; and the future psychiatrist's role as communicator and educator of GPs, mental health workers and the general public. In a time characterized by an abundance of models and theories in psychiatry, the authors stress the need to assist residents in integrating various theories and models into a comprehensive outlook regarding the psyche and psychiatric disorders. As mental hospitals vary greatly in their general psychiatric outlook, emphases, and competence of the senior staff in different fields and treatment modalities, the authors see programs for continuing medical education (CME) as the natural arena in which the issues mentioned in this paper should be addressed.

As in all other fields of medicine, professional training in psychiatry is an ongoing process that virtually never comes to an end. Not only must the psychiatrist continue to update his knowledge by familiarizing himself with recent medical literature, he must also be in touch with the "zeitgeist," as psychiatric disorders are always regarded in a cultural and environmental context. The basic psychiatric training, in the form of psychiatric residency, must inevitably be based on a certain ideology regarding the understanding of the psyche and psychiatric disorders, and of the role of the psychiatrist at large. In addition, as psychiatrists must take into account various cultural aspects and norms in their work, psychiatric training must address characteristic aspects crucial in treating local psychiatric patients.

It seems that the ideal psychiatrist today is one who is familiar with different aspects of medicine, psychology, sociology, anthropology, neuroscience, law, philosophy, education, spirituality, religion and more. The numerous fields psychiatry touches upon, alongside the endless pastures of knowledge that are relevant when dealing with the psyche and psychiatric disorders, obviously dictates that requirements from psychiatric residents be prioritized and sufficiently formalized and supervised.

Psychiatric training in Israel today consists of a four-and-a-half year residency program, of which three-and-a-half years are dedicated to clinical psychiatry (inpatient wards and outpatient clinics), six months of clinical neurology and six months of basic scientific research. All psychiatric residents are required to complete two exams, the first of which emphasizes the theoretical and scientific background of psychiatry, and the second in which clinical practice and technique are emphasized. Many psychiatric residents augment these requirements by studying in programs for continuing medical education (CME) (usually during the first years of their residency) and different programs of psychotherapy (usually during the latter years of their residency or after completing the residency). In addition, each hospital, acting as an autonomic academic unit, provides various supervisions and seminars.

This paper does not pretend to present a comprehensive outline regarding psychiatric training at

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large, but rather it will emphasize certain points that are currently not adequately addressed during contemporary psychiatric training, particularly those specific to psychiatric work in Israel. Most of these points will refer to clinical practice and general understanding of psychiatric disorders. However as teaching and research are regarded as inherent to the work of the psychiatric resident, these will also be touched upon briefly.

Clinical Practice

Doctor-patient relationship

Since it is taken for granted that psychiatric residents receive some form of psychotherapeutic training, many central issues of doctor-patient relationship are not dealt with directly in a profound and adequate manner during the residency. Though these issues are essential in all fields in medicine, they are even more so in psychiatry. Basic concepts regarding human behavior and interpersonal relationships are vital for the psychiatrist, whose understanding of human behavior and human experience should place him in the unique position of being able to create and monitor treatment plans that integrate both biological and psychosocial perspectives. Traditionally, psychiatric training based these concepts on psychodynamic understanding, but these issues can also be dealt with in a direct and practical manner, without addressing them through psychodynamic conceptualization. Moreover, many psychiatric residents begin attending programs of psychodynamic psychotherapy at a rather late stage in their residency or turn to other forms of psychotherapeutic training programs (such as cognitive-behavioral therapy [CBT]), thus undermining the assumption that they receive adequate training in doctor-patient relationship issues through psychodynamic training. The reality in which psychiatric residency programs devote less time and effort to psychodynamic training without adding training in basic psychosocial issues gives birth to a reality in which psychiatric residents receive less formal training in basic doctor-patient relationship aspects of clinical work than do residents in other fields of medicine. Family practice residency programs dedicate on average over 350 hours to psychosocial training (1), stressing issues of doctor-patient relationship and family awareness. Many of these hours are spent simulating situations frequently encountered in clinical practice. Medical school programs in Israel are dedicating more time and effort, particularly in pre-clinical years, to different aspects of the doctor-patient relationship, stressing its significance in all fields of medicine. Though a great many psychosocial aspects are dealt with throughout psychiatric residency, this is not done systematically as a formal part of the training, and psychiatric residents are at risk of not achieving adequate competence in these aspects. Formal training in doctor-patient relationship and psychosocial aspects of clinical work must be part of the residency curriculum.

Competence in various therapies

Over the past few decades, psychotherapies have proliferated to include several different forms of therapy, offering psychiatrists a relative abundance of treatment modalities. "Manualized" treatments that can be tested and proven effective by scientific standards have become increasingly popular. The U.S. Residency Review Committee (RRC) for Psychiatry has mandated that training programs "must demonstrate that residents have achieved competency in *at least* the following forms of treatment: brief therapy, cognitive-behavioral therapy, combined psychotherapy and psychopharmacology, psychodynamic therapy, and supportive therapy"(my italics)(2). Not surprising, this demand was met with great difficulties, many of which are still being dealt with: already overloaded training directors and departments having to contend with new and demanding challenges, not only requiring resources to providing the different types of psychotherapy training, but also requiring tools with which to assess residents' competency. Much literature has been published in the past few years regarding the complex issue of assessing competence in psychotherapy. One of the key papers on the subject, published in the Fall 2003 edition of Academic Psychiatry (dedicated solely to the subject of assessing competence in psychotherapy), comes to the conclusion that it is unrealistic to assume that training programs will ever be able to confirm summative competencies in these psychotherapies, and advises programs to define precisely the levels of formative

competence they expect, and design curriculum and measures accordingly (3).

In Israel, the scientific council has recently formalized its demands, requiring each resident to conduct at least three psychodynamic psychotherapies (at least one lasting more than a year), as well as two out of the following: supportive therapy, behavioral therapy, cognitive therapy, group therapy, couples or family therapy and brief psychotherapy. While this is an important step and keeps psychiatric training in Israel up-to-date, some central issues must be addressed: the scientific council must ensure that adequate supervision is available for all psychiatric residents, as psychiatric hospitals vary greatly in the therapies in which the senior staff is well trained and able to supervise; and more importantly, much thought and effort must be put into specifically formalizing the manner in which competence is to be assessed. Not only will this be an important tool for educators and supervisors, it may greatly clarify the pivotal points to be regarded by residents when engaging in various forms of therapy.

Cultural, religious and spiritual aspects

Different cultures, religions and spiritual outlooks hold different views regarding illness in general and psychopathology in particular. These views greatly influence patients' regard to their illness, the family's outlook and support, compliance to treatment, and at times specific psychopathologies (as in the case of culture-bound syndromes). Many of these issues fall into the realm of transcultural psychiatry, the branch of psychiatry that deals with how social and cultural factors create, determine or influence mental illness. In Israel, an immigration country by its very definition, the population consists of diverse ethnic groups and religions. Illness in general, and psychopathology in particular, is understood and addressed differently among secular Jews, ultra-orthodox Jews, Ethiopians, Arabs, etc. Understanding these differences may well be crucial for the efficient treatment of different psychiatric patients. In addition, as the professional literature studied is first and foremost that of American psychiatry coming from the U.S., the Israeli psychiatric resident is ultimately more familiar with epidemiologic data relevant to the U.S. than local epidemiologic data. Local training programs must directly address transcultural issues, which are currently unfortunately overlooked.

In addition, in modern-day Israel, as in most of the western world today, there is a great spiritual upsurge, evident in the widespread Buddhist, New Age, Kabbala movements, and more. Though psychiatry has traditionally distanced itself from spiritual and religious issues (young clinicians have even admitted avoiding research in these areas for fear of a negative impact on their careers [4, 5]), these views have taken a turn in recent years. In 1994, the DSM-IV acknowledged a non-psychopathological category entitled "religious or spiritual problem" under the section "other conditions that may be a focus of clinical attention." Residents are now encouraged to learn about the religious and spiritual practices of patients and to view them as possible recourses for improved physical and mental health (6) This is in tune with the recent attention in cultural sensitivity since religious beliefs and practices are often intertwined with cultural identity. An increasing number of residency programs abroad are now offering formal training in religious and spiritual issues (7), and psychiatric training in Israel should address these issues as part of formal training as well.

Complementary and alternative medicine (CAM)

Information published by the Institute of Medicine (IOM) of the National Academies clearly indicates that the American public considers CAM therapies increasingly to be conventional lifestyle choices rather than alternative practices (8). It is estimated that over 50% of patients that require health care use CAM either in conjunction with, or separate from, conventional health care (9). The situation in Israel is currently approaching that in the U.S.: in 2000, 10% of the general population reported consulting a CAM specialist, and CAM in Israel is no longer regarded as an infant industry, but rather as a mainstream medical modality (10). Despite the popular use of CAM, patients do not always inform their conventional medicine health carers of their CAM use, primarily because of concerns about a negative response by the practitioner (8). Many academic units and teaching hospitals in different fields of medicine have begun to incorporate a concise study of common methods of CAM into their curriculum

(11, 12), as dismissing these forms of therapy is no longer possible. As in other forms of therapy, the various CAM therapies differ greatly in their efficiency for different pathologies, their potential side effects, etc. Taking into account the great number of psychiatric patients receiving these treatments, it is important that psychiatrists have some kind of panoramic knowledge regarding the popular groups of CAM therapies, without dealing in particulars, while being aware of therapies considered evidence-based, as well as addressing major potential side effects. As doctors are increasingly asked to advise on suitability of CAM therapies (13), such a general knowledge will not only facilitate communication with the patients, it will allow the psychiatrist to take into account other treatment modalities the patient is using or considering, and recommend turning to, or refraining from, different CAM treatments.

Substance abuse

The high rate of co-occurrence of substance abuse and other psychiatric disorders is well established (14–18). Drug abuse in Israel is on the rise, and affects all social strata (19, 20). Though Jewish cultural background and the military policy of zero tolerance are assumed contributors to the low drug use levels among young populations in Israel relative to the United States, there is a clear increase of drug abuse in Israel, and time-trends of drug use in Israel parallel those in the United States and European countries (19). It seems that Israeli psychiatrists will be dealing with the consequences of this situation more and more in the future, both by directly treating cases of patients suffering from substance addiction and a co-occurring psychiatric disorder and as managers of mental health teams. Patients suffering from substance abuse and addiction will no longer be solely treated by those specializing in the field, and the lack of adequate addiction training, which is readily noticeable today, will pose a problem. Though the current psychiatric residency program in Israel requires a reasonable knowledge base, it is aimed primarily at recognizing manifestations of substance abuse and addiction, and does not sufficiently emphasize short- and long-term management skills. Training must be based on the notion that psychiatrists must take responsibility for treating addiction problems their patients are suffering from, thus increasing the chance of successfully treating any co-occurring psychiatric disorder. As the number of psychiatric wards and clinics specializing in the field is limited, most psychiatric residents are not exposed to knowledgeable treatment plans aimed at treating dual-diagnoses patients. Both a proper theoretical base regarding short- and long-term management of substance abuse and addiction, as well as adequate clinical training in the field (through supervision on a case emphasizing aspects of treatment of substance abuse and addiction, or a rotation in a ward or clinic specializing in the field), are becoming essential as part of psychiatric training.

Teaching

Whether working in an academic or clinical setting, psychiatrists frequently teach medical students, patients, physicians, other health professionals and the public. As mental health organization is changing in Israel as it is throughout the world, more and more psychiatric patients will be treated by non-psychiatrists (but rather by GPs, social workers, various therapists, etc.). Psychiatrists may well spend much of their time treating resistant cases, supervising therapists, GPs and educating the general public. All these require skills as communicators and educators that must be developed throughout psychiatric training. Though many psychiatric residents engage in teaching medical students, they rarely participate in other aspects of education mentioned above, and psychiatric training programs in Israel include no formal training in the field. This may include training in which both didactic organization of data and suitable methodological manners of teaching are addressed, as well as having residents participate in different assignments as educators.

Research

In an era of rapidly occurring scientific advances, research is considered by many to be an integral part of psychiatric residency. All medical residents in Israel, including those in psychiatry, must complete a six-month period of basic scientific research, after which a detailed report is handed in. Thus designing a study, critical reading of studies and statistical analysis are all part of the residential obligations. Though

the importance of such a period during residency, dedicated solely to research, is questionable and subject to ongoing debate, all the above-mentioned formal aspects of research are touched upon. Despite this, it is important to acknowledge that research in psychiatry carries unique ethical problems. Residents must understand principles of research ethics and implications of roles of psychiatrists as investigators and clinicians. Recommended components of residency training programs that have been proposed include basic ethical principles; scientific merit and research design; assessment of risks and benefits; selection and informed consent of patient-subjects; and integrity of the clinical investigator, including definition of roles, conflicts-of-interest, and accountability (21). These are crucial if responsible and worthy research is to be attained.

Integration of Psychiatric Knowledge

In an article published recently regarding the attitudes of medical students towards residency in psychiatry the authors conclude that:

> the population of students interested in family medicine and neurology…should be the source of psychiatry residents, and *their faith in the psychiatric paradigm should be strengthened* (22) (my italics).

What is the "psychiatric paradigm"? Does one such paradigm exist? Would the psychoanalytically-oriented psychiatrist necessarily agree with the biologically-oriented psychiatrist as to the nature of the paradigm? Is one such paradigm possible at all in such a field? These questions are crucial when dealing with psychiatric training and the professional ideology the psychiatric community wishes to pass on to the next generation.

In an era in which scientific advances in the fields of molecular biology, neurobiology, pharmacology, epidemiology, genetics, neuroimaging and cognitive neuroscience are developing rapidly and influencing psychiatric diagnosis and treatment, psychiatric residency programs must maintain flexibility in order to incorporate rapid advances into resident training. Alongside these, the psychotherapeutic arena is alive and developing, with new theories and novel therapeutic models emerging. Among qualified and distinguished psychiatrists it is not uncommon to encounter grave differences regarding even the most basic approach to the psyche and psychiatric illness. The book, "Of Two Minds: The Growing Disorder in American Psychiatry," by Tanya Luhrmann (23), is an anthropological study dedicated to discovering how psychiatrists are trained and how the enormous ambiguities in the field today affect psychiatric residents. Luhrmann observes how young therapists are expected to learn to become equally good at both psychotherapy and pharmacotherapy, and how few of them attempt (or are encouraged) to integrate these two approaches, that are taught as fundamentally different tools from the outset. For the psychiatric resident, at a stage in his career aimed at acquiring tools to assist him in the understanding of the basis of psychiatric disorders, it does not suffice to familiarize him with the various approaches, leaving him somewhat perplexed; one of the pivotal roles of modern psychiatric training must be to assist the resident in integrating the various approaches. Such an integrative approach need not compromise the differences between various approaches, but should assist the resident in organizing a more comprehensive and encompassing understanding of the basis of psychiatry.

In his renowned article, "A New Intellectual Framework for Psychiatry," Nobel Prize Laureate Eric Kandel calls for a rapprochement between psychiatry (and psychoanalysis) and neural science, in order to inform the search for a deeper understanding of the biological basis of behavior (24). The practical importance of such a rapprochement, alongside the conceptual importance of such a framework, is emphasized. Though we are no doubt far from achieving such a state of rapprochement, psychiatric residency programs are a natural candidate for the arena in which the assimilation of such an interdisciplinary approach should begin. As medical training encourages a scientific approach in which theories are either accepted or rejected based on scientific evidence, psychiatric residents commonly lack adequate tools to deal with the validity of the unique and complex theories in psychiatry. A short background in the philosophy of science may prove helpful, emphasizing the possibility of dealing with seemingly contradictory theories by regarding them as different narratives of the same basic structure, especially

when dealing with the complex relation between brain and mind.

Summary

Present-day psychiatric residency programs are based first and foremost on hospital-based training in inpatient wards and outpatient clinics, and secondly on university-based schools of continuing medical education and programs of psychotherapeutic training. Most commonly, residents in Israel participate in continuing medical education programs during the first years of their residency, and only later enroll in programs of psychotherapeutic training. As mental hospitals vary greatly in their general psychiatric outlook, emphases and competence of the senior staff in different fields and treatment modalities, the natural arena in which the aspects mentioned in this paper and others should be addressed are programs for continuing medical education (CME). There is a need to introduce new contemporary issues, emphasizing those particularly relevant to treating the local population. Special attention should be given to ensure that basic aspects of doctor-patient relationship and psychosocial aspects of clinical work are not overlooked due to a false belief that all psychiatric residents receive comprehensive training in psychodynamic psychotherapy that deals with these issues. Addressing the above-mentioned issues will contribute to allowing the psychiatrists of tomorrow to engage in their clinical practice with the appropriate knowledge, understanding, tools and responsibility.

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