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Education in Psychiatry

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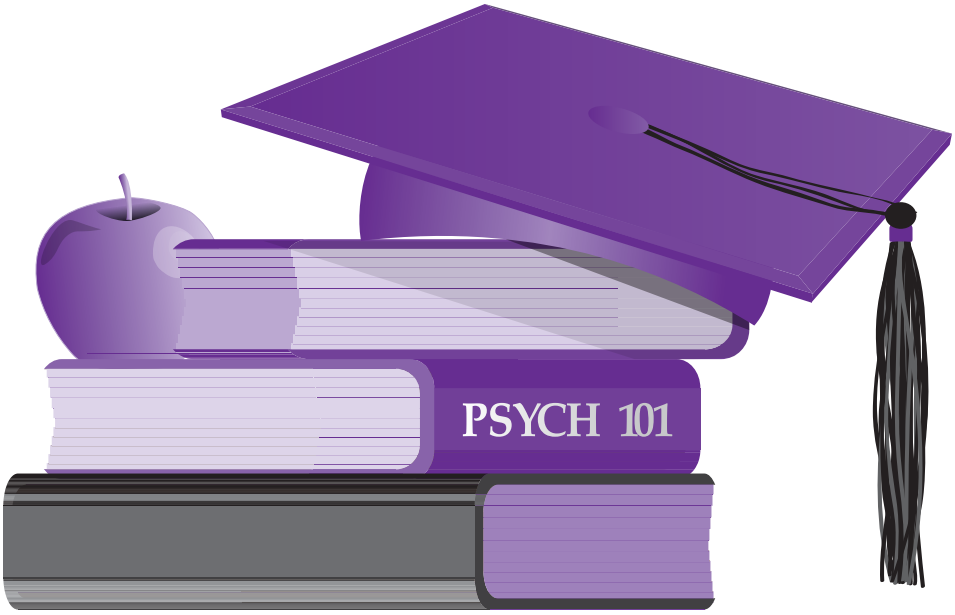

As residents and fellows, we are the continuous recipients of educational experiences as part of our training. However, many psychiatry trainees have an interest in education that extends far beyond their own personal educational experience. This issue illustrates that point well, with our colleagues from around the country sharing the scholarly approaches they have taken to education. Dr. Jennifer Alt starts us off with a poignant reflection on the steps she has taken to enhance the development of clinician educators within psychiatry. We then shift perspectives by addressing education of patients and their families as opposed to education of trainees. From there, Dr. Brian Cooke describes two innovative teaching techniques he has successfully used in medical student education. The 2008–2010 American Psychiatric Leadership Fellows share their approaches to finding sustainable funding for educational programs in psychiatry. They undertook a daunting task amid the "perfect storm" of the current economic climate and the ever shrinking financial support from pharmaceutical companies. Also, Drs. Pope and Coffey have contributed articles on their scientific approaches to enhancing neuroscience curricula and neurology, respectively, within psychiatry training programs. We hope these articles will inspire you to challenge the status quo in attempting to optimize education of medical students, residents, fellows, patients, and families.

New Year, New Editor-in-Chief

Sarah B. Johnson, M.D., Editor-in-Chief

As we enter 2010, I would like to take a few moments to reflect on the *Residents' Journal* and look ahead to the future. It has been an exciting year for the Blue Journal. We have expanded our readership (more than 2,000 subscribers); we have a new look (thanks to the wonderful graphic design and editorial staff!); and our monthly editors have done a fabulous job producing high-quality articles on a wide array of topics relevant to our readers.

It seems like only yesterday that I became Editor of the *Residents' Journal*, but it is now time to begin the search for the next Editor-in-Chief. Editing this journal has been a wonderful experience, and I highly encourage anyone interested to become involved. Responsibilities include:

- Designating an editor for each monthly issue
- Editing each issue in collaboration with the editor for that month and *The American Journal of Psychiatry's* (AJP's) professional staff
- Reviewing additional submitted manuscripts
- Working with the Editor of AJP on the future directions for the *Residents' Journal*

The commitment averages 5 hours per week. If you would like to be considered for the position of Editor-in-Chief for the 2010–2011 academic year, please send a CV and personal statement describing your vision and qualifications to sarah.johnson@louisville.edu no later than **February 15th**. The new Editor will be selected by mid-March and begin his or her term after the American Psychiatric Association (APA) annual meeting. If you are not selected for the position, you may have the opportunity to contribute by serving as a monthly editor. Applicants must be members-in-training of APA.

Thanks for your loyal readership and best wishes for 2010!

On Becoming a Medical Educator

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Residency is a unique moment in life when one is poised half way between being a learner and being a teacher. As medical students, we are trained to "take it all in" and "spit it all back." Our 16 years of education have taught us well how to learn. But upon graduation, we are expected to make a mysterious and rapid transition from spending all of our time learning to spending a significant portion of our time teaching. For most residents, however, teaching medical students, along with running a code, is one of the most anxiety provoking experiences in residency.

I experienced this anxiety when, early in my residency, I was asked to give a lecture on personality disorders to students in the physician's assistant program at the University of Wisconsin. Since I had been a resident for almost 2 months, it was somehow assumed that I had made the mysterious transition from full-time learner to at least part-time teacher. I threw myself into the preparation, spending hours reading up on the makings of personality, the treatment for various disorders, and the history of the idea of personality. I developed a comprehensive 10-page handout and delivered a dizzying lecture, complete with references to monozygotic versus dizygotic heritability rates and John Bowlby's attachment theory. It is hard to say who suffered more during that 1-hour lecture—the students or me—but by the end I was exhausted and humbled.

I was somewhere in the middle of this first lecture when I came to the abrupt realization that I had never been taught how to teach. In order to rectify this, and on the theory that practice makes perfect, I decided that the best way to become a better teacher was simply to spend more time teaching. Over time, I managed to teach physician's assistant students, social work students, medical students, and residents, although I continued to face the essential problem that I was educating myself about what worked and what didn't in my instructional endeavors. Further, while the few teaching skills I had gathered were useful for me, there was no formal structure for me to share them with other residents.

Eventually, in 2008, my program launched a 5-hour workshop series on residents as educators. It is targeted at PGY-I residents and focuses on some of the basic teaching skills residents will need on the wards: goal setting and using student learning plans, giving feedback, determining the student's level of learning, and using microskills or "1-minute teaching." This program has been very successful, with residents experiencing significant gains in their teaching abilities as a result of participating in the workshops. Additionally, in 2009 we started a clinician educator track, and courses in adult education, curriculum design, and medical education research will be offered as part of this track.

For me, these workshops have been a chance to connect more deeply with others who share my interest in medical education. I have always felt that developing an educational program is, in some ways, like constructing an extended family. In my more affectionate moments, I often refer to my students as "my kids," and I find that I love to see them strike out on their own, interviewing a psychiatric patient for the first time or writing up their first history and physical. I love to see them grow in confidence, making suggestions about treatment and interventions. And I feel for them when they struggle, failing to understand an important concept or being "pimped" before their peers. Developing programs to engage residents in education has finally given me a chance to share these feelings with others and expand my educational family.

Dr. Alt is a fourth-year resident at the University of Wisconsin Hospital and Clinics and a previous Issue Editor for the Residents' Journal.

Family Psychoeducation: How Do We Teach Patients and Families?

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As residents and fellows, many of us are interested in learning how to be better teachers of medical students and other trainees. However, how often do we think about psychiatric education in terms of how best to educate our patients and their families? Family psychoeducation is a well-validated form of psychiatric treatment that consists of a structured didactic program for patients and their family members. Participants are educated about mental illness, treatment, and how best to work as a family unit. However, we need not look too far into our profession's past to find problematic interactions between psychiatrists and family members in which frequent blaming of the family occurred (e.g., the "schizophrenogenic mother"). Families were told to confront their mentally ill loved ones about psychiatric symptoms, encourage their mentally ill family members to express very strong emotions (i.e., to display rather than suppress high-expressed emotion), and have the highest of expectations (1). These approaches to working with families did not have an educational focus. It also became increasingly clear that they were not helpful and perhaps were harmful (2). Psychiatrists then began to experiment with educational and collaborative approaches to working with families, and there has been accumulating evidence of the value of the family psychoeducation approach ever since.

Because residents in most psychiatry training programs are not formally instructed how to teach patients and their families about mental illness and because we recognized a gap in the complement of patient care services our facility offered, we created a year-long elective in family psychoeducation for schizophrenia. The purpose of the present article is to provide a description of the development of this elective as a useful tool for

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Table 1

Session	Topic
1	Introduction to psychoeducation: What is the history of schizophrenia and severe mental illness?
2	Epidemiology and life course of severe mental illness: Who gets it? Will it get better or worse with time?
3	The personal experience of severe and persistent mental illness: What is it like to live in the brain of someone with schizophrenia?
4	The public experience of severe and persistent mental illness: What is it like to interact with the world when you have schizophrenia?
5	Treatment of severe mental illness: how antipsychotic medications work and why they are needed.
6	Treatment of severe mental illness: side effects of antipsychotic medications and strategies to overcome them.
7	Treatment of severe mental illness: other medications besides antipsychotics.
8	Treatment of severe mental illness: psychosocial approaches such as talk therapy, community support programs, job training, and more.
9	The family and mental illness: the needs of the client.
10	The family and mental illness: the needs of families and their reactions to illness.
11	Common problems that clients and families face and what families can do to help, I (revise expectations, create barriers to overstimulation, set limits).
12	Common problems that clients and families face and what families can do to help, II (selectively ignore certain behaviors, keep communication simple).
13	Common problems that clients and families face and what families can do to help, III (support medication regimen).
14	Common problems that clients and families face and what families can do to help, IV (normalize living routine).
15	Common problems that clients and families face and what families can do to help, V (recognize signals for help).
16	Common problems that clients and families face and what families can do to help, VI (consult professionals).
17	Conclusions and wrap up.

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other psychiatry residents who wish to learn the skill set involved in psychoeducation for severely mentally ill patients and their families.

Method

We utilized various resources in putting together a family psychoeducation program at our local Veterans Affairs Mental Health Intensive Case Management center, which is an assertive community treatment model. Resources included a review of authoritative texts on family psychoeducation for schizophrenia, especially *Schizophrenia and the Family*, by Carol Anderson and colleagues (1); a review of additional literature; and discussions with local, national, and international experts in family psychoeducation.

Results

Each of these resources emphasized that the main goal of family psychoeducation is the improved well-being and functioning of patients. Family members incidentally might benefit from this treatment modality, but everything taught during family psychoeducation ultimately is to benefit the patient (3). We also found it important to investigate the reasons why family psychoeducation might work so as to be sure that we were incorporating the necessary "ingredients" in our curriculum. Research suggests (with varying levels of evidence-based support) that the necessary therapeutic components of a family psychoeducation curriculum should include the following topics: teaching structured problem solving techniques; encouraging family members to expand their social networks (e.g., NAMI); helping to improve the quality of family communication, especially to reduce critical and highly emotionally charged communication; developing explicit crisis plans; and coordinating family goals so that everyone is working toward the same objective (4). One of the most well-established findings in our appraisal of various resources was that the length of treatment matters. Family psychoeducation programs lasting less than 6 months on average show no effect on relapse rates, while those greater than 9 months result in significantly lower relapse rates (5). Accordingly, it was important that the program we developed fit the latter timeline.

Importantly, the literature demonstrates conclusively that family psychoeducation works, and we emphasized this to our patients and families in recruiting them for this treatment. Over the past two decades, more than 30 randomized trials have shown that family psychoeducation is highly effective in reducing relapse rates among clients with schizophrenia (6). Relapse rates for patients in families receiving psychoeducation are approximately 15% per year during intervention compared with 30%-40% for those receiving medication either with or without individual psychotherapy (6).

Incorporating the theoretically necessary elements, along with consultation with experts and use of the respected text by Carol Anderson and colleagues, we developed the curriculum as outlined in Table 1. We designed this curriculum to be taught over the course of 1 year and in a multifamily group setting, in accordance with the strong recommendations of William McFarlane (6), one of the most prominent researchers and clinicians in the field of family psychoeducation

Conclusions

We hope that this review of practical resources and literature in the field of family psychoeducation for schizophrenia, as well as sharing the curriculum we developed, will inspire other trainees to start similar programs within their residencies. The reward of helping patients with schizophrenia via an intervention that has efficacy demonstrated to be comparable to that of antipsychotic medications is itself sufficient cause for such an undertaking. In addition, the benefits to the psychiatry resident extend far beyond helping individual patients and families. We all know that to teach well, one needs to understand the material well. In teaching this curriculum, the resident will develop a much deeper understanding of each of the topics related to schizophrenia, pharmacology, families, and psychodynamics. Moreover, both residents and their supervisors will likely learn, as we have, newfound language to use and strategies to share in communicating with all of our patients and their families in whatever clinical setting we find ourselves.

The author wishes to thank two individuals for their input and assistance with this article detailing the program they developed: Robert M. Factor, M.D., Ph.D., and Douglas A. Kirk, M.S.W., L.C.S.W.

Dr. Factor is Professor Emeritus of Psychiatry at the University of Wisconsin and Medical Director of the Veterans Affairs Mental Health Intensive Case Management center in Madison, Wisconsin. Mr. Kirk is the Program Director of the Veterans Affairs Mental Health Intensive Case Management center in Madison. Dr. Reardon is a fourth-year resident at the University of Wisconsin Hospital and Clinics and the Editor for this issue. Address correspondence regarding this article to Dr. Reardon, University of Wisconsin Hospital and Clinics, Department of Psychiatry, 6001 Research Park Boulevard, Madison, WI 53719.

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Integrating Neuroscience Into Psychiatric Training

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You have just finished examining a patient, and the parents look to you for your diagnosis. You explain to them that their son has an underactive amygdala that is weakly connected to his ventromedial and dorsolateral prefrontal cortex. Further, it is likely that his anterior cingulate is not responding correctly to stimulus presented in the environment. Okay, so you would not actually say this to a parent, but someday clinicians may be thinking these thoughts as they diagnose a child with conduct disorder.

Our understanding of the neurobiological basis of mental illness continues to grow at a rapid pace. Genetics, imaging, and molecular studies have provided new insight into the mechanisms that result in mental illness. Further, these different modes of inquiry have begun to converge, allowing insight into these processes from several vantage points. Unfortunately, the communication and integration of this information into training and clinical practice has not kept pace. This creates the concern that the gap between scientific knowledge and clinical training may became so wide that we will lose the ability to effectively communicate this information to our patients.

To improve the transfer of scientific knowledge into clinical practice, there are several initiatives underway to develop a neuroscience curriculum that could be integrated into psychiatry residency training. The idea of a neuroscience curriculum is not a new one, but the need for such a curriculum seems to have taken on an urgency that has not been present in the past. This urgency was conveyed during a focus group of residents and early career psychiatrists at the 2009 Annual Meeting of the American Psychiatric Association (APA). During the focus group workshop, many participants identified the need to have more science integrated into training. This sentiment was echoed in an APA member survey conducted by the Future of Psychiatry Work Group, in which neuroscience was identified as the number-one priority in preparing the field for the future.

A number of different approaches are being taken to develop such a curriculum. One example is a lecture series created by Dr. James Hudziak at the University of Vermont. The series is presented by teleconference and addresses the major mental illnesses of childhood. It is also interactive, allowing viewers to ask questions and participate in discussions in real time. The National Institute of Mental Health piloted another approach during a "Brain Camp" that they sponsored in the spring of 2009. During the intensive program, residents were presented with cutting-edge research that addressed pathology from genes to behavior. While the best methods for presenting this information are being debated, there is consensus that a program is needed. It is also clear that one size will not fit all, as the resources to teach such a curriculum vary greatly among residency programs.

So back to our patient, should we use a behavioral intervention to strengthen the connection between his amygdala and prefrontal cortex, or should we use a dopamine enhancing medication to increase activity in the frontal cortex? Well, I do not think we really know the answer yet, but I am hoping that time will tell.

Dr. Pope is a fourth-year Child and Adolescent Psychiatry Research Fellow at Children's National Medical Center and the National Institute of Mental Health. Dr. Pope is also a previous Issue Editor for the Residents' Journal.

Improving Medical Student Lectures: Two Innovative PowerPoint Techniques

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Residency training often provides opportunities to teach medical students. At first, these invitations may evoke feelings of anxiety and self-doubt. However, available resources provide guidance and instruct an educator how to teach (1–3), and residents may improve didactic practices by seeking mentorship and feedback.

Experienced educators are aware that the presentation and accessibility of their classes may be as important as the content (4). "Nonlecture methods" have been reviewed to improve teaching practices (5). Moreover, residents may be at an optimal point in their training to try new technological strategies when teaching students.

In the present article, I describe two Microsoft PowerPoint-based classes that I have used to teach medical students in their psychiatry clerkship. These classes were designed as an attempt to break away from traditional lecture-style didactics. I transitioned to the two methods when my lectures seemed to become stale and lifeless. Both techniques encourage participation and allow students to influence what material will be covered.

Technique 1

The first class using PowerPoint was structured around an educational game based on the popular television show *Jeopardy!* The purpose of my class was to create an interactive environment for students to review psychiatric topics before an exam. This technique has been used in other areas (6-8) but to my knowledge has not been discussed in the psychiatric literature.

The rules of the review session are similar to those of *Jeopardy!* Teams of students answer questions to gain the most number of points. The questions test students' knowledge of psychiatric diagnoses, psychotropics, and other information expected to be mastered during their clerkship. Category headings group the questions by topic. A "daily double," hidden among the questions, allows the team who selects it to wager their points. I have found that it takes approximately 1 hour to play 25 questions (which I organize into five categories, each with five questions). A concluding "final jeopardy" question requires the teams to work together to determine the diagnosis presented in a more complicated clinical vignette.

Jeopardy-based PowerPoint templates are readily available online. While most PowerPoint presentations proceed linearly, instructors navigate through this review session by using action buttons to connect slides via hyperlinks. The *Jeopardy*-based game board is displayed on one slide, with each dollar amount hyperlinked to the corresponding question slide. Each answer slide contains an action button that links back to the game board slide. Pictures, sound effects, and video clips can easily be inserted into the slides. Residents may be the ideal individuals to lead this *Jeopardy*-based review session, since they are often energetic and enthusiastic instructors.

Technique 2

The second PowerPoint class is based loosely on the *Choose Your Own Adventure* children's books, which were a popular series in the 1980s and 1990s. Due to its overwhelming success, with more than 250 million copies sold between 1979 and 1998 (9), the majority of the present generation's medical students remember reading these books as children. The original *Choose Your Own Adventure* stories were narrated in the second-person point of view. The reader assumed the role of the protagonist and made choices to determine the protagonist's actions in response to the plot and its outcome. After the reader made a choice, the story unfolded, with more choices and multiple possible endings.

The *Choose Your Own Adventure* structure lends itself nicely to a problem-based learning class. Students are provided the opportunity to influence the clinical course of a fictional patient encounter and to dictate the direction of the class. This format also resembles the United States Medical Licensing Examination Step 3 Primum Computer-Based Case Simulations.

After explaining the format of the class, the PowerPoint begins with a brief clinical vignette. The class is highly interactive, as students take turns choosing the next step in obtaining the patient's history, ordering laboratory tests, formulating a differential diagnosis, and providing treatment.

Each PowerPoint slide includes informational text with choices located at the bottom. Each choice is inside of a text box that hyperlinks to a corresponding slide. Following the format of the *Choose Your Own Adventure* series, some of the available choices advance the "plot" (e.g., progress in evaluating and treating the patient), while other choices may lead to a negative outcome (e.g., prescribing a medication that results in adverse side effects). When the students make a choice that ends the "story," clinical implications are discussed, and the previous slide is returned to allow for another choice.

Discussion

Educators should consider searching for methods to improve their classes and update PowerPoint lectures to captivate their students. Using PowerPoint for a *Jeopardy*-based review session and a *Choose Your Own Adventure*-style class will transform traditional lectures into courses that are interactive, engaging, and fun. These courses provide an interface

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for the instructor and students to discuss the material in collaboration. With these techniques, students and instructors will experience a shared enthusiasm for medical education.

Dr. Cooke is a Forensic Psychiatry fellow at Yale University School of Medicine.

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Show Me the Money!: Sustainable Funding for Education in Psychiatry

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(2008–2010 American Psychiatric Leadership Fellows)

Introduction

The American Psychiatric Association (APA) American Psychiatric Leadership (APL) Fellowship Program was established in 1968 through a grant from the Maurice Falk Medical Fund (establishing its original name, the Falk Fellowship Program). Currently known as the American Psychiatric Leadership Fellowship, it is the oldest and considered one of the most prestigious fellowships in the APA and has launched the careers of many of the leaders in the field of psychiatry. The APL Fellowship is focused on developing tomorrow's leaders by involving awardees in a wide range of structured experiences. Attendance at APA annual meetings forms the basis for a rich experience, including presenting a workshop at the meeting. The Fall Components Meeting immerses awardees in the leadership structure of APA and in emerging issues in the field of psychiatry. Both meetings are greatly enhanced with additional structured activities designed exclusively for the awardees, which further develop their leadership competencies.

The overarching goal of the Fellowship is to prepare leaders in psychiatry. The Fellowship prepares residents for leadership in APA as well as for leadership roles in whatever setting they may enter, including academia, private practice, research, clinical care, and public psychiatry. A 2-year cycle of activities is designed to develop their leadership skills and political acumen, expand their collegial networks, and expose them to best practices in the field as well as to traditional involvement in APA's leadership structure.

It comes as no surprise that previously abundant streams of funding to support fellowships, such as the APL Fellowship, have dried up in the current economic climate. Upon being selected for the 2008 APL Fellowship, Fellows were presented with the stark reality that funding was to be discontinued. Thus, the main project that presented itself to our incoming group was to rise to the challenge of finding sustainable sources of funding, especially from nontraditional sources (i.e., nonpharmaceutical). Traditional providers of financial support met our solicitations with polite reluctance—there was a lack of means but no lack of desire. This circumstance left our Fellows reflecting on not only the *privilege* of formal leadership development in times of plenty but also the *necessity* of it in challenging times like the present. With mentorship guidance, we made honest—and sometimes difficult—reassessments of the goals and objectives of the Fellowship. In turn, we could prioritize the directions in which we would place our focused efforts and limited resources in seeking funding. This recalibration of goals and objectives, along with a nontraditional approach to a core prerequisite demand for education and training, led to the planning of the survey project, which we have called "Show me the money!"

Method

We developed a list of categories of potential donors to psychiatry educational programs, specifically to the APL Fellowship. These categories included charitable foundations and large companies, APA members, APL Fellowship Alumni, the APA itself, and pharmaceutical companies. Specific foundations and companies were chosen based on their previously having donated to medical education projects or personal connections we had with them.

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Table 1. Survey Questions

1. What types of programs are supported?
2. What is the application process to secure such support?
3. What is the typical type/amount of support offered?
4. Is support renewable from year to year? If so, is it automatic, or is re-application necessary?
5. What is the timeline for applying for support?
6. Are there guidelines for cultural/philosophical compatibility with donees?
7. What type of advertisement, if any, does your organization require?

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Each category of potential donors necessitated a different process through which we approached representatives within that category. For APA membership as a whole, we developed a notation on the American Psychiatric Foundation website. To alumni of the Fellowship, we wrote letters and sent follow-up emails. We requested funding for the Fellowship from the APA itself via a presentation to the Board of Trustees. We learned that the American Psychiatric Foundation preferred to be the entity requesting funding from pharmaceutical companies, and thus we allowed the Foundation to make those contacts. Finally, charitable foundations and large companies represented the largest number of entities we contacted and required the most planning. For these groups, we wanted to undertake a quantifiable approach that would yield categorizable data. As such, we developed a brochure describing our Fellowship and mailed/e-mailed it with a standard questionnaire, which we also developed, to each organization. We followed up these mailings with phone calls.

We employed a number of general strategies in soliciting donations from all of these various groups. We made sure to emphasize the importance of the program for which donations were being sought.

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Table 2. Survey Results

Name of Funder	Types of Programs Supported	Application Process	Typical Award Size	Funding Renewable?	Required to Acknowledge Funder?
Institute for Healthcare Improvement	Mission is to improve quality of health care	No awards given	None	None	No
Lean Organization	No response	No response	No response	No response	No response
Cyberonics	Mission is to improve lives of people with disorders that can be treated with VNS	Unsolicited applications accepted	No specific limit	Yes	Did not respond
Partners Healthcare	Mission is to improve community based care	Not specified	Total awards for 2007 $15 million	Did not respond	Did not respond
Robert Wood Johnson	Several areas	Solicits proposals	$1000 to $50 million	Yes	Grantee use of name sometimes allowed
Blue Cross Blue Shield	Excellence in the provision of care by hospitals and physicians	No response	No response	No response	No response
Kaiser Foundation	Health policy, media and public education	Does not accept unsolicited proposals	No response	No response	No response
Kingenstein Third Generation Foundation	Research and training in child and adolescent psychiatry	Unsolicited applications submitted online	4 $60,000 fellowships per year	No	None
NARSAD	Funds prevention research	Unsolicited applications accepted	$60, 000-$200,000	No	No
Apple	No funding available	No	No	No	No
Google	Several areas including research	Unsolicited applications submitted online	No specific dollar amount	Yes	No response
Qatar Foundation	Educational Programs	No unsolicited applications accepted	No response	No response	No response

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Likewise, we emphasized the unique nature of the Fellowship. Importantly, we offered something in return, such as public acknowledgement or advertisement. Finally, we utilized name recognition, for example, by having well-known Fellowship alumni sign our letters and e-mails requesting donations.

Survey Design

We designed a survey to be distributed to the largest category of potential donors (the charitable foundations and large companies) in order to standardize the data we would be collecting. In an effort to compare the philanthropic activities of the different categories of potential donors, questions were designed to be nonspecific and generalizable to varying organizational structures. Furthermore, as several of the APL Fellows were new to the field of philanthropic giving, the questions were designed to be exploratory, potentially yielding new information beyond the scope of our basic knowledge.

The objectives of the survey were to identify the philanthropic interests of each organization, to understand the cultural and/or philanthropic compatibility with the mission of the Fellowship, to determine renewability of the grants offered, and, ultimately, to create a relationship with the organization of interest.

Based on these objectives, we developed a survey consisting of seven open-ended questions following a qualitative design (Table 1). The questions were concise, allowing the survey to be administered efficiently by the Fellow via telephone or completed in writing through e-mail. Overall, the intention was to avoid creating a laborious survey that could dissuade participation.

Results

We sent our survey to 12 charitable foundations and large companies. We received a response from 11 of them, although to varying levels of detail and completeness with regard to our survey questions. Table 2 delineates responses from each organization we contacted, with several organizations requiring multiple contacts before we heard back from them. Given the variation in the degree and quality of responses received, further quantifiable summation of the data are unlikely to be valid.

Qualitatively, we were told many times that while these organizations would like to help programs such as ours, they simply did not have the financial means to do so at the present time. As such, we were not able to secure funding from any of these organizations. Regarding our other pursuits, we received a modest amount of donations from APA members and APL Fellowship Alumni. However, the American Psychiatric Foundation was unable to secure funding from any pharmaceutical companies. The APA has generously agreed to fund the Fellowship at least through the spring of 2010, although difficult financial times make the future of this and other APA fellowships uncertain.

Conclusions

These qualitative data press the point that new sources of funding for educational programs in psychiatry are needed. They also call attention to two important directions for future leadership training and fellowship activities: teaching philanthropic skills and developing new approaches for the involvement of residents in professional organizations and societies apart from sponsored fellowships. It is our hope that the APL Fellows' future work will continue in these directions.

Previously presented at the Annual Meeting of the American Psychiatric Association, San Francisco, Calif., May 16–21, 2009. *Dr. Alsuwaidan is a fifth-year resident at the University of Toronto. Dr. Burpee is a fourth-year resident at the University of Massachusetts. Dr. Coffey is a fourth-year resident at the University of Michigan. Dr. Pope is a Child and Adolescent Psychiatry Research Fellow at Children's National Medical Center and the National Institute of Mental Health. Dr. Reardon is a fourth-year resident at the University of Wisconsin and the Editor for this issue. Address correspondence and reprint requests to Dr. Reardon, University of Wisconsin Hospital and Clinics, Department of Psychiatry, 6001 Research Park Boulevard, Madison, WI 53719.*

Peer Education: An Effective Strategy for Teaching Clinical Neurology to Psychiatry Residents

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Despite emphasis from the American Board of Psychiatry and Neurology, teaching behavioral neurology and neuropsychiatry to psychiatry residents remains a challenge of growing importance. Psychiatry residency directors identify neuropsychiatric conditions as the most important topics in neurology for psychiatry residents to master (1). Many departments of psychiatry lack the necessary faculty expertise to teach neuropsychiatry to their residents (2). Moreover, there are very few reports characterizing the types or effectiveness of educational experiences in neurology or neuropsychiatry that psychiatry residency training programs offer.

We evaluated the effectiveness of an interdisciplinary peer education program designed to teach psychiatry residents the fundamentals of clinical neurology. We implemented an 8-week resident-designed summer grand rounds series required for all psychiatry residents in our adult psychiatry residency training program. All psychiatry fellows, as well as any interested faculty or staff, were also invited. Each lecture was delivered by a senior resident or fellow in our department of neurology or psychiatry and included a 45-minute didactic portion followed by a 15-minute discussion. If a senior resident or fellow was not available, the lecture was given by a highly regarded clinical teacher of the topic (rather than a faculty member of research expertise). The series was clinically focused on key topics in behavioral neurology and neuropsychiatry. The series included the following topics: neuroradiology, stroke and stroke syndromes, movement disorders, neuropsychology and the dementias, epilepsy and nonepileptic seizures, sleep and sleep disorders, pain and pain syndromes, and catatonia.

More than 95% of all trainees attended, and each trainee completed an evaluation at the conclusion of each lecture in the series (response rate: 100%). Evaluations were also collected from any psychiatry fellow who attended. Trainees rated all eight grand rounds favorably on 5-point Likert scales measuring perceived clinical relevance (mean=4.26 [SD=0.78]) and educational helpfulness (mean=4.23 [SD=0.79]).

Conclusion

Interdisciplinary peer education is a strategy that is both effective and efficient for teaching psychiatry trainees the fundamentals of clinical neuropsychiatry. Possible drivers of the program's success include selecting topics that psychiatry residents perceive as highly clinically relevant, selecting speakers who are highly regarded for their teaching skills, and creating an environment for enjoyable peer education tailored to the needs of general psychiatry residents.

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