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TRAINING OF PSYCHIATRISTS

**Twelfth Report
of the Expert Committee on
Mental Health**

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EXPERT COMMITTEE ON MENTAL HEALTH

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TRAINING OF PSYCHIATRISTS

Twelfth Report of the Expert Committee on Mental Health

The WHO Expert Committee on Mental Health met in Geneva from 25 September to 1 October 1962. The meeting was opened by Dr P. Dorolle, Deputy Director-General of the World Health Organization. Professor P. A. H. Baan was elected Chairman and Professor T. Lin, Vice-Chairman; Professor J. R. Ewalt and Professor I. Matte Blanco were elected Rapporteurs.

1. NEED FOR PSYCHIATRISTS

The growing demand for psychiatric care that is becoming evident all over the world is due to two sets of circumstances. The first is the general increase in mental disorders requiring treatment; this is so marked that even countries with very ample resources in money and manpower are beginning to worry about the future. The second is the rapid growth of theoretical and practical knowledge, which, in recent decades, has broadened the scope of psychiatry far beyond the traditional custodial care of the insane, giving more and more opportunity for the care and prevention of all kinds of mental disorders, including the neuroses, disturbances in social behaviour and certain psychosomatic illnesses.

As these developments take place, there is growing recognition of the fact that it is neither necessary nor desirable that all psychiatric work should be done by specialists. Just as is the case with internal medicine and surgery, a large number of the professional tasks can, and should, be the responsibility of others, such as general medical practitioners, public health officers, and even certain non-medical personnel.¹ This means that the role of the psychiatrist should be limited, on the one hand, to the carrying out of medical activities for which thorough specialized training is necessary and, on the other, to the teaching and guidance of non-specialized workers.

¹ See also, in this respect, the ninth and eleventh reports of the Expert Committee on Mental Health, on the subjects of "The Undergraduate Teaching of Psychiatry and Mental Health Promotion" and "The Role of Public Health Officers and General Practitioners in Mental Health Care" (*Wld Hlth Org. techn. Rep. Ser.*, 1961, 208, and *Wld Hlth Org. techn. Rep. Ser.*, 1962, 235).

However, it would be a mistake to conclude from the foregoing that the growing scope of psychiatry might eventually diminish the need for trained psychiatrists. In fact, the contrary is true. As psychiatric treatment is demonstrated to be more efficacious than heretofore, larger numbers of persons are likely to seek it. Nor will the increasing use of psychopharmacological techniques reduce the need for psychiatrists; on the contrary, this approach calls for simultaneous psychotherapy and sociotherapy if the initial response of the patients to these drugs is to be sustained. As to the non-specialized workers, they do not replace psychiatrists; rather, they tend to increase the need for them, for purposes of training, supervision and consultation. Moreover, it is obvious that arrangements that extend the possibilities of meeting the community's mental health needs cannot but create a greater demand for fully trained specialists.

In the opinion of the Committee, psychiatrists are required for the following activities :

- (1) to treat a large sector of the mentally ill ;
- (2) to take an active part in the planning and organization of psychiatric services ;
- (3) to take the lead in mental health activities, including the information and education of the public ;
- (4) to communicate competence in handling minor psychiatric disorders to other workers, especially to medical practitioners ;
- (5) to advance the knowledge of psychiatry and of its basic subjects.

This means that, in spite of being relieved of many preventive and curative tasks, the psychiatric specialist of the present day has a considerably wider field of action than that of the alienist of the past. It should be noted, moreover, that the growing scope of psychiatry is of great significance not only to the number of psychiatrists needed, but also to the type and the quality of the specialist training to be offered.

2. AVAILABILITY OF PSYCHIATRISTS

As was pointed out by the Expert Committee on Mental Health in its tenth report,¹ all countries complain of a shortage, or at least a maldistribution, of psychiatrists. In preparation for the present meeting a questionnaire² was sent to the governments of Member States and associate members of WHO, with requests for information on the existing numbers of specialists in psychiatry and neurology, the facilities for their training, and the requirements and organization of training. Up to the time of the

¹ *Wld Hlth Org. techn. Rep. Ser.*, 1961, 223.

² C.L.7, 1962, Annex.

meeting, responses had been received from 76 of the 109 governments approached.

On the basis of the replies, and of other available information from non-responding countries, tables were drawn up showing numbers of psychiatrists and/or neuropsychiatrists per 100 000 population. Wide variations were found, ranging from 0 for eight of the responding countries (with a combined population of about 20 million) to more than 7 per 100 000 population for one country. The following table gives a further rough indication of the numbers of psychiatrists available in the countries considered.

NUMBERS OF PSYCHIATRISTS AND/OR NEUROPSYCHIATRISTS PER 100 000 POPULATION IN COUNTRIES, 1962 OR LATEST AVAILABLE YEAR

Number of psychiatrists and/or neuropsychiatrists per 100 000 population	Number of countries	Aggregate population (millions)
0	8	20
up to 0.49	35	890
0.5 - 1.99	13	194
2.0 - 4.0	21	582
over 4.0	8	265

The required information was not available from 24 countries (aggregate population 191 million).

The majority of psychiatrists and/or neuropsychiatrists indicated in the response were recognized as having completed a formal training and/or having passed a qualifying examination. However, it became apparent from responses to later questions that the standards of training thus recognized were very different.

The Committee noted that in at least one country the number of trained physicians is as low as nine per million population. In this connexion it pointed out that, if psychiatrists are to be provided, there must be physicians available to undergo the specialized training required. Moreover, in countries with very few physicians, the question arises of the proportion that should specialize in psychiatry. Governments may wish to consider this point more fully, possibly in collaboration with WHO.

The Committee did not deem it possible to suggest valid estimates for optimal numbers of psychiatrists per population. It agreed that the need for more psychiatrists is everywhere felt to be large and immediate. However, the numbers of psychiatrists required would depend on the medical systems of countries, on their social structure and level of development, on the availability of institutions, including psychiatric facilities, and on

their cultural conditions and traditions. In this connexion the fact was noted that the percentage of psychiatrists employed in public institutions differs greatly from one country to another.

3. AVAILABILITY OF TRAINING

The questionnaire mentioned above also asked for information on present training facilities.

The responses indicated that in each WHO region some training is being undertaken, as shown by the following provisions: in the African Region, three complete training-courses and one to begin shortly; in the Americas, more than 200 three-year courses and about 70 shorter ones in the United States of America, and about 50 courses providing one to three years' training in part fulfilment of requirements in Canada, and one to four courses in a few of the South American countries; in the Eastern Mediterranean Region, preliminary training under a regional plan before sending candidates abroad to complete their courses; in Europe, at least some facilities for psychiatric training in most countries; in the South-East Asia Region, about 12 partial or complete courses; in the Western Pacific Region 46 courses in Japan, and about 15 in other responding countries.

The Committee noted the fact that important differences exist between various countries, some being more or less satisfactorily provided with training facilities and others having only very few facilities. It also gave consideration to the wide variations in the intensity and quality of the training provided.

As to intensity, certain conclusions can be drawn from the prescribed duration of training. According to the information received, this varies from one to five years for broad general training (one year in two countries; two to two-and-a-half years in seven countries; three to three-and-a-half years in 25 countries; four to four-and-a-half years in nine countries; five years in five countries). In some cases a year of internship in general medicine is included in this period. Certain countries referring to one to three years of training require, however, up to six years of clinical experience for recognition as a psychiatrist. The largest number of training-courses is to be found in the United States of America and in the Soviet Union. In both countries the broad general psychiatric training is given in psychiatric hospitals approved for training, in some cases sponsored by a university. This training lasts three years. In the United States of America a further two years' experience is required for admission to the examination for certification in psychiatry or neurology. In the USSR an additional five months of intensive theoretical and clinical specialization in psychiatry at special Institutions of Higher Studies in Medicine are required before

examination for acceptance as a psychiatrist of the third category. Another examination, taken after two to four years of further specialization, leads to qualification as a psychiatrist of the second category. According to their experience and qualifications, some eventually become first-category psychiatrists.

In respect of quality, much less can be concluded from the questionnaire. However, it was noted with interest that about half of the total number of courses referred to are organized by universities, which in many cases have an attached university psychiatric hospital. Some countries provide both university-sponsored courses and training entirely organized by the public psychiatric service. Some new training-courses are being established which are organized jointly by the university, the teaching hospital and the local hospital board. Almost all countries providing training-courses have an official body in charge of certifying or recognizing them, usually set up by a ministry or a medical organization. In many instances, however, psychiatric training is carried out under a clinical apprenticeship system without any organized training according to a set curriculum. In these cases particularly, but occasionally also in specifically planned courses, the training is often rather biased, either overstressing or neglecting the somatological, psychological or sociological aspects of mental disorder, the phenomenological description or the dynamic interpretation of psychiatric symptoms and the in-patient or out-patient centred approaches to the treatment and care of the mentally ill. Nevertheless, as far as can be judged from the responses to the questionnaire, selective training of this type is now becoming rather less frequent.

4. PATTERNS OF TRAINING

Owing to the wide variation in existing resources, needs and patterns of health care in different countries of the world, it would be unrealistic to recommend a single pattern of training. There exists, however, a measure of agreement on the training that should form part of the experience of every clinical psychiatrist. Accordingly, the Committee considered it appropriate to indicate certain basic requirements that should be taken into account in the standard professional preparation, wherever local socio-economic conditions permit "broad" training. It also deemed it appropriate to suggest the additional training and experience desirable for psychiatrists who wish to concentrate on specific areas of the specialty — "differential" training.

The Committee noted, moreover, that the training of psychiatrists is becoming more exacting as a result of the constant rapid increase in knowledge of recent years. It thought it essential, therefore, to stress the

necessity for a continuing training of psychiatrists, by special courses and by continuous self-education throughout their professional careers.

4.1 Broad training

Important differences in content are to be found between training-courses in different countries and within the same country. One concerns the preparation of the "general psychiatrist", trained to carry out the functions outlined in section 1, as distinct from the psychiatrist with a differential specialization. There are some centres where psychiatrists specializing in child psychiatry or mental hospital administration, for example, receive all their graduate psychiatric training with their specialized function in mind and do not obtain instruction or experience in the other branches of psychiatry. The Committee deplored this tendency. It was strongly of the opinion that physicians wishing to devote themselves to a particular sub-specialty of psychiatry should receive an adequate broad training before doing so.

The Committee recommended, in respect of broad training, that the *minimum* duration of clinical experience and study should be three years. The first year might be devoted to clinical practice, under supervision, in a mental hospital or clinic which has been recognized for this purpose. In order to be recognized, the hospital must show that it provides the trainee with systematic clinical supervision, access to basic reference books and guidance in his studies. During the three years the trainee should have opportunities of seeing adult and child patients (including the mentally subnormal) and their families in various treatment settings—in-patient, out-patient, day hospital—and in the community prophylactic and treatment services. He should also have some experience of clinical work in neurology. The order in which the trainee obtains different parts of his clinical experience will vary according to local exigencies. The *standard* duration to be aimed at is, in the opinion of the Committee, a period of not less than four years. The *optimal* training can be expected to differ from the standard training in its intensity and in the degree of sub-specialization. It can be expected to last for not less than five years.

Some teaching in neurology forms part of broad psychiatric training in every country and the Committee endorsed this practice, recommending that a period of three to six months should be provided for teaching in this subject. In the opinion of the Committee, however, the necessity of recognizing separate specialization in psychiatry and neurology is unquestionable, since identification of the two usually operates to the detriment of psychiatry.

As to child and family psychiatry, the Committee recommended that a period of three to six months should be devoted to this part of the curriculum of "broad" training. This practice, which is already in force in France,

the United States of America and the USSR, has proved to be of great value.

With regard to general clinical experience, the Committee stressed the need to keep the psychiatric trainee in the closest possible contact with his community. His training should include sound knowledge of the principles and procedures of psychotherapy, practice in leading the psychiatric team in hospitals and in other services, experience in the conduct of therapeutic groups and communities, and thorough familiarization with the techniques of community care in general. In order to comply with this programme, some instruction in medical psychology and sociology, social anthropology and public health practice is necessary. The Committee preferred, however, not to make specific recommendations on the amount of time to be set aside for these subjects.

The Committee deemed a qualifying examination to be desirable. It considered, however, that this examination should test not only the trainee's theoretical knowledge, but also his practical skills, taking into account his superiors' appraisals during the training period.

4.2 Differential training

In the opinion of the Committee, broad psychiatric training cannot be sharply separated from the differential training that leads to sub-specialization in one particular branch of psychiatry. It considered, in fact, that all students of psychiatry should be encouraged, after completing their standard training, to devote a further year or more to enlarging this knowledge or to engaging in research. It was pointed out, however, that full differential training might require a longer period of time and that it would doubtless be necessary to establish systematic curricula for the various sub-specializations.

Thus, differential training in child and family psychiatry should include a thorough study of child psychology and family sociology, as well as clinical work in a paediatric institution; sub-specialization in social or forensic psychiatry would require the acquisition of some knowledge of the social sciences and of personal experience in subjects like public health, industrial medicine, medical jurisprudence, etc.; systematic training in psychotherapy would have to go beyond the theoretical acquaintance with various methods that should be obtained by every psychiatrist, but should be based on a process of systematic self-exploration through an insight-producing technique such as "personal analysis".

Further to these recommendations the Committee laid stress on two important points. One is the need to obtain further knowledge in psychiatry. The Committee considered that, even though it may not be feasible or even desirable for all trainees to undertake research, they should receive enough instruction on basic research methods to enable them to evaluate work done

by others. Moreover, an effort should be made to stimulate an inquiring attitude and a desire to attempt an evaluation of the results of therapy. Although a considerable amount of research in psychiatry is being undertaken in different parts of the world, few provisions have so far been made for specific higher training for research in psychiatry.

The other consideration is the need to impart existing knowledge. Special preparation of psychiatrists in the techniques of teaching appears so far to have received little attention, although a few countries, notably France and the USSR, have specially organized advanced training for teachers of psychiatry. In section 7 the Committee gives suggestions for promoting education and experience in how to teach psychiatry.

4.3 Continuing training

The need for continued self-education in psychiatry has already been stressed. In some countries this has become more formalized through the organization of refresher courses for continuing the training of psychiatrists and bringing their knowledge up to date. This practice was warmly recommended by the Committee. In the USSR the principle has been taken a stage further, in that attendance at refresher courses lasting four months every four to five years is obligatory for specialists in psychiatry, as in other branches of medicine.

4.4 Need for flexibility

As has been pointed out above, the Committee thought it unrealistic to prescribe a single pattern of training for all circumstances. On the contrary, it recommended a large measure of flexibility, in order to allow for the specific needs and preferences of given areas at given times.

It recognized, for instance, that the proportion of "all-purpose" to "special-purpose" psychiatrists may vary with the communities served, according to their social structure and the level of their economic and educational development. In this respect, the Committee emphasized that the level of social and educational development should have a bearing upon the content of training.

In stressing this, the Committee by no means favoured the idea that, for countries in different stages of development, different qualities of training should be provided. Neither did the Committee recommend fundamental differences in content. While considering, for instance, that in developing countries a sound knowledge of general health and public health was particularly necessary to the psychiatrist, it felt that similar knowledge was also essential to psychiatrists in developed areas. The difference would be limited mainly to the approach: in the first case, the approach would be more clinical and, in the second, more organizational.

In stressing the need for psychiatrists in developing countries to have special knowledge of cultural anthropology in relation to their own countries, the Committee did not wish to convey the idea that knowledge of his own society is less necessary to the psychiatrist in developed areas, although in this latter case, knowledge of this type may fall more into the pattern of classical sociology. In referring to the developed areas, the Committee recognized that special importance would have to be placed on training for teaching and research, but, at the same time, it was of the opinion that, wherever psychiatrists were trained, an attempt should be made to prepare them for passing on the knowledge acquired and for dealing with their patients not only from the point of view of clinical practice, but also from that of scientific inquiry through observation, experiment and conceptual analysis.

The Committee noted that the patterns of training prevailing in certain areas are to quite an extent determined by tradition and that it would be unwise to abandon all historical and philosophical differences in favour of a more or less uniform and universal design. It was felt, however, that different training orientations should not be mutually exclusive and that the various schools should be sufficiently tolerant of each other to avoid the rigid imposition of completely unilateral patterns of training.

5. BACKGROUND FOR SPECIALIZATION IN PSYCHIATRY

Psychiatry attracts a variety of people of different backgrounds and personal qualities. Since the teaching of psychiatric techniques depends largely on individual tutoring, a clear understanding of the trainee's motivation in entering psychiatry and of his ability, personality and socio-cultural background, together with a careful assessment of his knowledge and previous experience in medicine at large and psychiatry in particular, are essential in determining his suitability for specialization.

The recent considerable progress in psychiatry as a medical science has led to increasing intellectual challenges to young medical students. Three major types may be distinguished among these interested students. The first group consists of those whose main attraction to psychiatry lies in the search for scientific knowledge of the intricate functioning of the brain or of the mind-body relationship. Others come to psychiatry mainly because of their interest in the psychodynamic genesis of human behaviour and the use of the psychological approach to mental disorder. The third group of students comprises those who have a special interest in the social and environmental aspects of human life, in particular in the ways in which environmental factors influence the development of personality patterns; this includes interest in education as a major social force in moulding human personality and behaviour patterns.

As a profession and career, psychiatry presents diverse pictures in different societies. On the one hand, there are a few societies where young students are attracted to psychiatry because of its financial reward in private practice and, in rare cases, because of its professional standing. On the other hand, there are some countries where mental hospitals are staffed by people of mediocre ability who work there as a means of earning a stable living without showing genuine interest in psychiatry. The latter may be found in societies where mental health services are poorly staffed, where stigma is still attached to mental illness, or where psychiatry does not rate high in professional standing.

As regards the personal quality of the trainee, the Committee expressed its views on the attributes desirable in a psychiatrist: namely, emotional warmth in interpersonal relationships, sensitiveness and intuitive understanding of human emotions, coupled with intelligence and a high degree of flexibility in learning. In view of the lack of objective criteria in evaluating the above qualities, with the possible exception of intelligence, and taking into account the gross shortage of supply of psychiatrists, the Committee recommended the elimination of applicants with clearly undesirable personalities as the only practical method in selecting the trainees. The main criteria for exclusion should be character traits of a psychotic type and a high degree of emotional instability and of irresponsibility. The emotional demands on a psychiatrist are such that people with vulnerable personalities rarely find themselves able to bear the burden of managing their own emotional reactions in the daily encounter with mental patients.

The teaching of psychiatry in the medical school plays an important role not only in motivating undergraduates to enter psychiatry for specialization, but also in the formulation of a post-graduate training-course. Their concept of psychiatry, knowledge about human behaviour and skills in the diagnosis and treatment of mental illness, their understanding of the position of psychiatry in relation to basic sciences and to their clinical studies, their understanding of the role of mental health in the community and their image of a psychiatrist, all of which have been acquired during the undergraduate teaching of psychiatry, should be taken into account in planning a post-graduate course.

Certain progress has been made in the teaching of psychiatry in the past decades and increasing interest and effort have been noted in many quarters recently. As yet, it remains to be seen how many medical schools in the world fulfil the suggested "minimum requirements" for the teaching of biological sciences, psychology, sociology or clinical psychiatry and mental health promotion, as outlined in the ninth report of the Expert Committee on Mental Health.¹

¹ *Wld Hlth Org. techn. Rep. Ser.*, 1961, 208.

Experience gained by the trainee after qualification, through general practice, other medical specialties, public health, laboratory sciences, or social and psychological sciences, can be of value to his further training in psychiatry. The type of experience which will be judged most appropriate will vary according to the nature of the psychiatric services in different places. The Committee agreed that experience leading to the trainee's personal and professional maturity is what matters most and recommended that careful attention should be paid to the differences in individual trainees in order best to utilize their assets to enhance their training.

6. BROAD TRAINING

When he first starts clinical work, the trainee should be instructed in the technique of the psychiatric interview. He should be taught to observe and assess his patients carefully, to marshal his observations systematically and to record them in simple terms in well-kept case-histories. He should have ample opportunity to acquire clinical experience by looking after patients, under supervision. At the same time he should be offered instruction in relevant aspects of the biological and social sciences and in the theoretical basis of psychiatry. This instruction should cover the following topics:

(a) *Basic sciences*

Neuroanatomy and neurophysiology (including the principles of electroencephalography and an introduction to the biochemistry of the nervous system).

Neuropathology (including the pathophysiology of psychoses, oligophrenias and neurological disease).

Medical psychology (including theories of personality development).

Medical sociology (including relevant aspects of social psychology and social anthropology).

Genetics.

Epidemiology of chronic diseases (including techniques of recording and methods of surveying).

(b) *Psychiatry proper*

History of psychiatry.

Clinical phenomena of psychiatric illness (including mental disorders of the senium and psychosomatic disease).

Dynamic processes in psychiatric illness.

Clinical neurology.

Child psychiatry (including mental subnormality).

Psychosomatic disorders.
Social psychiatry.
Therapeutic techniques in psychiatry.

6.1 Basic sciences

6.1.1 *Neuroanatomy, neurophysiology and neuropathology*

There is unquestionably a relationship between the anatomy and physiology of the central nervous system on the one hand and mental function (normal or pathological) on the other. Detailed knowledge about this relationship is, however, to a great extent unknown, so that it is not possible to regard it as a firm basis for a comprehensive understanding of mental disorder. At the present stage of our knowledge of brain physiology, only some of the numerous psychiatric syndromes can be described in physiological terms and, even in those, our physiological knowledge often remains very incomplete. The "functional organs" that perform particular mental processes are incomparably more complex in their activities than the neurone systems which subserve movement and sensation. In view of this, determination of the primary lesion of the brain associated with psychopathological syndromes is much more difficult and more tentative than is the case with neurological syndromes. The student should be taught to avoid the naïve attitude of equating mental with physiological function. With the above proviso, he should be given a broad understanding of the structure and functions of the brain, so far as these are known. This will have immediate application to his work in the fields of oligophrenia and the psychoses of "organic" nature. Moreover, it will provide him with a theoretical framework for the study of psychosomatic illness. Finally, it will help him to keep abreast of new research findings in applied neurophysiology and psychopharmacology.

6.1.2 *Medical psychology*

6.1.2.1 *Theories of personality development*

The Committee recommended that trainee psychiatrists should not be taught only one of the several theories of personality development, but rather should be instructed in the basic principles of each major school. Particular attention should be given to the study of the dynamic processes of the mind, the relation between conscious and unconscious mental activity, and the commoner mental mechanisms: an attempt should be made to help the student to recognize that the several theoretical formulations (whether expressed in psychoanalytic terminology, in that of the Pavlovian conception, or in the language of communications theory) represent so many attempts to organize the same facts of observation in a meaningful way.

He should be given the opportunity to deepen his knowledge of any of these theories that he finds particularly interesting ; at this stage of our knowledge he should be discouraged from denying or belittling the importance of alternative points of view.

6.1.2.2 *Body build and temperament*

The trainee should be acquainted with the theories on the relationship of body build and personality attributes and with their applications to clinical psychiatry.

6.1.2.3 *Clinical psychology*

Instruction should be given on the theory and practice of intelligence tests, personality inventories, objective assessments of mental functioning, measurements of attitudes and opinions, and the application of statistics to psychological data. The trainee should learn the elements of experimental design and should be shown examples of fruitful collaboration in research between clinical psychologists and psychiatrists.

6.1.3 *Medical sociology*

The teaching of this subject should be co-ordinated with that of genetics, in order to give the student a balanced appreciation of the interplay between inherited and environmental factors in health and disease. The following points should be considered :

Sociology of the family.

Sociology of small and large groups.

Sociology of institutions—with detailed study of the sociology of mental hospitals.

Social status and social role : learning of social roles (including the role of the physician and the sick role).

Study of public opinion ; technique of opinion surveys.

Traditional concepts of sickness and healing.

Organization of health services ; place of psychiatry in relation to these services.

History of recent developments in social policy regarding the mentally ill.

6.1.4 *Genetics*

Besides learning the facts so far established about the inheritance of mental disorders, the student should be given an introduction to the theory of genetic transmission and of genetic studies in total populations. He should also be instructed in recent developments in chromosome analysis and their relevance to the inheritance of subnormality and mental illness.

6.1.5 *Epidemiology*

Besides receiving formal instruction in the findings of epidemiological research on psychiatric illness and on the methodology of carrying out such surveys (including simple demographic statistics) the student should have an opportunity of taking part in a field inquiry, however modest, or in a follow-up study. The Committee stressed the great importance for the psychiatrist in training to be reminded, preferably by first-hand experience, of the wide range of minor psychological abnormalities in the population as a whole. This should help him to keep a balanced judgement when evaluating morbidity in adult patients and in children.

6.2 **Psychiatry proper**

6.2.1 *History of psychiatry*

This teaching should show the correspondences that exist between pre-scientific concepts of mental illness in different cultures. Moreover, it should trace the evolution of contemporary psychiatric thought and of changing public attitudes towards the mentally ill and should place a salutary emphasis upon the succession of bizarre treatments and ill-founded therapeutic claims that punctuate this history, together with an indication of the emotional factors underlying this phenomenon. Throughout, this teaching should emphasize the interplay of medical and social factors in the development of psychiatric practice.

6.2.2 *Clinical phenomena of psychiatric illness*

This teaching should enable the trainee to systematize the observations that he makes on patients under treatment. It must refer to all types of psychiatric illness as they are seen in hospital and out-patient settings, including the mental disorders of advanced age and the current psychosomatic diseases. The instructor should constantly remind his students of the need to distinguish between data of observation, which they should learn to record and where possible to measure in an objective manner, and data inferred subjectively as a result of personal interaction with the patient. Both types of data are valid, but they should not be confused since the latter are partly determined by the psychiatrist's own conceptual frame of reference. If students grasp this distinction clearly they will be less likely to become confused by differences of opinion between schools of psychiatry.

6.2.3 *Dynamic processes in psychiatric illness*

A description of a mental disorder remains incomplete unless it takes into account the time dimension, so as to show the evolution of the illness. Psychiatrists of every school have tried to supplement purely descriptive

accounts of the phenomena by advancing theories about the underlying pathological processes. In some explanatory systems, emphasis has been placed upon pathophysiological changes, either demonstrable or hypothetical; in others, disturbances in different levels of organization of the central nervous system are hypothesized; and in others yet, the principal concern has been to relate the pathological events to underlying mental phenomena, such as conscious and unconscious drives and phantasies.

The Committee fully appreciated that there are still some teaching centres that place dogmatic emphasis upon one particular point of view (basing their theory either on a completely physiological or on a purely psychological etiology) and belittle alternative explanatory concepts. This tendency is to be deplored. It is proper that the teacher should advocate the theory which he personally finds the most convincing; but in the present imperfect state of our understanding of psychopathology it is essential that the student should be given as unprejudiced an account as possible of all the major explanatory systems.

6.2.4 *Clinical neurology*

Teaching on the phenomena, syndromes and disease entities of neurology forms an essential counterpart to the student's clinical experience in psychiatry. Emphasis should be placed upon the temporal evolution of these disorders. The student should not only be told what is known, but should also be reminded of how much still remains to be discovered about the etiology and pathogenesis of neurological disease.

6.2.5 *Child psychiatry*

The Committee agreed that teaching in child psychiatry should form an important part of every psychiatrist's training, because it provides the trainee with valuable examples of normal and abnormal development at an early stage. It also brings home the importance of interpersonal factors, particularly within the family, in the genesis and evolution of psychiatric disorders. This teaching should include an appreciation of the interaction of the mental and physiological stages of maturation and of the emotional consequences (both for the patient and for his family) of lesions of the central nervous system, including those associated with loss of motor or emotional control, and with various forms of mental subnormality.

6.2.6 *Psychosomatic disorders*

This important aspect of psychiatry requires to be taught with special care because of the danger of imprecise thinking and over-generalization which is already implicit in its title. Every psychological disorder involves a physiological dysfunction, and *vice versa*; psychosomatic medicine,

however, particularizes this very broad statement by studying the detailed processes of this interaction in a number of diseases (such as peptic ulcer, bronchial asthma, ulcerative colitis, coronary thrombosis) where psychological factors are found to contribute significantly to serious pathophysical changes, and in others (such as migraine or asthma) where emotional disturbance appears to trigger off a sensitive pattern of physiological dysfunction. This subject requires to be taught by someone who has had a thorough training in internal medicine and in psychiatry (particularly in psychodynamics). Alternatively, it should be taught by a physician and a psychiatrist working in collaboration. Emphasis should be placed on experimental studies that have brought some precision to certain limited areas in this wide field.

6.2.7 *Social psychiatry*

Teaching in this subject should centre upon the clinical application of the concepts of medical sociology and anthropology. It should also supplement the student's field experience of co-operating with non-psychiatric workers and agencies in the community by showing him the public health aspects of psychiatric activities and by informing him of alternative patterns, evolved in different countries, for the integration of psychiatry into community welfare planning and services. Instruction in this subject should include the theory of the therapeutic community approach in patient care. It should emphasize that systematic evaluation is no less important for social psychiatric interventions and programmes than it is for new drug therapies, and an account should be given of the methodology and findings of operational research of this type.

6.2.8 *Therapeutic techniques*

The "general" psychiatrist must be competent to treat patients suffering from psychosis, psychoneurosis, psychosomatic disease, mental subnormality and character disorders, including addiction. He must also learn how to treat community problems indirectly by serving as consultant, supervisor and teacher to the nurses, social workers, psychologists, teachers, clergy, correctional officers or other persons who work with people whose symptoms are manifest principally by social maladaptation of some type.

The educational experience must therefore equip the post-graduate student to select the forms of treatment that are appropriate to the number of patients to be treated in relation to the number and training of the staff available to the community in which the patients live. For example, areas with few psychiatrists must have a programme that is based on public health techniques, the use of group management, and a heavy reliance on non-psychiatric personnel. In such a setting the psychiatrist will spend a small proportion of his time in directly treating patients and most of his

time serving as a consultant and supervisor to the community health workers and the general physicians of the area. Conversely, areas more adequately supplied with psychiatrists will offer a wider choice of treatments to be provided, including individual medical care and long-term psychotherapy.

Not all psychiatrists need have technical competence in all forms of therapy. But all psychiatrists should have a working knowledge of all, or most, forms of therapy and know for what disorders, and under what conditions, they are likely to be most beneficial.

6.2.8.1 *Somatic therapies*

Preparations classed as "tranquillizers", used for treating anxious, over-active and deluded patients, are the most widely used somatic therapy at this time. The post-graduate student must know the proper uses and the contra-indications and complications of the use of such preparations, or a substantial number of them. The use of drugs to combat depressive illness should also be mastered. At this stage in his training the student should be taught the design of controlled clinical trials and, if possible, should participate in one; he should be familiar with the "placebo effect" and understand the logical and statistical principles by which to evaluate therapeutic claims.

The student must also be prepared to administer drugs of the barbiturate series used to facilitate communication in some patients by methods known as "narco-analysis" or some similar term. The use of such preparations as sedatives, for treating convulsive disorders or for prolonged "sleep treatment", must be reviewed to refresh these parts of his undergraduate instruction.

The treatment of neurosyphilis and arteriosclerosis, hypertension, and various toxic states involves the use of a variety of pharmaceutical preparations and the psychiatrist should be aware of their proper use and preferably be skilled in the administration of the appropriate preparation to patients suffering from organic brain disorders.

Of the many other somatic therapies that have been in vogue in recent decades and which include prolonged baths, fever therapy, frontal leucotomy and insulin coma, electroshock treatment is the only one that is still in common use in psychiatry. The psychiatrist must know the proper uses of this method and preferably be skilled in the techniques of its administration.

6.2.8.2 *Psychical therapies*

6.2.8.2.1 *Physiologically oriented psychotherapy*

The psychophysiological approach to the study of man's behaviour is mainly based on Pavlov's work on conditioned reflexes. The psychiatrist

should be familiar with the original techniques and theories of this school and with the development of the concepts of the primary and secondary signal systems. Teaching should specially refer to the conditioning of organ systems and functions which are potentially useful for therapeutic purposes. Whenever possible the student should be given experience in the applications of conditioning and learning theory to the extinction of faulty behaviour patterns and to the relief of psychiatric symptoms.

Another type of physiologically oriented psychotherapy about which the future psychiatrist should become informed in theory and practice is that based on relaxation procedures.

6.2.8.2.2 *Psychologically oriented psychotherapy*

Every psychiatrist should have some training and experience in psychotherapy whether he intends to practise this form of treatment or not. It would appear advisable that training in psychotherapy should start from the very beginning of training in psychiatry. The student should be taught that his first interview with a patient already involves a psychotherapeutic transaction. In some cases, if not in all, the student will find his understanding and skill in the conduct of this form of treatment enhanced if he himself undergoes an experience of therapeutic self-improvement (see section 7.4). He must in all cases learn the part played by his own personality and how to use this to the best therapeutic advantage. The student should become conversant with the techniques and aims of all major types of psychotherapy. He should be taught to recognize the similarities and the crucial differences between the various schools, including didactic psychotherapy, suggestion and hypnotism, the "client-centred" approach and the various forms of analytic psychotherapy. However, he should restrict his more intensive study and practice to only one, or a very limited number, of these techniques. This restriction is inevitable because psychotherapy is best learned under the close personal supervision of an experienced therapist, who himself will usually adhere to a particular technique.

Special importance should be given to the teaching of group psychotherapeutic techniques. In spite of the many uncertainties that still exist in this area of knowledge, the group approach is at present of prime importance, since, at least for the time being, there is no other way of making psychotherapy available to greater numbers of patients. Moreover, it should be remembered that training in these techniques greatly increases the trainee's understanding of group psychological processes and thereby his ability in efficacious team leadership and community work.

7. DIFFERENTIAL TRAINING

After completing their broad training psychiatrists assume increasing responsibilities for patient care. Some will find their chief interest in general clinical psychiatry, in the conduct of in-patient, out-patient and community treatment. If their preliminary training has succeeded in creating a spirit of sustained curiosity, they will continue to study the clinical phenomena presented by different groups of patients and to supplement these observations with follow-up inquiries. Moreover, they will have a special responsibility to test new drugs and new therapeutic procedures in controlled clinical trials, so that their value can be objectively assessed.

Mental inertia is the principal obstacle to good clinical practice. It will be more easily resisted if the clinician works in a professional group in which there are regular meetings for the exchange of clinical and research reports, if he participates in the teaching of students, and if he is offered the stimulus of promotion in his career as a recognition of good clinical work. The Committee deplored the tendency, already apparent in certain countries, to make professional advancement conditional on the passing of competitive examinations in internal medicine. This compels young psychiatrists to devote time and effort to studies that are largely irrelevant to their future work. A more appropriate criterion for promotion is the attaining of a higher degree on the basis of research in psychiatry or some closely related field, or the publication of sound contributions to the literature.

Many psychiatrists will branch out into one or more forms of differential training, which differ from broad initial training in that they require that a subject be studied more intensively and practised over a longer period, or that a new topic is introduced that calls for the mastering of new techniques. All forms of differential training have been evolved in response to the emergence of special tasks in psychiatry. Completion of this differential training carries the implication that the psychiatrist will thereafter devote a large part, if not the whole, of his time to work in that particular field.

7.1 Child and family psychiatry

The organizational demands of psychiatric practice—the need for the earliest possible case-finding and treatment of developmental anomalies of all kinds, the setting up of child guidance centres and provisions for the specialized hospitalization of the severely mentally defective—have resulted in a need for psychiatrists specialized in the problems of children. They are required to engage in preventive work, diagnosis and therapy in close collaboration with paediatricians, general physicians, nurses, psychologists

and social workers. Although historically the main focus of child psychiatric practice has been on the school-age child, more recently the interests of child psychiatrists have been extended to problems of early infancy, particularly problems of mother-child relationships, and to the problems presented by adolescents. The child psychiatrist's clientele shows a series of problems mostly due to inadequacies of development of genetic, traumatic, toxic and psychical origin, and a wide range of cases of varying severity presenting behavioural, intellectual and emotional disorders. Because every child's development is intimately affected by his environment, increasing attention is being given to the importance of family relationships and, consequently, to a method of approach in treatment that emphasizes a concern for the problems of the family as a whole.

As has been said above, the Committee was of the opinion that the broad training of all psychiatrists must include a study of childhood disorders, not only because of their manifest importance but also because the understanding of many adult psychiatric disorders can only be brought about through an understanding of their development and their childhood roots. Similarly, the Committee considered that specialists in child psychiatry should normally be drawn from the ranks of generally trained psychiatrists, who should undergo specific training directly applicable to child psychiatry, with a strong emphasis on the study of paediatrics.

The differential study of child psychiatry demands a more profound attention to the study of general psychology, particularly the psychology of development and learning, and to the study of the development of interpersonal relationships. Practice with the mentally subnormal involves an appreciation of anomalies of the central nervous system, of sensory handicaps, and consequently of the neurology of childhood. The therapeutic techniques of child psychiatry demand a close understanding of educational difficulties and their handling, a knowledge of special psychotherapeutic techniques involving methods that are less verbalized than those applicable to adults and a knowledge of group therapy techniques applicable to families. Special demands are placed on the child psychiatrist to understand the professional work of psychologists and social workers. His training should therefore include knowledge of the principles of teamwork in diagnosis and therapy and of the special problems involved in collaboration with the professional categories mentioned. Further, the necessity for the child psychiatrist to adopt a family-centred approach requires a deep understanding of the emotional problems of parents and therefore of the normal psychology and psychopathology of adults, both neurotic and psychotic.

As to the duration of the differential training in child and family psychiatry, the Committee agreed that it would be advisable for most countries to insist that broad general psychiatric training should be followed by at least two years' further study and work with children. The predominant

method to be used in the training of child psychiatrists must be that of supervised practice, with appropriate observation of the work done by the trainee through the use of one-way screens, magnetophones and so on. This should be supplemented by group teaching in case conferences, and theoretical seminars and academic teaching of basic subjects must, of course, be provided. As to the overlap between child psychiatry and paediatrics, it must be recognized that paediatricians in many countries are becoming increasingly responsible for the treatment of minor behaviour disorders in children. The extent to which this practice should be encouraged and assisted through consultation will vary according to the interests and abilities of those concerned.

Recent developments in chromosome analysis, in studies of disorders of metabolism and in the epidemiology of congenital brain damage, together with renewed emphasis on rehabilitation and community care, have led to important advances in psychiatric practice concerning mental deficiency. It can be argued that the care of mental defectives should be included within the scope of adult and child mental health services. Most members of the Committee urged that this should become the accepted pattern of teaching. In their view, while specialized teams were required to meet the particular needs of the subnormal for education, occupational training, family case-work and social supervision, the medical assessment and treatment of these patients should form part of the work of both adult and child psychiatrists. On the other hand, it was generally recognized that many countries have already made separate provisions for those of the mentally subnormal who require prolonged care. In any case, although the care of the mentally subnormal is usually undertaken by qualified psychiatric and paediatric personnel, the psychiatric attention given to these patients will surely be improved if this type of work is made the subject of organized advanced study and supervised clinical experience, lasting for at least one additional year.

7.2 Social psychiatry

Social psychiatry, in so far as it concerns the study of social factors contributing to the onset, course and outcome of mental illness and the adequate organization of community care, should form part of every psychiatrist's broad training. Within this broad area, however, a number of sub-specialties is emerging, each of which demands some additional training.

7.2.1 *Organizational and administrative psychiatry*

It is a *cliché* that effective treatment in psychiatry is the product of teamwork, but it has only recently been realized that special skills are

involved in the deployment of the psychiatric team. These skills demand an understanding of the structure and functions of complex organizations and also an understanding of group dynamics. The Committee was strongly of the opinion that the director of a psychiatric team, whether in the mental hospital or in the community, should be a psychiatrist and not a lay administrator. It recommended the further development of courses in psychiatric administration, such as have been tried out in the United Kingdom and the United States, for present and future leaders in this field.

7.2.2 *Public health psychiatry*

In both developed and developing countries community agencies (including antenatal and infant welfare clinics, school health services, health education, rural health clinics) are becoming increasingly involved in preventive and ameliorative mental health care. Psychiatric participation in these programmes is essential; but, in order to make it as useful as it should be, broad psychiatric training will have to be supplemented by a special course of study, lasting for at least one year, emphasizing medical sociology, social administration and practical experience of public health activities, before the psychiatrist can contribute effectively in this field. This special training for psychiatrists has an obvious relationship to the courses that are now being given to public health medical officers and nurses in order to familiarize them with psychiatric disorders and the basic principles of psychiatric treatment, including prevention, rehabilitation and after-care. Courses of this type have already been organized in a few schools of public health.

7.2.3 *Geriatric psychiatry*

In the diagnosis of psychiatric disorders in the elderly, a thorough knowledge of clinical medicine and of the pathophysiology of old age is most important; in their treatment, as in other branches of psychiatry, somatic, psychological and social measures have to be applied in a co-ordinated fashion. In geriatric psychiatry, as in the care of the mentally subnormal, it is of crucial importance to organize integrated community services, with guidance centres as their core,¹ that will give proper attention to the general medical aspects of treatment. The study of these conditions undoubtedly forms part of every psychiatrist's broad training. In view, however, of the very large numbers of elderly patients and the danger that insufficient attention may be given to their special problems, there are strong practical arguments in favour of encouraging some psychiatrists to devote two years to acquiring specialized experience and instruction in this

¹ See the sixth report of the Expert Committee on Mental Health, entitled "Mental Health Problems of Aging and the Aged" (*Wld Hlth Org. techn. Rep. Ser.*, 1958, 171).

field, with a view to taking responsibility for the planning and conduct of treatment for the elderly both in hospital and in the community.

7.2.4 *Industrial psychiatry*

The demand for psychiatric help in industry comes both from industrial medical officers, who have come to realize that emotional factors play a large part in causing certain psychosomatic disorders and absenteeism, and from managements, who turn to psychiatrists for advice on group dynamics, interpersonal communication and the handling of human relations within the industrial community. This is a field of work to which sociology, social psychology and psychotherapy, as well as clinical and epidemiological psychiatry, can contribute. Hitherto, psychiatrists working in industry have had to educate themselves in the special problems of this field, but doubtless there is a place for special instruction, lasting from six to twelve months, to supplement single practical experience of this work. Such instruction could be given either in institutions (such as the Tavistock Institute of Human Relations) that have special experience in this field, or else in courses organized in collaboration by university departments of psychiatry and of occupational or social medicine.

7.2.5 *Military psychiatry*

The problems of military psychiatry have much in common with those of industrial psychiatry and could, therefore, be appropriately included in the above course of study. These, however, are the problems of the armed forces during peacetime. It will remain the task of the military services to arrange additional courses of training to instruct their psychiatrists on the lessons learned during previous wars (for example, on the advantages of front-line treatment and speedy rehabilitation) and on the special problems that they can expect to encounter if atomic warfare is ever unleashed upon mankind.

7.3 **Forensic psychiatry**

In many countries psychiatric advice and treatment is being increasingly employed in adult and juvenile courts, in prisons, reform schools, etc. While this work is obviously based on clinical adult and child psychiatry it also presents special problems that can be recognized and mastered only through practice under the guidance of a psychiatrist with extensive experience in this field. The trainee should have an opportunity to work under supervision for at least two years, gaining experience in each of the major divisions of this work, before he can be considered as a fully fledged forensic psychiatrist.

7.4 Psychotherapy

It is becoming evident to most psychiatrists that, in order to become really proficient in psychotherapy, it is necessary to obtain deep insight into one's own personality, and this can best be acquired by personally undergoing an experience of a psychotherapeutic nature. There are several reasons for recommending this learning procedure.

One is that in this field of knowledge simply to read books and listen to lectures is quite insufficient for proper training, yet in many cases it is impossible to allow the student to sit in on a psychotherapeutic session conducted by his teacher. Efforts have been made to circumvent this situation by magnetic-tape recording or one-way screens. These procedures offer interesting help, but have obvious limitations. Thus, there are, for instance, skilled therapists who will not perform naturally under such circumstances and, as a consequence, the examples offered to trainees will be distorted.

The second reason is that the psychotherapist works with and employs as tools the most delicate aspects of his own mental functions and for this reason it is important for him to obtain deeper insight into these functions in himself. This will also permit him to modify, as far as possible, the repressions, inhibitions, projections and other mental mechanisms that may hamper him in a serene view of others.

It is conceivable, theoretically, that a person may achieve a practical understanding of the delicate variables involved in psychotherapy without having passed through the personal experience mentioned. But in a systematic plan of training it seems wiser not to count on this, as even very gifted psychiatrists tend to reach a higher degree of psychotherapeutic proficiency if they have the opportunity to obtain deeper insight into their own mental processes.

While the personal experience just mentioned would seem to be of fundamental importance, a certain amount of academic teaching is also required. This can be offered in the form of lectures or of case and literature seminars. In this part of the training programme special attention should be given to the teaching of psychology, sociology and cultural anthropology.

The practical training should consist in conducting a few appropriate cases under the supervision of experienced therapists. The supervision may take the form of regular "control meetings" in which the various happenings in the sessions of treatment are discussed in detail. These may be individual (with one student only) or collective (with a group).

The Committee was of the opinion that thorough training in one form of psychotherapy, followed afterwards by the learning of other orientations, was better than a composite form of teaching, which frequently results in incompetence to apply any kind of method. In certain circumstances, however, it may be appropriate to gather various orientations under one

roof and with a common administrative management, while granting them at the same time complete independence, regarding both scientific aspects and internal organization.

Closely related to this point is the question of the opportunities for training. In most places the broad training in psychotherapy is offered by the chairs of psychiatry, while the more specialized training is generally provided by other institutions, either in the university or outside. These may be partly or wholly supported by the State.

Training in group psychotherapy is governed by the same principles as those of individual psychotherapy. However, it differs in certain practical aspects in so far as, on the one hand, groups may be formed with the prospective psychiatrists themselves and, on the other, there are ample opportunities to participate as an observer in a group led by an experienced therapist. The systematic study of the psychology of groups and of group psychotherapy is at an early stage of development and offers perhaps great prospects for the future, which may result in considerable improvements in the efficacy and practicability of psychotherapy. It seems most important to be alive to these possibilities.

Through participating in the conduct of staff, staff-patient and family groups, the trainee should learn how to observe and discuss personal interactions in these situations. The present tendency in many mental hospitals to divide patients into small semi-autonomous treatment groups provides opportunities for psychiatrists in training to learn how to run these groups. Practice in the analysis of his own and other staff members' attitudes and role relationships is essential in order to learn how to mobilize therapeutic forces in the patient's social environment both in the treatment situation and after his return to the community. This practice in the conduct of a therapeutic community can also serve as useful preliminary training for the psychiatrist who may later assume wider administrative responsibilities.

As to the duration of differential training in psychotherapy, opinions may differ according to the theoretical orientation. In any case, it would seem that at the very least it should last two years.

8. TRAINING FOR PSYCHIATRIC RESEARCH AND TEACHING

The Committee was unanimous in recommending that a sound broad training in clinical psychiatry should be the prerequisite of training for psychiatric research and teaching, as of other forms of differential training, in order to prevent the specialist from developing a private language and mode of thought so that he can no longer communicate with his psychiatric colleagues.

It was noted that, in the course of the development of psychiatric teaching, different views have been expressed about the inclusion of research

experience as part of every psychiatrist's training. The recommendation of the conference on psychiatric education held in the United States in 1952 was that "exposure to problems of scientific research in general be a part of scientific training but that a demand on each resident that for reasons of so-called scientific training he must do a piece of independent research is highly unrealistic".

On the other hand, nine years later at a meeting in the same country it was stated quite positively that "to be adequately trained for his practice today the psychiatrist must have training in research; he must have this in addition to his clinical training, so that he can relate himself to other disciplines on an equal basis".

The Committee agreed about the necessity for productive research performance as one of the qualifications for promotion to senior positions in psychiatry, and particularly in psychiatric teaching. This incentive has been formalized in some countries by the requirement of a higher degree, incorporating a research thesis, as a condition of promotion. Systematic instruction in research method is becoming necessary as such requirements spread. This is usually offered in the form of seminars organized by the university department or training institute. The best training for research consists in working along with one or more experienced research workers. Clearly, no centre of psychiatric teaching can expect to cater for every branch of research; it may be necessary for the trainee to spend one to two years in another centre, or in another country, to obtain this experience. It is however, the responsibility of those organizing any training programme to realize that, quite apart from special requirements such as laboratories and technical equipment, all research demands access to (a) a good library, with wide coverage of journals as well as reference books, (b) well-kept clinical records, and (c) secretarial assistance.

Psychiatric departments that are connected with university medical schools will be well advised to promote research in certain fields (such as biochemistry, pharmacology, neurophysiology, psychology and sociology) in collaboration with the relevant departments in the school. This will not only exploit the specialized knowledge available in the several departments; the demonstration of research activity and competence on the part of members of the department of psychiatry will strengthen the standing of this specialty in the medical faculty as a whole. The collaboration between neurophysiologists and psychoanalysts in devising sophisticated experimental studies of abnormal mental functions seems a particularly promising field of research.

It is a curious anomaly that teachers in medicine (and indeed in most university subjects) receive little or no instruction in the art of teaching. Even quite senior appointments are made on the strength of the candidate's academic and research attainments and with very little regard to his gifts as a teacher. In recent years, members of the medical faculties have them-

selves become aware of this fact. In certain countries, organizations for the study of medical education have been instrumental in stimulating a constant scrutiny of the content and methods of medical school teaching and in encouraging new experiments.

In the absence of formal training in how to teach, it is important that medical faculties should provide opportunities at least for self-education in this role. This can be done in several ways, of which the following are examples.

1. The post-graduate's training can be arranged so that he takes responsibility for tutoring undergraduates and more junior post-graduates in their clinical work.

2. Post-graduates may be required to give presentations of their cases and reviews of articles before audiences of their fellows. In such exercises the trainee should be discouraged from reading a prepared text and given practice instead in speaking extemporaneously, with the aid of notes; he should be taught the difference in style between verbal and written presentation.

3. As part of the training programme, measures can be designed to show whether the trainee's attitudes and skills, as well as his store of information, have changed at the end of his course. This exercise is of special importance to future teachers, as it will impress on them the importance of obtaining "feed-back" from their students in order to evaluate the effectiveness of their own teaching.

4. Familiarity with varied techniques of teaching (lecture, seminar, case conference, demonstration interview, use of one-way screen, closed-circuit television, film, tape recordings, etc.) can be acquired by participation, the trainees taking turns in the later stages of their training at conducting the interviews and subsequently discussing them with their fellow students and instructors.

5. Good research workers are sometimes rather bad at communicating their findings, a handicap that can often be modified if their supervisor emphasizes the importance of style as well as content in the presentation of their work at scientific meetings.

6. In recent years certain new tasks for psychiatric teaching have emerged, notably:

(a) teaching the recognition and management of psychiatric features in persons under treatment by colleagues in general medicine and surgery, or in general practice;

(b) teaching clergymen, lawyers, nurses, schoolteachers, police and other members of the community about the prevention and management of minor psychiatric crises in everyday life.

Since there are no established precedents for these types of teaching, it is particularly important that they should be carried out in a spirit of experiment and evaluation.

In the process of self-education in the art of teaching, the most important ingredient is the feed-back from students to teacher, which gives a measure of the effectiveness of different elements of their instruction. Provision should be made in every programme of teaching, at both the undergraduate and the post-graduate level, for annual appraisals, not only of the trainees' performance in formal examinations but also of their skills as interviewers, their ability to recognize and interpret clinical cues and their attitudes towards different aspects of medical and psychiatric practice. Studies of this kind provide excellent experience in research method; they will contribute most effectively to improving the future psychiatrists' skills as teachers if their findings are presented and discussed while the experience is still fresh in mind. Such exercises are also invaluable as a precaution against complacency and conservatism in the teaching department itself.

It would add to the efficiency and contribute to the equalization of standards at a high level, if teachers of psychiatry (both the directors of teaching institutions and their senior assistants) could periodically confer with colleagues from their own and other countries. The organization of such conferences on psychiatric teaching could be an appropriate activity for WHO.

9. ORGANIZATION AND METHODS OF TRAINING

A post-graduate training programme in psychiatry requires an adequately financed sponsoring agency, which may be the government, private wealth, a professional organization, or a co-operative enterprise in which several groups contribute money or facilities to the support of a post-graduate programme for psychiatrists.

9.1 Broad training

Programmes for broad training are, in many cases, based on a university medical school, but some are sponsored by psychiatric hospitals, and a substantial number are the result of collaboration of university and hospital resources.

Whatever the nature of the sponsoring and supervising agency, the educational programme must provide modern clinical facilities, so that the student in his early post-graduate years can have first-hand experience of the phenomena of mental disorder and the treatment of the mentally ill. It cannot be stressed sufficiently that from the beginning of his training the

student should have personal contact with patients and continuing responsibility for their care. Learning about mental disorders and learning about the therapeutic use of the doctor-patient relationship cannot be separated: the student should learn that therapy begins with his first interview with the patient or his family. Through supervised clinical experience he should be taught the diagnosis, treatment, rehabilitation and after-care of individual patients of all ages. He should become familiar with the full range of psychotic, neurotic, psychosomatic and personality disorders. In the course of this training he should also acquire practice in the therapeutic management of the patient's social interactions in the ward and in the hospital community, in his family setting and in his wider social relationships. Moreover, the young psychiatrist should learn to perform his role as one member of the medico-social team.

The extension of psychiatric practice into preventive work increasingly involves the psychiatrist in collaboration with public health workers of many kinds, with general practitioners and with the community's social workers. He must therefore learn to understand not only the clinical problems that they encounter but also those connected with their relationships in the communities in which they work. Moreover, he will need to become acquainted with the methods of consultation through which other health workers may avail themselves of his special knowledge. This makes it, of course, specially important in this part of his training to clarify the psychiatrist's role relative to that of his collaborators. However, no general rules can be laid down in this connexion, since the definition of the psychiatrist's role in public health practice will have to depend on the social structure of the community in which he works.

Many programmes start broad training by assigning the trainee to supervised clinical work with psychotic and neurotic patients. This plan permits the trainee to treat at least three or four severe cases over a long period of time; in this way he can learn about mental disease from the longitudinal, as well as from the cross-sectional or short-term, view. In some places two years of this basic experience are required, in others three. In the years that follow more specialized experience may be sought. Special psychiatric care for children and old people, public health work, psychoanalytic training, or participation in teaching or research may be incorporated in the ordinary clinical activities with psychotic and neurotic patients.

The staff of the educational programme should be composed of physicians and other scientists who can supervise the trainee as he develops his own knowledge and skills in diagnosis and treatment. This requires a staff sufficiently large that senior members may do their required clinical work and in addition have scheduled time as well as free time to devote to the teaching and supervision of the post-graduate students. In some programmes each trainee has four or five hours per week of individual and

small group supervision. In addition, lectures and seminars for the presentation and discussion of theoretical material may occupy another four or five hours per week. Staff conferences, in which the student presents his own patients for discussion and consultation, are a valuable teaching device if the person conducting the staff meeting is a competent teacher. The trainee should be enabled to divide his time equally between clinical work with the patients for whom he has responsibility and theoretical studies, including organized teaching exercises, interviews with his supervisors in psychotherapy and free time for reading and research.

The Committee endorsed the following opinions expressed in a recent publication. During his training the student should participate in seminars, case conferences, tutorial classes and formal lectures. In few of the latter is imparting facts the main purpose of the teacher: his concern is far more how he can help the student to learn from his patients, to reason well about his findings, to apply to current clinical problems the knowledge he has gained in his basic studies and in his reading, and to recognize the limits and the possibilities in each clinical situation he encounters. He should attend, and take his turn in addressing, journal meetings in which he can learn critical evaluation of contributions to psychiatric literature and become familiar with the lines of current progress. He should be encouraged to carry out follow-up studies in order to obtain a just evaluation of prognosis, and thus protect himself against becoming the dupe of his own or other people's hopes.

Whenever possible, active participation of the student should be stimulated, in preference to formal didactic instruction.

A formal examination should be taken at the completion of the students' broad training. This examination should, if possible, be the responsibility of a national body: it should not necessarily be a severe test of academic knowledge, but should serve as an indication that the trainee has attained an acceptable standard of competence as "general practitioner" of clinical psychiatry.

In the advanced years there must be free time for educational activities in addition to clinical work. Young physicians tend to accumulate too many patients and some find themselves spending all their time in treatment activities, with no time for assimilating their experience or consolidating the practical and theoretical aspects of their training. Some so-called "training" institutions exploit post-graduates by giving them heavy clinical responsibility, little supervision and no formal education. Such programmes are sometimes called "practical", although inspection usually reveals that this term is a euphemism for a lack of a real educational programme.

Post-graduates should, in the advanced portion of their training, have access to facilities that will prepare them for the sub-specialty they wish to pursue.

Some major training-centres have staff and resources for training at both the basic level common to all post-graduate programmes and some or many of the sub-specialties. Other centres have resources for training only at the basic level, or only for one or more sub-specialty. Training institutions should develop programmes of high quality in the area of practice best suited to their staff and clinical facilities, because post-graduate students will come to a good programme but they tend to avoid poor ones, whether specialized or offering a wider choice of training.

9.2 Differential training

Some parts of differential training, such as public health training or psychoanalytic training, are not available in or near all training institutions. Thus the student desiring experience of this sort may have to move to a training-centre near such educational facilities so that he may combine these refinements of his education with the continuation of fundamental supervised clinical work with patients. In making his plans in this respect, he will often need counselling about the best place to find the educational opportunities and training he requires for his career. However, a certain amount of vocational guidance is probably indicated in all cases. As it is, some trainees spend all their time in high-prestige university centres, although these may not be best suited for training persons who will later work in mental hospitals or in community health programmes, or, for that matter, in developing countries. Some may receive all or part of their education in the region in which they intend to work after qualification, but others will find it necessary to move to other areas for all or part of their training and, in that case, it will be essential to seek out the programme that is best equipped to supply the trainee with the education and experience he will need when he returns home.

Whatever the method of financing, education of post-graduates in psychiatry is costly. (The service rendered to patients by the trainee will contribute but a small portion to this cost.) Not only will additional senior staff be required to do the teaching, but space for conferences, lectures, seminars, an enlarged library and research laboratories must be provided. The clinical programme will be enriched by the presence of the teachers, students and educational programme, but, like most desirable things, it must be paid for.

The post-graduate student himself must also have financial support if education is to be available on the basis of qualification and not of personal wealth. Many trainees are married and some have children. Compensation by means of a fellowship, salary, or some other form of support must therefore be supplied. Increasingly, governments are assuming the cost of education in this field, but attention is necessary to ensure that the stipends

are adequate to support young physicians. In this context it should be pointed out that at present many fellowships do not allow for analytic training. Inadequate support forces the student to take additional employment of a professional or other nature, and consequently to turn some of his attention and energy away from his education. This is poor economy indeed.

9.3 Training abroad

Owing to the increased recognition of the mental health needs of the community in developing countries, the shortage of mental health manpower in such countries has become an important matter of concern. The almost total lack of training facilities in most developing countries has made it imperative for them to rely for their supply of trained personnel on either foreign personnel or their own nationals trained abroad. The latter is undoubtedly the better solution to this problem and efforts have been increasingly made in this direction, and will continue until the establishment of national or regional training-centres for such countries. Training abroad will continue even after the establishment of such training-centres, as the need to elevate the quality of the regional training institute will undoubtedly call for an advanced training programme abroad for teaching and research personnel.

The training of foreign students presents a host of important issues¹ and constitutes a challenge to the individuals concerned as well as to the medical and psychiatric profession of both the "sending" and the "receiving" countries.

The candidate should be selected on the basis of his intellectual capacity and emotional maturity as well as his motivation to psychiatric work. Assessment of his strength and weakness should include the evaluation of suitability for overseas training with regard to his linguistic facility, ability to adjust to new environments, etc. Since these trainees are expected to become teachers or leaders in their own country, ability in teaching or providing leadership is also an important qualification. The trainee's understanding of his own future role after return, with respect to the over-all mental health programme, should, in any case, be an important factor to be considered. Accordingly, the Committee emphasized the importance of discussing the object of his study with each trainee before he goes abroad. First, there is a need to clarify the purpose and nature of the particular study programme in relation to the over-all mental health planning. This

¹ See the sixth report of the Expert Committee on Professional and Technical Education of Medical and Auxiliary Personnel, entitled "The Foreign Student and Post-graduate Public Health Courses" (*Wld Hlth Org. techn. Rep. Ser.*, 1958, 159).

facilitates the selection of a suitable candidate to complete such a study with specific tasks and helps the receiving country to plan better for the trainee.

The plan of study must be carefully designed to be practical, taking into consideration the purpose of the study and the trainee's capacity to learn, as well as the merits of different training-centres. There are conflicting views about the desirability of sending these trainees to large training-centres in medically highly developed countries. The advantages of training in such centres are self-evident. Moreover, it cannot be overlooked that there is a prestige value in such training which may help the trainee in future work in his home country. One cannot, however, overlook either the risks or the disadvantages involved. The trainee often finds the large cities, in which these training-centres are usually located, too inhuman and complex for his initial adjustment, which may require more than three months to achieve. Classes in these centres may be too large to provide individual attention. The foreign students may find it difficult to follow courses that were originally planned for students of the host country. The instructors in these highly developed centres are usually busily engaged in highly sophisticated research projects, which may mislead the trainee into believing that research can only be done at such a level, although this may be exactly the contrary of the original aim of exposing the students to such a group of investigators. Moreover, the courses are usually planned for three or more years which, with only a few exceptions, most foreign trainees are not able to complete. In spite of these difficulties, it is essential that the developing countries should endeavour to make provision to enable a few selected young candidates to receive the best possible psychiatric training over an extended period for future teaching and leadership positions.

How best to help the trainee to readjust to his home country and to start his work with renewed vigour, making the best of his enriched experience, knowledge and skills, and visions as well, is of utmost importance. Yet past experience has shown that negligence or difficulty in this final and crucial stage of overseas training have been responsible for many unsuccessful developments. No single rule can be found to make the whole process successful, except for emphasizing the need for a co-operative effort on both sides—the accepting body and the returnee—to work out problems constructively based on understanding, mutual respect and sharing of professional competence.

The Committee repeatedly stressed the need for establishing national or regional training-centres for developing countries, to ensure the sound development of mental health programmes. Moreover, it agreed on the desirability of international experience for psychiatrists from both developing and developed countries, in order that they may be exposed to different schools of thought and also gain wider cultural experience.

10. THE ROLE OF WHO IN THE TRAINING OF PSYCHIATRISTS

The Committee realized that the training of psychiatrists is a matter that, in principle, should be organized and carried out by national organizations. However, it believed that an international organization like the World Health Organization can contribute to national efforts in several ways and that in certain cases, at least for some time, it will even have to carry the main responsibility for the training of psychiatric specialists.

The World Health Organization should have the same function in respect of the training of psychiatrists as it already has in so many other fields—namely, that of collecting information and of making it available to the various national authorities. This information should include noteworthy developments in training requirements, the content of the training offered and the methods employed. In the opinion of the Committee, regional and inter-regional meetings are particularly suitable vehicles for speeding up the dissemination of such information.

Closely related to the provision of information is the assistance that might be given by WHO in establishing and maintaining minimum standards of training. In recommending that WHO should have this role, the Committee did not envisage any kind of supervision by the Organization, but rather that it should give concrete support to national authorities that will enable them to make a realistic comparison of their own standards with those of others. In order to achieve this, in the opinion of the Committee it would be desirable to sponsor and facilitate study tours for those entrusted with the training of psychiatrists. In certain circumstances the provision of outside teachers for a short or long period in national training institutions might be recommendable.

Since, in many countries, there is no possibility of organizing the training of psychiatrists at a reasonable standard, the Committee felt that the World Health Organization should attach special importance to the development of national training. The provision of fellowships for teachers of psychiatry would seem to be the most important need. However, attention should be paid also to the provision of basic libraries and to assistance in making available to trainees certain fundamental literature in their own language.

Where there are as yet no candidates, or an insufficient number of candidates, for training to become teachers of psychiatry, and especially where the number of existing psychiatrists is so small that the training of a minimum number of specialists must have first priority, it would, of course, be necessary to continue to give fellowships to young physicians which would enable them to receive a broad training in psychiatry elsewhere. The Committee recommended that, as long as this is necessary, care should be taken to send candidates to be trained in surroundings that are not too

unfamiliar to them and that an interest be taken in their physical and mental welfare during the training period. The Committee also considered that, while, in principle, no candidate should be admitted to training in psychiatry unless he can devote at least three years to it, the World Health Organization might reduce the financial difficulties of extended training by organizing it in two periods : the first period might be spent in the country of origin and might consist mainly in obtaining clinical experience ; in the second period, spent abroad, the trainee, while continuing clinical experience, would concentrate on theoretical instruction. The Committee agreed, however that this would be possible only if the institutions entrusted with training in the first period could guarantee a minimum level of education, the establishing of which could, perhaps, be carried out under the sponsorship of the World Health Organization.

The Committee did not consider it feasible for the World Health Organization to be expected also to provide fellowships for differential training, with the sole exception of those offered to future teachers of psychiatry. When, however, differential training is really necessary for such candidates, it should not be withheld, even if it refers to subjects of a more peripheral nature, such as psychology, sociology, public health, etc. In the opinion of the Committee, it might even include, in selected cases, so-called personal analysis in the course of psychoanalytic training.

Finally, the Committee expressed the opinion that the training of psychiatrists for countries so far devoid, or practically devoid, of psychiatric specialists is likely to give better results if, at the same time and in training-centres in close proximity, the education of psychiatric nurses, psychiatric social workers, and other assistant personnel is provided for. Such an arrangement would make it possible for the trainees to understand, at a very early stage, the need to collaborate with other professional categories with the same goal and would facilitate the creation of national patterns of multi-professional teamwork.

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The Committee acknowledges the special contributions made during the deliberations of the Committee by the following staff members : Dr D. F. Buckle, Regional Health Officer, Mental Health, WHO Regional Office for Europe ; Dr Maria Pfister, Medical Officer, Mental Health, WHO ; Dr Tigani el Mahi, Regional Adviser, Mental Health, WHO Regional Office for the Eastern Mediterranean.

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