The Preclinical Teaching of Psychiatry

formulated by
the committee on medical education

Group for the Advancement of Psychiatry

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The Preclinical Teaching of Psychiatry

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The Group for the Advancement of Psychiatry has a membership of approximately 185 psychiatrists, organized in the form of a number of working committees which direct their efforts toward the study of various aspects of psychiatry and toward the application of this knowledge to the fields of mental health and human relations. Collaboration with specialists in other disciplines has been and is one of GAP’s working principles. Since the formation of GAP in 1946 its members have worked closely, and other specialists as anthropologists, biologists, economists, statisticians, educators, lawyers, nurses, psychologists, sociologists, social workers, and experts in mass communication, philosophy, and semantics. GAP envisages a continuing program of work according to the following aims:

1. To collect and appraise significant data in the field of psychiatry, mental health, and human relations;
2. To re-evaluate old concepts and to develop and test new ones;
3. To apply the knowledge thus obtained for the promotion of mental health in good human relations.

GAP is an independent group and its reports represent the composite findings and opinions of its members only, guided by its many consultants.

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The Preclinical Teaching of Psychiatry

I. INTRODUCTION

The past 15 years have witnessed a surge of spirited experimentation in medical education. Innovations, mostly involving the first two (preclinical) years, include family medical care plans, integrated basic science courses, research fellowships in clinical departments, overlapping of premedical and medical curricula, and increased time for psychological and social science teaching.

The psychiatric educator has been a participant, sometimes a prime mover, in these new efforts to improve the education of medical students; and within his specialized area of responsibility is questioning, evaluating, and testing his own teaching efforts. To determine just what is being taught and what discarded, what innovations are being tried and with what success, the GAP Committee on Medical Education undertook, during the 1959-60 academic year, to survey preclinical teaching in the psychiatric departments of the 81 American and 12 Canadian four-year medical schools. The last such survey was completed in 1940. Events during the 20-year interim, including a World War, have so tellingly affected psychiatric practice, theory, teaching, and acceptance that this new study seems due.

The findings of this recent survey are presented against a brief historical background, aligning them with the data of two important previous studies, the Graves report of 1914 and the Ebaugh-Rymer study of 1932-40. The survey itself is a cross-sectional view of preclinical psychiatric teaching in 1960, a record of current practices and achievements by which a psychiatric educator may gauge the comparative state of his own program. In later sections the trends and issues revealed by the survey are discussed, and the reform focused on developing the basic biological and physical sciences, introducing laboratory training, and establishing research programs in medical schools (as opposed to the then prevailing strictly didactic training), this response reflected the acceptance of psychology not only as a science, but as the basic science of neurology and psychiatry. In a 1912 symposium concerning the proper content for an introductory course, Watson suggested that attention be placed largely on presenting perception, motor control and fatigue, and on association, memory, and retention. He believed that the content should be "purely objective." A remarkably modern discussion by Prince in 1912 emphasized the "subconscious," instincts, complexes, the phenomena of repression and resistance, and the mechanism of dreams. However, published reviews of medical educators showed a predominance of support for the objective school, as reflected in the following quotations: "I believe that the wave of so-called psychology which is spread over medical literature in the past ten years is not worthy of the name. It has been a distinct injury to medical science. It is, in my opinion, very erroneous and misleading. None more so than Dr. Morton Prince's and Dr. Freud's." "It seems doubtful that the instruction in psychology can be introduced into the already crowded undergraduate course." During the next 20 years progress was slow, although one might assume that earlier recommendations were receiving some attention. In 1914, the psychiatric educator's goal was to teach the student how to recognize overt psychosis and the common neurologic disorders. By 1930, the shift to courses in psychobiology, often in the preclinical curriculum, indicates that teaching objectives had expanded beyond the limits of syndrome recognition into areas pertaining to the understanding of individual patients in a longitudinal perspective. The training of this period emphasized the collection of detailed anamnestic data and writing of personal biographies.

The Ebaugh-Rymer Report of 1932-40

In 1942 the Commonwealth Fund published PSYCHIATRY AND MEDICAL EDUCATION, written by Franklin G. Ebaugh and Charles A. Rymer. This book, a comprehensive analysis of psychiatric education at 67 American and two Canadian medical schools, presented data concerning preclinical and clinical instruction of medi-
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cal students and, in addition, training of residents. It covered an eight-year period, beginning with data first obtained in 1932 under the auspices of the Division of Psychiatric Education of the National Committee for Mental Hygiene. Subsequent data were obtained for the years 1934, 1938, and 1940, so that developmental trends could be documented.

The data were obtained by questionnaires, analysis of school catalogues, and site visits. The questionnaires requested descriptions of the medical school, the actual psychiatric curriculum, and attitudes toward psychiatry and psychiatric teaching of the Dean, the Professor of Medicine, and the Professor of Pediatrics. The book included the authors' evaluation of each teaching program. They told of difficulties they had encountered in evaluating methods and philosophy of teaching and, consequently, their report on content was the more informative.

The authors reported that in 1932, 13 schools presented courses in "medical psychology." However, at this time, psychiatry remained a division under medicine in 32 medical schools, combined with neurology in 17, and a separate department in only 21 schools. Preclinical instruction of psychiatry did increase more sharply. In 1932, 39 schools offered some preclinical instruction; the average number of hours at schools having such programs was 17½. The study of component emotional factors in all illness, beyond and not excepting illnesses specifically referred to psychiatrists, was included in curricula of the late 1930's. Concomitantly, preliminary attempts were made toward the integration of psychiatric teaching with the teaching of other basic science departments, such as physiology and pharmacology, and toward the establishment of liaison services with other clinical departments as well. At that time 43 per cent of the schools offered preclinical psychiatric instruction. The total increased in 1934 to 61 per cent, in 1936 to 72 per cent, and in 1940 to 88 per cent. The average number of hours devoted to preclinical psychiatric instruction was as follows: 1932, 17½ hours; 1934, 20 hours; 1936, 22 hours; 1940, 26 hours.

The title given the introductory course on normal behavior by many schools in 1940 reflected the influence of Adolph Meyer. The course was called "Psychobiology" in 27 schools, "Biopsychology" in one, "Biological Basis of Personality" in one, and "Medical Psychology" in 18. Among other labels were "Mental Hygiene" in two

schools, "Introduction to Psychiatry" in nine, and just "Psychiatry" in 11. Signs of things to come were in the titles "Structure of the Normal Personality" in three schools, "Basic Human Relations" in one, and "Human Behavior" in two.

In the last chapter "Retrospect and Prospect" of the Ebaugh-Rymer book, the authors' prediction of changes in psychiatric education anticipated a shift from "the nihilistic organic approach" to a more psychodynamic one. They mentioned also the probable extension of psychiatric instruction into all four years of the medical curriculum, with emphasis on the psychosomatic aspects. They considered it reasonable that three to four per cent of the total curriculum hours should be devoted to the field of psychiatry. Thus, in the curriculum of 3,600 to 4,400 hours, approximately 150 hours should be allotted to psychiatry. They recommended that preclinical training emphasize normal personality development, in the psychobiological sense, during the first year; a typical psychopathology course in the second year; a study of the major and minor psychoses, beginning with organic reactions and ending with psychoneurotic reaction types, supplemented by a clinical clerkship, in the third year; and in the fourth year, supervised therapy on a minimum of six cases followed in an outpatient clinic throughout one year. Their proposal for the fourth year is probably the least realized as yet. They stressed the importance of interdepartmental consultation services to effect liaison teaching in the preclinical departments with appropriate demonstrations in the physiology, biochemistry, and pharmacology laboratories.

The authors suggested that the quality of success in future psychiatric education would depend on the interchange of information among psychiatric educators, to the advancement of which function this Committee offers this report. They recommended that a symposium on psychiatric education be held every two or three years under the auspices of the American Psychiatric Association. Also, they proposed a survey subsequent to theirs that would give particular attention to aims and methodology of teaching.

Psychiatric Education, 1940-60

Since 1940 several significant reports on psychiatric education in the United States have appeared. Three of these are especially worthy of review in connection with the present report:
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MEDICAL EDUCATION, GAP Report No. 3, March, 1943.13


AN OUTLINE FOR A CURRICULUM FOR TEACHING PSYCHIATRY IN MEDICAL SCHOOLS, prepared by the Committee on Medical Education of the American Psychiatric Association, 1956.14

MEDICAL EDUCATION. This paper formulated the function of psychiatry in medical education, pointing out that psychiatry had come to have a great responsibility for educational leadership, instead of being concerned merely with diagnosis and care of psychotic and psychopathic patients. The report advocated that psychiatry be taught throughout the medical course, not as a speciality, but as an integral part of medical science and medical practice. Moreover, it pointed to the need for students to see and study people, from the first year on, in order to learn that there are psychiatric implications in ministrations to any patient as a person. Psychiatric teaching should acquaint the student with the necessary techniques for relating himself to the patient thoroughly enough so that he may consciously apply these techniques, with some understanding of their dynamics, for the benefit of the patient, whatever his presenting disease or disorder. It urged that teaching be as non-didactic as possible, centering on the demonstration of actual patients and their biographical histories. It recommended teaching in cooperation and integration with other departments, together with an increased number of hours assigned to psychiatric teaching. It suggested that, during the preclinical years, more attention be directed to the interviewing of patients by students, and that teaching be done principally in sections rather than by lectures to the whole class. (SMALL GROUP TEACHING IN PSYCHIATRY FOR MEDICAL STUDENTS, GAP Report No. 40, discusses this aspect of psychiatric education in detail.)

PSYCHIATRY AND MEDICAL EDUCATION. Among many major topics discussed were selection of medical students, deficiencies and potentialities of medical schools, and administrative problems of integrating psychiatric teaching in the medical school curriculum. From the viewpoint of the present report, however, the most significant topics considered were those pertaining to the objectives, content, and methods of teaching psychiatry in medical schools.

THE PRECLINICAL TEACHING OF PSYCHIATRY

The basic aim of undergraduate psychiatric teaching, as stated by the Ithaca group, is "to equip the student with a reasonably adequate knowledge of the facts of human nature; the clinical aim is to familiarize him, through representative clinical experience, with the common and the most important problems of patients as persons, and to cultivate in him at least rudimentary skill and judgment in managing the doctor-patient relationship." In addition, psychiatric teaching should promote the student's (1) ability to interview, (2) ability to diagnose correctly, and (3) understanding of what the physician who is not a psychiatrist can and should do and what he cannot and should not do.

From questionnaires issued for the 1951 study, data returned by 49 medical schools showed that a diversified pattern of teaching practices existed. This diversity appeared appropriate in such a comparatively new and rapidly expanding field. Two general trends were observed: first, psychiatry was being taught in all four years (36 of the 49 schools); and second, much psychiatric teaching was being integrated with that of other departments, especially in the social aspects of medicine.

In nearly all of the 49 schools surveyed, the lecture was the method of choice for teaching psychiatry in both first and second years. "Personality Structure and Development" and "Psychotherapy" were the chief topics or titles of courses. A trend was noted toward introducing students, during the second year, to patient-material through the use of living subjects during the lectures and the offering of courses on interviewing. A few schools were experimenting even then with sound films, tape recordings, and one-way vision rooms. In 14 of the 49 schools small group discussions were held, usually following the lectures or demonstrations.

Of particular significance in the report on the 1951 Ithaca Conference was the chapter "Human Ecology and Personality in the Training of Physicians," consisting of a statement by Dr. Norman Cameron, then Professor of Psychology and Psychiatry at the University of Wisconsin Medical School. This particular statement has become recognized as a knowledgeable blueprint of the design and specifications for the curriculum courses or programs in social psychiatry, or the science of human behavior.

AN OUTLINE FOR A CURRICULUM FOR TEACHING PSYCHIATRY IN
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MEDICAL SCHOOLS. An outgrowth of the 1951 Ithaca Conference, this paper was prepared by the Committee on Medical Education of the American Psychiatric Association in response to many requests for a more detailed statement on what medical school graduates should know about psychiatry, and on how schools could convey psychiatric knowledge and skills to their students. The report contained an outline of curriculum content but did not discuss teaching methods or philosophy of psychiatry in medical school education. It pointed out that progress in psychiatry requires constant experimentation in teaching and continuing re-evaluation of conceptualizations. It suggested that the following material should be taught during the first two years:

1. Personality growth and development, including the adaptive needs of the personality (the interrelationship and interdependency between physical maturation, environmental experiences, and interpersonal background of the growing child; personality structure and integration; social and cultural forces affecting personality and behavior; introduction to the role of language and mentation in human behavior; and the role of emotions in physiologic functioning).

2. Psychopathology.

3. Interviewing techniques and the therapeutic use of interpersonal relationships in medicine.

In addition to these three reports, the large number of articles on psychiatric education published in recent years, viewed with the current variety of methodological procedures that are being tried or used, documents the rapid change and growth in this field. This interest in medical school psychiatric education is not a preoccupation of American teachers exclusively; the 1960 meeting of the World Health Organization’s Expert Committee on mental health was devoted to this topic.11

To recapitulate, the 1930’s seem to have been a period of psychobiologic and psychosomatic expansion, the 1940’s a period of psychodynamic and psychoanalytic expansion. Foresight of this was mentioned only briefly in the Ebaugh-Rymer report of 1940; and there was small basis at that time for anticipating the important influence psychoanalytic concepts were soon to exert in psychiatric education. Ninety of 91 schools now state that they teach psycho-

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analytic theory to medical students, and many report psychoanalysts on their staffs. The scope of psychiatric education has been further broadened to include courses in interviewing technique, the doctor-patient relationship, and the student’s future role as a physician.

Psychiatric Education in the 1950’s

If the 1940’s was an era of psychodynamic and psychoanalytic expansion, the 1950’s can be considered the introductory period of the social or behavioral sciences. There is little foreshadowing of this possible development in the Ebaugh-Rymer report of 1940, although a statement attributed to Bayne-Jones suggested that some orientation in the social sciences was desirable.15 This was intended, however, simply to prepare the doctor for his role as a citizen, rather than to enhance his professional understanding of the individual in health and disease. The orientation of today’s social scientist toward culture and personality, and its value in understanding illness, were merely mentioned in that report. This latest trend logically parallels widening applications of psychoanalytic theory which emphasizes man’s coping with instinctual biological drives in terms of the demands of his society. Correspondingly, human ecology is being introduced into the preclinical curriculum; and social psychologists, sociologists, and anthropologists are functioning as medical educators. As this is the newest facet of psychiatric education, it is given prominent focus in the present report.

Our survey substantiates the common impression that the quantity of psychiatric teaching in the first two years of medical school has continued to increase. The Ebaugh-Rymer study presents some data which can be compared with data from our present survey. Table I illustrates changes over a 20-year period in the 66 schools surveyed in the 1940 study. The number of psychiatric departments presenting both freshman and sophomore courses has risen from 25 to 61. One single school continues to teach psychiatry in the first year only, and just four schools in the second year only.

The average number of hours offered in the first year has risen most dramatically from six to 37, and in the second year from 14 to 36. The total increase for both years is 53 hours—from 20 to 73.

This comparison demonstrates that after a gradual development preceding World War II, psychiatry was catapulted from a minor to a major role in the preclinical medical curriculum. This evolu-
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tion was undoubtedly attributable, in part, to the impact of events centering about and connected to the war itself.

Table I

Psychiatric Teaching in the First Two Preclinical Years
65 Schools*

<table>
<thead>
<tr>
<th>Year</th>
<th>1940</th>
<th>1960</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First year</strong></td>
<td>30</td>
<td>62</td>
</tr>
<tr>
<td><strong>Second year</strong></td>
<td>51</td>
<td>65</td>
</tr>
<tr>
<td><strong>Both years</strong></td>
<td>25</td>
<td>61</td>
</tr>
</tbody>
</table>

**Number of schools teaching psychiatry in each year**

<table>
<thead>
<tr>
<th>Year</th>
<th>1940</th>
<th>1960</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>First year</strong></td>
<td>6</td>
<td>37</td>
</tr>
<tr>
<td><strong>Second year</strong></td>
<td>14</td>
<td>36</td>
</tr>
<tr>
<td><strong>Both years</strong></td>
<td>20</td>
<td>73</td>
</tr>
</tbody>
</table>

**Average hours of teaching in each year**

*The 65 schools in the Ebaugh-Rymer report of 1940.

Whatever the determinants, psychiatry was assigned a significant role in the experiments which evolved in medical education immediately following World War II. However, this assignment was not exclusively to departments of psychiatry. Programs of "family care," and of "comprehensive medicine," emphasized the common responsibility of all physicians to the previously neglected emotional and social aspects of patient problems.

Many of these programs to produce better physicians centered their concern on beginning medical students, on the theory that the traditional curriculum, with its initial two years of isolation in the laboratory, fostered attitudes hindering a physician's ability to relate to his patient. Thus it was that the preclinical curriculum came of age in respect to both psychiatric education and the general problem of educating the physician toward a philosophy of comprehensive care.

From our data and historical review it would seem that certain expectations of psychiatric educators in earlier years failed to materialize. First, the prediction of 1914 that academic psychology would become the basic science of psychiatry and neurology was in error. Second, the personal biography and life-history chart of the psychobiologic school is largely obsolete. Third, the psychosomatic and liaison services, as well as the cooperation with the basic science departments of physiology or pharmacology, have not developed to the extent predicted by Ebaugh and Rymer in 1940. Fourth, it seems to this Committee that some of the enthusiasm for integrating psychoanalytic concepts completely with psychiatric education, so prominent immediately following World War II, has now leveled off. Each, however, has left its mark on the teaching of psychiatry.

References for Chapter II


III.

SURVEY OF CURRENT PRECLINICAL TEACHING

Collection of Data

The survey of the 93 four-year medical schools in the United States (including Puerto Rico) and Canada was accomplished by preliminary field trips to 28 psychiatric departments geographically accessible to committee members, and then by means of questionnaires. The idea of analyzing medical school catalogues was discarded because these accounts of courses are frequently incomplete or out of date.

For the site visits each committee member selected two or three medical schools nearest his own community. He interviewed course instructors, the department chairman, and, when possible, medical students. The geographical spread of the committee members permitted investigation of schools in the South, Mid-west, and Far West, as well as in several Eastern metropolitan centers.

The cooperativeness and interest shown by the people who were seen during the 28 field visits stimulated the Committee to prepare and send a questionnaire to the remaining 66 medical schools. From the experience gained in the personal interviews and the analysis of data they yielded, a set of questions was formulated, tested, revised, and distributed.

In its initial form the questionnaire was in two parts.** Part I was directed to all individual course instructors and included check-off lists for factual data and open-ended questions for opinions. This part of the questionnaire elicited usable data from 79 of 81 Ameri-

*These schools were visited: Albert Einstein, Baylor, Boston, California (Los Angeles), Chicago, Cincinnati, Columbia, Cornell, Duke, Florida, Harvard, Jefferson, Johns Hopkins, Kansas, Louisiana State, Maryland, McGill, North Carolina, Northwestern, Oklahoma, Pennsylvania, Saskatchewan, Temple, Texas (Galveston), Toronto, Tufts, Tulane, and Utah.

**See Appendix for the text of the questionnaire.
can schools and from 10 of 12 Canadian schools. Part II, which was directed to department chairmen, inquired into their philosophy of teaching with particular reference to social and behavioral science. Complete replies were obtained from all 81 American and from 10 of 12 Canadian department heads. A gratifying number of respondents appended to the returned forms helpful unsolicited data, such as annotated outlines of courses and two- to four-page letters earnestly discussing issues highlighted by the survey.

Teaching Practices

Content of Courses. The titles of courses in preclinical psychiatric teaching are often so general and vague as to give little indication of the actual subject matter, e.g., “Psychobiology,” “Introduction to Psychiatry,” “Clinical Psychology,” “Ontogeny of Behavior,” “Freshman Psychiatry.” It is significant, however, that there has been a shift in the most popular titles from the almost universally used “Psychobiology” and “Medical Psychology” in 19401 to the present-day titles “Personality Growth and Development” and “Psychodynamics.” It is apparent, from the descriptions of individual courses in the questionnaires, that the teachers themselves usually determined the actual course content. Precision in this determination was impossible because the responses varied in their completeness of detail. Nonetheless, major trends seem clear.

What first becomes apparent is the vast range of subject matter covered by preclinical psychiatric educators; everything to do with human behavior becomes grist for the mill. The range of course titles extends from “The Neurophysiology of Behavior in Lower Animals” to “Concepts of Comprehensive Medicine,” and from “History of Psychiatry” to “Research and Statistical Methods.” There is, however, a definite common core of attention to the psychology of the individual human being, in particular, a concern with psychological development and pathology.

Table II lists the subject matter of courses in the order of the frequency with which they were taught, as accurately as could be determined from answers to the questionnaires.

Psychodynamics. All the department chairmen indicated that their teaching program includes a “dynamic” approach to psychiatry. This raises the question of the meaning of “psychodynamics.” The second Ithaca Conference on “The Psychiatrist, His Training and Development,” held in 1952, struggled with this problem. For this report, the Committee decided to use the statement drawn up by the Commission on Psychodynamic Principles at that conference, namely, “that psychodynamics is concerned with understanding the motives of human behavior.” The Commission “was in agreement as to the great importance of events of early childhood and social experience in shaping the general course of personality development and in the formation of the system of value judgments by which the persons are guided, or perhaps morbidly constrained, during life’s later quest for adventure and security.” Moreover, “between individual persons there exist great differences of potentialities and limitations, inately determined, and . . . behavior is influenced by physiological and pathological changes in the organism.”

The analysis of the replies to the questionnaire indicates that course material reflecting this view actually appears in all the curricula. Indeed, the majority of the schools include the term “psychodynamics” in either a course title or description. The universality of this approach and the inclusion of content dealing with psychodynamics represents one of the most significant developments during the last two decades in psychiatric education.
**Personality Growth and Development.** All but three schools present this approach in the preclinical years, and one of these teaches it in the third year. It can therefore be presumed that psychiatric departments consider it their responsibility to offer students a basic framework of psychological development. The courses in Growth and Development are variously conceived. The prevailing frame of reference derives from Freudian psychosexual concepts. The general Meyerian genetic-dynamic framework is also in evidence, but much less so than 20 years ago.

**Psychopathology and Clinical Psychiatric Syndromes.** Eighty-seven per cent of the schools teach certain aspects of psychopathology in the preclinical years. Obviously, this subject is dealt with by all departments at some time, but at a few schools largely in the clinical years. The presentations vary from the traditional descriptive approach to material emphasizing symptom formation and psychopathological processes in health and disease. In some schools psychopathology is treated as a separate entity; in others, psychopathological processes are dealt with in relationship either to growth and development or to a psychodynamic understanding of the personality.

The variety of approaches described is impressive. The traditional descriptive categorization of psychiatric syndromes still forms the core material, but numerous schools are attempting to expand this approach.

At the University of Cincinnati a separate course entitled “Psychotic Reactions” is given. It is described as “a working concept of the psychotic behavior disorders, ranging in origin from those conditions stemming primarily from pathological tissue changes in the nervous system and toxic disturbances to disturbances in habit patterns, and coping mechanisms resulting from personal and social life stresses. The lectures attempt to integrate the students’ previous course studies in anatomy, physiology, pharmacology, biochemistry, neurophysiology, and pathology towards understanding the etiological factors involved in these behavior disorders. Its content: psychotic reactions, functional and organic.”

At Northwestern University a course entitled “Survey of Human Disease” encompasses all medical specialties. The department of psychiatry is allotted six hours in which to introduce psychopathology.

At the University of Michigan the presentation of psychopathology is oriented to “give an understanding of the theoretical basis behind the symptom formation in character disorders and in psychoneuroses. The information is generalized to the point where such principles of personality development and symptom formation could be applied to patients in general rather than just psychiatric patients.”

The average time that the schools devote to psychopathology is between 20 and 30 hours.

**Contributions from Related Disciplines.** Among the noteworthy findings of this survey is evidence that departments of psychiatry are endeavoring to include concepts and techniques from other scientific disciplines in their teaching. However, there is little agreement as to what extent this should be done or exactly what material should be included. This ranges from work with enzyme chemistry by biochemists on the one hand to contributions by cultural anthropologists on the other. The most distinct trend seems to be an increasing use of concepts from the social sciences with growing emphasis on the cultural environment. Further, neurophysiology, animal behavior, basic psychological concepts, etc., are being drawn on to amplify the more traditional “growth and development” and “psychodynamics.” Fifty-three per cent of the schools clearly have advanced beyond the traditional boundaries of psychiatric teaching. However, there is wide variation, ranging from those importing for a few lectures material and/or representatives from related disciplines to those developing extensive courses with the avowed purpose of inculcating a broad multidisciplinary understanding of human behavior.

Representative examples include the following:

1. Twelve-hour course (Mississippi), Freshman Psychiatry. Psychiatrist, four hours; pediatrician, five hours; sociologist, anthropologist, chaplain, one hour each.
2. Purpose: to provide an introduction to the integrated and systematic study of physical, neurological, and behavioral development as it relates to normal human behavior and personality structure in children and adults.
Content: definition of human behavior; growth and development during the first year of life; anthropology, sociology, and religion as factors influencing human behavior.

(2) Forty-hour course (Greighton), Human Ecology. Psychiatrist, five hours; public health physician, 14 hours; pediatrician, eight hours; surgeon, one hour; clinical psychologist, seven hours; sociologist, five hours.

Purpose: to provide a broad base upon which the student can build a thorough comprehension of normal and abnormal interpersonal relations.

Content: the nature of personality; motivation and frustration; conflict and stress; emotion; perception and learning; language and thought; adjustment techniques; normal child behavior; adolescent behavior; social organization and disorganization; the community; the community organized for health; environment and its effect on the individual; health and the individual's job; human genetics.

(3) Fifty-six hour course (North Carolina), Human Ecology. The following participate as a team throughout the course: one psychiatrist, psychoanalyst, clinical psychologist, social worker, sociologist, anthropologist, preventive medicine physician, internist.

Purpose: to introduce the student to what is known medically, psychologically, sociologically, and anthropologically about why people act as they do, sick or well; and to instruct him in methods of gathering and evaluating data.

Content: concepts in the various fields presented initially as ways of studying man and then applied to patients and "normals," roughly following the life cycle from preconception to senescence.

Interviewing and Psychiatric Examination. Forty-two per cent of the schools teach elements of interviewing, history taking, and psychiatric examination by the end of the sophomore year. Certain schools emphasize the traditional mental status examination for psychiatric patients in preparation for the department's clinical clerkship; others present the techniques of interviewing and history taking as preparation for the examination of all patients. These two approaches are not mutually exclusive. In some instances the teaching technique is chiefly demonstration; in others the students interview patients with supervision. A common pattern is to teach interviewing as part of a course in physical diagnosis given jointly with other departments, most frequently the department of medicine.

Psychophysiology. Aspects of psychophysiology presumably are presented at some time in the majority of psychiatric curricula; most likely, in courses in psychopathology. About one-third of the schools seem to give some special emphasis to physiological responses relating to emotional states as they occur in everyday life. The most extensive illustration of this is in a course at the University of Colorado, consisting of over 40 hours of actual work in the psychophysiology laboratory. Other schools offer laboratory experiences or demonstrations that usually illustrate physiological responses to psychological stresses. In some instances, although no laboratory studies as such are demonstrated, this area receives considerable attention when psychosomatic medicine is discussed; and end results of psychophysiological processes are shown in clinical presentations of medical and surgical patients. Both the University of Rochester and George Washington University make extensive use of clinical presentations of general medical and surgical patients, and, in discussion regarding them, correlate psychological and physiological processes.

Doctor-Patient Relationship. Almost certainly the doctor-patient relationship is dealt with to a limited extent by a majority of the departments of psychiatry; 25 per cent indicated explicitly that consideration of this important transaction is a major function in their teaching. In many instances this enlightenment is given as part of the teaching of interviewing. In others the relationship is discussed concomitantly with the study of the psychology of illness.

At the University of Chicago most of the preclinical teaching is centered around patients actually seen by the students and discussed in small groups, so that the students' knowledge of human behavior extends outward from a consideration of the doctor-patient relationship.

A unique 55-hour course, "Medical Psychology," at the Wayne University School of Medicine, is oriented toward the development of the physician's perspective of himself in this relationship. The
Survey of Current Preclinical Teaching

Principal topics are: All observation is self-observation, stresses of medical school living, family living, student’s need to fail, importance of inner motivations upon the quality of medical practice, the importance of self-insight for the developing physician.

History and Scope of Psychiatry. Twenty-one schools make some particular, although usually brief, reference to the history and scope of psychiatry. When it is specifically emphasized, one to four hours are devoted to the topic.

Multidisciplinary or Correlation Courses. Because of psychiatry’s unique position in the medical school both as a basic science and a clinical department, its collaborative teaching efforts are conveniently divided into two types. The first is exemplified by a joint attempt of several preclinical departments, including psychiatry, to present related scientific concepts. At the University of North Carolina members of the psychiatric department combine in laboratory exercises with the departments of physiology, biochemistry, and pharmacology. This joint participation occurs when topics of mutual responsibility and interest, such as anxiety, psychophysiology of organ systems, and pharmacology, require consideration.

The second type represents integrated clinical teaching, and several techniques of presentation are being tried. One is the so-called Correlation Clinic in which, during the first two years, a number of clinical departments jointly participate in patient demonstrations. At Stanford University the Departments of Medicine, Surgery, Pediatrics, Psychiatry, Obstetrics and Gynecology, and Preventive Medicine present an “Introduction to Clinical Medicine.” Over 90 hours at Western Reserve University are devoted to the first-year course called “Clinical Science, Phase I,” in which a psychiatrist, clinical psychologist, social worker, sociologist, pediatrician, public health physician, obstetrician, and internist participate.

Miscellaneous. A number of medical schools report special programs which do not fall strictly within any of our categories. Research methods and statistics are taught by the department of psychiatry in several schools. The University of California, the University of Louisville, and Temple University have elective courses in psychotherapy beginning in the preclinical years. Howard University School of Medicine and the University of Louisville give courses in social illness. Temple University conducts a second-year course in medical hypnosis.

Course Patterns. Seventy-seven of the 89 schools teach psychiatry in both preclinical years. Forty of these adhere to a basic pattern of two courses only: first year, “Personality Growth and Development”; second year, “Psychopathology.” An additional 20 schools similarly follow this subject sequence but use three, four, or more separate courses, variously titled. Thus, 60 psychiatric departments (78 per cent of those surveyed) comply with the traditional order of the basic-science years: anatomy before pathology, physiology before pharmacology.

The chief variation from this pattern is the presentation of normal and abnormal behavior together. First-year courses may teach normal growth and development but also include such topics as the concept of anxiety and mental mechanisms, as well as concepts of illness. Live patients and case histories may be utilized in discussing health and disease, psychosocial factors in medical and surgical patients, abnormal reactions to stress, etc.

Several schools teach only normal behavior in the preclinical years, leaving psychopathology for the third year.

Purpose of Courses.

In the questionnaire each instructor was asked to state the primary aim or purpose of his course and to describe its content. As a cross-check on the answers to these two questions he was asked to place his course on a continuum represented by a straight line.

A

“A” represents teaching which emphasizes a psychiatric approach to all patients and prepares the student for his general role as a physician. The opposite pole, “B,” represents teaching which is directed toward the effective understanding and management of psychiatric patients.

 Appropriately, the instructors of broad survey courses consider their preparations preparation for general medical rather than psychiatric practice alone (47 courses to two).
This point is emphasized by the ratings for the standard preclinical psychiatric course, “Personality Growth and Development.” Thirty-four of 49 teachers consider such a course preparation for general practice.

Even in such strictly psychiatric teaching as psychopathology, 26 of 55 courses are pinpointed on the “A” side of the continuum—preparation for general medicine.

Teaching Personnel

The survey shows that 33 types of professional specialists are participating to some extent in preclinical psychiatric teaching.

Not surprisingly, 87 of 89 departments list a psychiatrist as one of their preclinical teachers. The exceptions are Queens College of Medicine in Canada and the Medical College of Virginia, each with a clinical psychologist as its only preclinical psychiatric instructor. In 56 schools in the United States, and in one in Canada, psychiatrists with psychoanalytic training teach in preclinical years.

An important development of the last two decades is the integration of clinical psychology into psychiatric teaching and practice. In 51 medical schools clinical psychologists teach during the first two years. Other types of psychologists who teach in 11 schools in this country are experimental, developmental, physiological, individual, and research. The Canadian schools list only clinical psychologists.

In a number of programs psychologists are given major responsibility for courses. At the University of Alabama, in a 36-hour, first-year Behavioral Science course, a physiological psychologist teaches 24 hours. In a 72-hour course at Duke University (First Year Psychiatry), three clinical and experimental psychologists teach 34 hours. At the University of Oregon, 44 of the 48 hours in “Introduction to Medical Psychology” are presented by an experimental psychologist, and the 48 hours of laboratory work are taught by a second experimental psychologist.

Social workers comprise the next most numerous group of teachers. They teach in preclinical psychiatry in 22 schools in the United States and two in Canada.

The remaining categories of specialists are in the United States schools only, with the exception of two Canadian schools that use pediatricians in their teaching programs and one Canadian school that uses a sociologist. In the United States there are 19 schools with sociologists and eight with anthropologists teaching preclinical psychiatry. Twenty-one schools in all list one or more of these social scientists. Turning to specific courses, the survey shows that four social scientists participate in general survey courses, 15 in courses on basic human behavior, 11 in personality growth and development courses, and only one in the teaching of psychopathology.

Pediatricians are teaching collaboratively with psychiatrists almost as frequently as social scientists. Nineteen departments have pediatricians as preclinical instructors. Other physicians participating include internists (14 schools), public health specialists (eight schools), surgeons (four schools), obstetricians (four schools), gynecologists (two schools), general practitioner (one school). From a historical perspective it is interesting to note that only one neurologist is listed. There are, however, neurophysiologists in nine schools and a neuroanatomist in one.

The inclusive range of subject matter and experimentation in psychiatric teaching is illustrated in the variousness of additional associates named by respondents: geneticist, embryologist, pharmacologist, biochemist, hematologist, child therapist, chaplain, philosopher, economist, educator, statistician, electronics engineer.

An investigation of the courses themselves reveals that when courses are assigned primarily to a single faculty member, it is most common for a psychiatrist to be given this responsibility. Among courses which are described as “General Survey,” “Human Behavior,” or “Personality Growth and Development,” 30 are taught by one faculty member alone and 51 by more than one faculty member. Of the 30 courses with one instructor, 90 per cent (27) are taught by a psychiatrist or psychomentalist, and the remaining 10 per cent (3) by psychologists.

Teaching Techniques

Utilization of Time. All 89 schools teach psychiatry in the first two years. Seventy-eight (87 per cent) teach it in both years; seven do not present courses in the first year and four do not in the second. The average number of curriculum hours available to psychiatry in these two years is 78 (36 in the first year, 42 in the second). However, the range varies widely: eight schools teach less than 30 hours and 14 more than 120 hours.
About two-thirds of the schools allot from 10 to 49 hours to the psychiatric department in each of the first two years. Of the 82 schools that teach psychiatry during the first year, three present less than 10 hours and four over 90. Of the 85 that give courses during the second year, only one presents less than 10 hours and eight exceed 90 hours.

Teaching Methods. Part I of the questionnaire lists six standard teaching methods used in nonclinical courses: lecture, assigned reading, patient demonstration, laboratory work, small groups, student interviews with individual patients. Under the heading “other,” respondents added audio-visual aids and role playing. Tables III and IV illustrate the distribution of these eight techniques by courses and schools.

The lecture method remains the core of teaching; it is used in 90 per cent of all the courses, and by 88 of the 89 psychiatric departments. At Stanford the first-year material is presented by a multidisciplinary panel of five instructors.

Students are assigned reading in 130 courses. However, in 77 courses in 14 departments reading is not assigned; the majority of these courses give instruction in interviewing and psychiatric examination.

One of the relatively recent developments in medical education, mentioned in the Introduction, is the breakdown of the traditional separation of basic science and clinical years. Because in psychiatry the clinician has had to teach his own basic science, psychiatric departments have pioneered in the use of live patients, particularly in first-year teaching. Demonstrations with patients are a supplementary technique in no less than 54 per cent of all the preclinical courses, equally divided between the first and the second year.

Table III
Psychiatric Teaching in the First Two Years of Medical School Teaching Methods Used in 207 Courses

<table>
<thead>
<tr>
<th>Teaching Method</th>
<th>No. of Courses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lecture</td>
<td>188</td>
</tr>
<tr>
<td>Assigned reading</td>
<td>130</td>
</tr>
<tr>
<td>Patient demonstration</td>
<td>12</td>
</tr>
<tr>
<td>Laboratory</td>
<td>28</td>
</tr>
<tr>
<td>Small Group</td>
<td>62</td>
</tr>
<tr>
<td>Student-patient interview</td>
<td>30</td>
</tr>
<tr>
<td>Role playing</td>
<td>1</td>
</tr>
<tr>
<td>Audio-visual aids</td>
<td>31</td>
</tr>
</tbody>
</table>

Table IV
Psychiatric Teaching in the First Two Years of Medical School Teaching Methods Used in 89 Schools
(Figures refer to number and percentage of schools)

<table>
<thead>
<tr>
<th></th>
<th>First Year only</th>
<th>Second Year only</th>
<th>Both Years</th>
<th>Total schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lecture</td>
<td>9 (10%)</td>
<td>6 (7%)</td>
<td>75 (82%)</td>
<td>88 (99%)</td>
</tr>
<tr>
<td>Assigned reading</td>
<td>18 (21%)</td>
<td>18 (20%)</td>
<td>44 (49%)</td>
<td>70 (80%)</td>
</tr>
<tr>
<td>Patient demonstration</td>
<td>13 (14%)</td>
<td>18 (20%)</td>
<td>31 (35%)</td>
<td>66 (73%)</td>
</tr>
<tr>
<td>Laboratory</td>
<td>12 (13%)</td>
<td>7 (8%)</td>
<td>29 (32%)</td>
<td>48 (55%)</td>
</tr>
<tr>
<td>Small Group</td>
<td>6 (7%)</td>
<td>14 (16%)</td>
<td>20 (22%)</td>
<td>40 (45%)</td>
</tr>
<tr>
<td>Student-patient interview</td>
<td>6 (7%)</td>
<td>19 (21%)</td>
<td>2 (2%)</td>
<td>27 (30%)</td>
</tr>
<tr>
<td>Role playing</td>
<td>1 (1%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Audio-visual aids</td>
<td>11 (13%)</td>
<td>4 (4%)</td>
<td>8 (9%)</td>
<td>23 (26%)</td>
</tr>
</tbody>
</table>

Curricular provision for laboratory work seems a relatively recent addition to psychiatric teaching (28 courses in 24 schools). Most of the laboratory assignments occur in courses combined with physiology, pharmacology, and experimental psychology. The announced aim of these courses is improved integration of basic biological and psychological data.

Sixty-two courses in 40 schools provide small group discussions with a faculty leader. There is a trend toward the increasing use of small group teaching in preference to lectures. In one course all 18 hours are devoted to such teaching; the other 61 combine lectures and small groups. In five courses the majority of time is allotted to the groups, in 10 courses one-half the time and in 12 one-third of the time. A common pattern is to present material in a class lecture and then to discuss it in small groups.

A frequently voiced dissatisfaction expressed by instructors is lack of curriculum time and teaching staff to "afford" small groups. Some departments do not consider these difficulties insurmountable. As might be expected, those courses with a large number of hours commonly include time for discussion sessions; but so do many smaller courses. Over 60 per cent of the courses allotted less than 50 hours include small groups, and one-fourth of these are listed as less than 20 hours. A typical example is a 16-hour course in "Psychodynamics" at the University of Louisville, which consists of eight lectures and eight small group meetings. One apparently satisfactory solution to the problem of limited staff is
the use of third-year residents as group leaders (Colorado, Kansas). Apparently some teachers who believe in the small group approach to learning find a way to put it to use in spite of obstacles.

Preclinical teaching at the Albert Einstein College of Medicine is presented in 50 three-hour blocks spanning the two years. Each block includes one hour of lecture and two hours of small group meetings. The two-hour sessions provide a variety of activities appropriate to the subject matter: discussion of the lecture, reviews of outside reading, interview of a patient, demonstration of psychological tests, etc.

Relatively few small groups supplement lectures in psychopathology and psychiatric syndromes. In these categories 26 first-year and 36 second-year courses use groups, most of the latter being in history-taking and interviewing.

Four schools report large group discussions. At the University of Maryland, for example, the basis for both the freshman and sophomore courses is a teacher’s interview with a patient which is preceded and followed by general group participation of the 100 students in the class. In the first year the patients are from medical and surgical services; in the second year they are from the psychiatric service.

Student interviews with individual patients is a technique confined almost entirely to second-year instruction in history-taking and interviewing. Eight departments employ this method in first-year courses, most of which attempt to teach something about the doctor-patient relationship in medicine. One school uses role-playing to aid in this instruction.

Twenty-three departments volunteered information on the use of audio-visual aids. These include sound films, tape recordings, one-way vision rooms, and closed-circuit television. Films are the most popular. The department at Temple University has a large library of films ready for immediate use whenever time becomes available because of a cancelled class, etc. The department at Kansas University uses the school's closed-circuit television system for demonstration interviews in both first- and second-year courses. In the first year, normal children and adults may be demonstration subjects; in the second year, they may be patients suffering anxiety, depression, and thought disorder.

Satisfactions and Dissatisfactions

To discover current attitudes of psychiatric educators, each course instructor was asked whether he was satisfied with his course as constituted and what, if anything, he might wish to do differently. The responses were too varied and individualistic to report in detail. However, putting the courses into five categories (growth and development, psychopathology, broad survey, interviewing, and miscellaneous) makes possible some useful generalizations.

Instructors of the 58 courses in normal personality growth and development are the most dissatisfied. A large minority (45 per cent) anticipate improvement in either content or teaching technique. Uniformly reiterated was the wish to expand the course material in order to provide a more comprehensive integration of sociological and biological data with the psychodynamic core. Thirteen instructors hope to add social science; 10, biological science; two, psychological science; and one, pediatrics. Most of the desired additions refer to personnel: sociologists, neurophysiologists, etc.

Thirteen expressed a need for more curriculum time for freshman courses, and 16 wanted extra staff and more time for small group teaching. Three wanted more teachers to help with the course but two planned fewer teachers in the future, having found the multiple-instructor approach disorganizing and confusing to the students. Eight looked forward to more frequent use of demonstrations—five patients, film, or television.

Relatively little dissatisfaction with content was expressed with regard to the rest of the preclinical curriculum. Almost complete satisfaction was registered with 22 miscellaneous courses which, for the most part, represent projects of special interest to the instructors (research methods, psychotherapy, statistics, medical hypnosis, etc.).

Psychopathology seems a settled curriculum item: of 79 course instructors only eight mentioned a desire for content changes; five would add social science and three biology. The chronic need for more curriculum time was voiced by 23, and 18 wished more staff personnel for small group teaching. Seven wanted more teachers; and two planned to reduce the number of instructors.
Broad survey or multidisciplinary courses were described as generally satisfactory by 23 teachers. Proposed minor changes included further broadening of content by adding biology (7), sociology (5), psychology (3), pediatrics (2), and psychodynamics (2). The instructors of these courses voiced the familiar cry for more curriculum time and more staff for small group teaching. One teacher is looking for more competent behavioral science instructors to replace himself.

Psychological Frame of Reference

In Part II of the questionnaire the 91 psychiatric department chairmen, presumably the most influential in guiding the direction and development of psychiatric education, were asked to describe the prevailing psychological orientation of their departments. All stated unequivocally that their psychological frame of reference is psychodynamic. The historical polarity to psychodynamic psychiatry has been descriptive, or possibly organic, psychiatry; American psychiatry now seems to represent the psychodynamic point of view.

It was felt that a more precise definition of the psychological approach of the various department heads might be obtained by requesting them to categorize their educational philosophy as either psychoanalytic or multidisciplinary. Twenty-three educators professed the psychoanalytic frame of reference; the other 68 described their approach as multidisciplinary. Responses to another question revealed that 67 of the 68 multidisciplinary approaches include presentation of psychoanalytic theory. Therefore, only one of 91 departments does not teach psychoanalytic concepts to freshman and sophomore medical students.

One might ask why only two choices were given. The decision to phrase the question in this fashion arose from the experience with the original personal-interview survey of 27 medical schools. The participants had been asked whether their orientation was essentially psychoanalytic or eclectic, but the latter term was found to be confusing. However, the term “multidisciplinary” proved satisfactory to the Committee and its respondents. All 91 educators selected one of the two choices, made no objection to our manner of stating the question, and in their free comments (which we solicited) suggested no alternative.

Although Part II of the questionnaire allowed for no particular indication of what “multidisciplinary” meant to each respondent, the course descriptions in Part I did. It may mean several things: inclusion of (1) material in a course from several psychological “schools”; (2) biological and sociological data in a psychological course; (3) representatives from other disciplines in the psychiatric team—clinical psychologist, social worker; (4) cooperative teaching with spokesmen of medical disciplines such as physiology, genetics, and pediatrics; (5) extramural disciplines such as psychology, sociology, and anthropology.

Table V

<table>
<thead>
<tr>
<th>Psychological Frame of Reference</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Is your psychological frame of reference psychodynamic?</td>
<td>91</td>
<td>0</td>
</tr>
<tr>
<td>2. What is your basic educational philosophy?</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>a. Primarily psychoanalytic?</td>
<td>68</td>
<td></td>
</tr>
<tr>
<td>b. Multidisciplinary?</td>
<td>67</td>
<td>1</td>
</tr>
<tr>
<td>3. If multidisciplinary, does it include psychoanalytic theory?</td>
<td>67</td>
<td>1</td>
</tr>
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</table>

References for
Chapter III

IV.

DISCUSSION OF CURRENT TRENDS AND ISSUES

The General Trends

It is evident from our survey that psychiatry, in 1960, had been assigned a significant role in preclinical medical education. Virtually without exception, the schools included in the survey contain Departments of Psychiatry, teach psychiatry in the first and second years, and allot considerably more curriculum time than in the past to psychiatric teaching. While the increase is apparent in almost every school there is still considerable variation in the amount of time allotted. It is significant that in the newer schools, without the problem of a well-entrenched curricular structure, psychiatry is truly a major subject. The teaching programs at such schools as the University of North Carolina, Albert Einstein College of Medicine, and the University of Florida are examples.

Another major trend is a shift in attitude concerning the purpose of preclinical psychiatric education. The traditional orientation was primarily toward specific preparation for clinical psychiatry; the current view explicitly acknowledges that an understanding of human behavior is essential to the functioning of all physicians. This change in educational goals is exemplified by the move to bring medical students into contact with patients (both directly and via a variety of audio-visual aids) early in their careers.

As has been documented earlier in this report, the orientation of American academic psychiatry is thoroughly psychodynamic. This is the most striking development since the survey two decades ago.

General Issues

There is general agreement that the core material of medical education should include elementary knowledge of personality growth and development, psychodynamics, and psychopathology. There are, however, widely varied emphases and depths of inquiry and idiosyncratic interpretations concerning these areas. For the most part, individual psychology is the primary focus around which the preclinical presentation of psychiatry is developed. There is extensive agreement, also, regarding the addition to curricula of material from the biological and social sciences. However, what should be chosen for presentation, and to what degree it should be condensed or abbreviated, remains a matter of controversy.

Recent advances in neurophysiology, genetics, biochemistry, and psychopharmacology have come to be regarded as closely relevant to the basic study of human behavior. The question is, to what extent, if at all, is it the legitimate responsibility of a department of psychiatry to teach these particular basic aspects of human behavior? Should this material be presented by psychiatrists, or by personnel from the other basic disciplines involved? Would this teaching proceed best through collaboration across departmental lines, or by integration within one department of teachers representing the various disciplines?

Similar questions arise concerning information derived from animal psychology, experimental psychology, and developmental psychology. Representatives of these disciplines are not ordinarily found on a medical school faculty. Consequently, if this material is to be taught, the psychiatrist must either assume responsibility for teaching it himself or invite guest specialists.

There has been recent expansion of psychiatrists’ interests into studies of the influence exerted by the family, the group, and the community as determinants of health and disease. At the same time sociologists, anthropologists, and social psychologists have become interested in the study of medical institutions, in problems peculiar to the education of physicians and other health personnel, and in more general problems concerning the psychosocial aspects of illness. Comparatively little precedent exists for the social scientist and the physician to collaborate as educators. Nevertheless, with psychiatry as one of the main catalysts, the integration of social scientists into the health field is developing rapidly.

One method of teaching is the use of guest lecturers in the psychiatric department. There seems little justification for this
method beyond its expediency, since it has produced dissatisfaction when used. The part-time visitor from across the campus is somehow a less effective medical educator than the individual who is more fully absorbed in the medical school environment. Thus, many departments of psychiatry deem it advisable that clinical and experimental psychologists, sociologists, anthropologists, and a variety of biological scientists become involved integrally as members of the department. Such involvement has not been uncomplicated: the department of psychiatry can quickly take on the aspects of a little university. In addition, the biological or social scientist who undertakes full-time responsibility as a medical educator in a department of psychiatry risks estrangement to a disturbing degree from peer loyalties within his own professional group or discipline. It is not uncommon for the man who tries to bridge two disciplines to feel incompletely accepted by both of them.

To alleviate and avoid such deterrent difficulties, the creation of a separate department for the sciences of human behavior has been proposed, its proponents pointing to the model of the other basic science departments such as physiology and biochemistry. They suggest that separating the new department from the clinical department of psychiatry would tend to make for a more broadly based and a more basic program. Implicit in this position is critical recognition of the idealistic conflict which can occur between teachers of basic science and those of clinical medicine.

The 1950’s, as we stated earlier, might be designated the era in which social or behavioral sciences were introduced into psychiatric education. To provide perspective for the understanding of this trend, and the controversies which are part of it, we are inserting here a review of what has been called the “behavioral science movement.”

The Behavioral Sciences: A Definition

Behavioral science*, as the term is used currently, is hardly more than a decade old. It represents an attempt to integrate several older parent or basic areas of scientific inquiry within a more comprehensive and up-to-date approach to the study of man. Its integrative and interdisciplinary character is clear. However, opinions differ concerning which scientific disciplines should be included within its rubric.

Two major definitions of behavioral science are distinguishable: One is a comprehensive view including an array of biological, psychological, and social sciences in collaborative inquiry concerning the behavior of man. The other is an interdisciplinary view in a much more limited sense, restricted primarily to collaboration among the fields of sociology, anthropology, and social psychology.

The comprehensive approach to behavioral science started in 1949 when "a group of scientists at the University of Chicago, some of whom have now moved to the University of Michigan, began to consider whether a sufficient body of facts exists to justify developing an empirically testable general theory of behavior." Miller explains that the term “behavioral sciences” was coined with the intention that its neutral sound be acceptable to both social and biological scientists, and that it supersedes the alternative, “social science,” which some might confuse with socialism. Later the Center for Advanced Study in the Behavioral Sciences was established at Palo Alto; and in 1956 a new journal, Behavioral Science, appeared. The Mental Health Research Institute at the University of Michigan, a division of the Department of Psychiatry in the Medical School, developed a staff drawn from psychiatry, psychoanalysis, general psychology, social psychology, neuropsychology, political science, economics, mathematical biology, and education. Sociologists and anthropologists were added later.

The second definition of behavioral science equates it with social science. Anderson and Senett explain that the term “social science” was dropped in favor of “behavioral science” in the study of health and illness because social science was regarded as too generic, including not only sociology, anthropology, and social psychology, but also economics, political science, and history. Another consideration was their reluctance to confuse “social” with “socialism.”

The two major applications of the phrase “behavioral science,” described above, are not the only ones. Additional variations in

*There are several forerunners of this development, such as the recently disbanded institute of Human Relations at Yale University.
meaning appear, particularly in the medical setting. For some, the phrase sets aside psychiatry, psychology, sociology, and anthropology from biology and general medicine. For others, the term designates sociology, anthropology, academic psychology, and experimental psychology; and excludes psychiatry, psychoanalysis, and clinical psychology.

Yet another point of view advocates eliminating the phrase altogether. Two prominent contributors to the study of man, Ludwig von Bertalanffy, theoretical biologist, and Margaret Mead, cultural anthropologist, were interviewed by a member of the Committee. Both thought that "the science of human behavior" is presently the only appropriate label for the various interdiscipline collaborations that are being attempted.

The Committee's consultants, and others, suggest that "behavioral science" becomes a meaningful term only when its immediate context is understood. The content of a behavioral science course in a medical school will necessarily vary from that of a university graduate school or a law school. Therefore, the Committee offers a third definition: In a medical context, the minimal connotation of behavioral science should be an integrated study of biological, psychological, and socio-cultural facets of human behavior. The term "sciences basic to human behavior" might therefore be more appropriate.

Another illustration of the significance now being given to behavioral science is the fact that, in 1958, the National Institute of Mental Health, in an effort to improve training in psychiatry for students of medicine, offered grant support to stimulate the expansion of teaching programs leading to a broader understanding of human behavior as it relates to health and illness. The purposes of the program were described as follows:

1. To bring more knowledge of human behavior to the student and to acquaint him with the ways and means by which this knowledge is acquired.

2. To develop research models for the study of behavior which will be as meaningful and strong in their impact on medical education as those presently available for teaching in long-established basic science departments and in other branches of medicine.

3. To provide improved ways and means for the student to learn about the nature of the multiple factors—social, psychological, and biological—which affect the maintenance of health and the prevention of disease and disability.

4. To make possible the development of behavioral science teaching as an integral part of the modern physician's education.

The first of the NIMH grants for teaching of human behavior in medical schools were activated in July 1960. Currently nine such awards are in effect. These programs are being conducted at the following teaching centers: Albert Einstein College of Medicine; Baylor University College of Medicine; University of California College of Medicine (San Francisco); University of Colorado Medical School; Duke University Medical School; University of Florida College of Medicine; University of Kentucky Medical Center; State University of New York Research Foundation (Syracuse); Vanderbilt University School of Medicine.

Social Sciences in Medicine

Medical Sociology has been described as a generic term which includes two major categories: (a) the sociology of medicine; (b) sociology in medicine. The former is "concerned with studying such factors as the organizational structure, role relationships, value systems, rituals, and functions of medicine as a system of organized human behavior responding to a group of basic human needs." Sociology in medicine "consists of collaborative research or teaching . . . in the role of a colleague with medical faculty or staff status." These categories are not mutually exclusive. The sociological study of medicine is closely interwoven with the development of an active role for the sociologist within medicine and its institutions.

Among the earliest examples of the influence of sociology in psychiatry is the work of Sullivan, particularly his studies of a schizophrenic ward. Soon afterward, and heralding the descriptive studies of informal social life in the mental hospital which have become so important recently, came Howard Rowland's classic study, published in 1938. George Devereaux's excellent report of the year in which he was an observer at the Worcester State
Hospital, published in 1944, brought the field of anthropology into
junction with this type of study. Following quickly after the war
were the studies by Maxwell Jones,11 Stanton and Schwartz,13
Barrabee,12 Caulfield14 Greenblatt,15 Beikman,16 Goffman,17 von
Mering and King,18 and others.

Symbolizing the growing commitment of sociology to medicine
is the new section on Medical Sociology of the American Sociolog-
ical Association. Originally, this group started in 1955 as an inde-
pendent organization called the Committee on Medical Sociology.
In 1959, with 300 members, it was officially incorporated into the
American Sociological Association. In 1961 its membership was
more than 750.

In 1960, 19 sociologists were full-time members of 14 medical
school faculties, and nine others were members of public health
school faculties. Twenty-two sociologists held full-time research
appointments in either medical or public health schools. An addi-
tional 174 were engaged in part-time medical sociology as teach-
ers or researchers.19 In Canada, one medical school employs a full-
time sociologist and five of the other 11 schools use part-time soci-
ological teachers.20 The evolving role of the sociologist in medical
schools has recently been discussed by Bloom,21,22 Steinbrook
and Wexler,23 and Straus.24

The pressing problem for the sociologist, as for all behavioral
scientists, in medical education is to discover the applicable sub-
stantive content of his specialty: "What concepts, theories, and
methods in sociology are most directly relevant for medical edu-
cation, and how can they best be communicated to medical stu-
dents?"24 Toward this end several detailed reviews of the contribu-
tions of sociology to medical research have been published. Papers
by Caulfield in 1953,25 Freeman and Reeder in 1957,26 and Reader
and Goss in 195927 describe a solid core of material upon which to
base a medical contribution to the education of tomorrow's phy-
sician. This core includes such considerations as the place of medi-
cine in the social system, the social roles of physician and patient,
the social structure of medical institutions, and the psychosocial
factors in disease and health.

Several writers have compared the general position of sociology
in medicine with that of physiology 75 years ago. According to
this analogy "... sociology did not, like pathology or biochemistry,
develop out of attempts to explore conditions of health and disease
per se. Like physiology, it arose in an effort to describe human
functioning, but as this occurs in the social group rather than in
the individual organism. Further in this vein, clinical medicine
has benefited in the past from the division of labor in science,
accepting specialists from different disciplines in its preclinical
curriculum. An important consequence, Reader and Goss conclud-
e, "has been the training of investigators who are able to establish a
new frame of reference for medical problems and to make careers...
(such as) medical bacteriology or biochemistry without having to
learn the clinical skills of the physician. . . . There would seem to
be little doubt," they add, "that sociologists, along with other
social scientists, are qualified to join the increasingly large and
specialized procession of scientists who are engaged in medical re-
search either directly or indirectly."

Although it is too early to state with certainty that the future
of sociology in medicine will bear out this analogy, there is no
question that a substantial evolution of the role of sociologists in
medicine has already established a significant relationship between
the two disciplines. Acknowledgment of the appreciable contribu-
tions made by anthropologists28 and psychologists29 could be simi-
larly stated.

The Psychiatrist and Behavioral Science

As previously mentioned, the Committee believes that a mean-
ingful definition of behavioral science in medicine includes bio-
logical, psychological, and sociological components. Biology is the
core of the medical curriculum; furthermore, as this report shows,
some aspects of psychology are part of the curriculum in each
medical school. Social science, then, is the frequently missing
ingredient. In common with that of most physicians, the typical
psychiatrist's academic education and technical training are basic-
ally biological. Selected knowledge from psychology is added
during and after residency training. The medical school's depart-
ment of psychiatry seems the logical place to add and integrate
the teaching of the social scientist. Three of the Committee's con-
sultants with practical experience in bio-psycho-social medicine
rhetorically inquired, "Who else can do it?" This philosophy obt-
ains at the Universities of Michigan, Syracuse, and Oklahoma.
where Behavioral Science research and teaching are defined by
title as functions within the Department of Psychiatry.

That this is not the universally accepted view of medical or
psychiatric educators or of social scientists, is evidenced in a parallel
move to establish separate departments of behavioral science which
has a small beginning (University of Kentucky) and several cham-
pions. Both extremes of the issue, and intermediate points, were
expressed by the 91 chairman of psychiatric departments in their
responses to Part II of our questionnaire. The department heads
generally considered the introduction of social science into the
medical school curriculum to be highly desirable. Eighty-seven
favored teaching social science in both premedical and medical

Table VI
Social and Behavioral Science
Opinions of the heads of 91 Psychiatric Departments

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When should social science be taught?</td>
<td>91</td>
<td>4</td>
</tr>
<tr>
<td>a. Not at all?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Premedical only?</td>
<td>87</td>
<td></td>
</tr>
<tr>
<td>c. Premedical and medical?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Who should teach medical sociology?</td>
<td>64</td>
<td>1</td>
</tr>
<tr>
<td>a. Psychiatrist?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Preventive medicine department?</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>c. A new, separate department?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Do you favor a separate behavioral science department?</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>4. Who should head this new department?</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>a. Psychiatrist?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. A physician?</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>c. The best qualified person?</td>
<td>20</td>
<td>70</td>
</tr>
</tbody>
</table>

school; four preferred restricting it to premedical education. Almost
without dissension psychiatric educators consider acquittance
ship with social science important to the practicing doctor.

In reply to the question “Who should be responsible for de-
veloping and integrating social science into the medical school?” 64
of our informants favored the Department of Psychiatry, one the
Department of Public Health, and 20 a separate Department of
Behavioral Science. Two prefer interdepartmental teaching, and
oppose restricting social science teaching and social scientists’ re-
sources to any one department.

Of the 20 men recommending a separate department, five think
it should be headed by a psychiatrist. Consequently, 69 of the

professors would have a psychiatrist retain control of social science
teaching. Why? Expressed opinions emphasized (1) the impor-
tance of physicians as teachers of medical students; (2) the need
to integrate social science with psychology and psychiatry; (3) the
conviction that the best (or only) avenue of entrance for social
science into the medical curriculum is through the department of
psychiatry.

Even though the professors of psychiatry believe they should
be responsible for social science, few of them feel that psychiatrists
alone can teach it. Twenty think they can adequately present social
science concepts in a behavioral science course for preclinical medi-
cal students. Presumably the other 70 prefer to have a social scientist
do it.

Concerning the general issue of behavioral science in the pre-
clinical curriculum, the department chairman expressed a variety
of opinions:

“We are not convinced as a group that there is a behavioral
science to be taught by anyone to anyone as yet. Much of the talk
about a basic science of behavior is still, I feel, partly wish and
partly mumbo-jumbo.”

“It appears to me that what is sought for is an opportunity for
clear and effective communication between scholars who have

certain interests in common. I see no reason why this cannot be
accomplished more easily through the existing and traditional me-
diums of existing departments. If there is little or no genuine
interest in sharing or communicating ideas germane to human
behavior among the existing faculty, I doubt very much that a
superimposed additional department structure with all the attendant
administrative and political problems would help.”

“I believe that a body of knowledge will grow which will
evitably allow for the organization of a preclinical department of
behavioral sciences which will relate to other colleges of the uni-
versity, and to the clinical departments in much the same way as
do biochemistry and microbiology. These departments allow for
the teaching of a discipline in a modified, but meaningful, way
within the framework of a medical college. The manner in which
the behavioral sciences can do this is, at the moment, unclear; it is
eventually to departments of psychiatry, therefore, to bring these
scientists into the medical setting to help them grow and eventually to help launch them as independent departments."

Although the majority of the respondents evinced some doubt or opposition, 20 favored a separate department of behavioral science. One of the most articulate proponents of a separate department replied approximately as follows: From the standpoint of the psychiatrist, a practical view of human behavior is in the framework of health and disease: a view which encompasses biology, psychology, and anthropology. In all these disciplines, validation of data is possible, and for the present we should concern ourselves only with scientifically verifiable disciplines. In 1900, anatomy and biochemistry were taught in medical schools by M.D.'s. Now they are taught by Ph.D.'s. It is not improbable that instruction in the basic science of human behavior will follow this pattern. Thus far, it is being taught largely by psychiatrists; but if history repeats itself, human behavior will ultimately be expounded primarily by psychologists and sociologists, with the cooperation of the psychiatrist. Each medical school should set up a separate department of human behavior and relieve the psychiatric department of being alone responsible for its teaching. This would give to the subject status equivalent to that of the biological sciences. So long as it remains under the wing of the clinical department of psychiatry, it will never achieve status. If a separate department of behavioral science were established, it could then be horizontally integrated with anatomy, biochemistry, and physiology. The teaching of real integrative theory might then become possible.

In many medical schools there is still regrettable apparent antagonism between the traditional organic principles of medicine and the principles of dynamic (psychoanalytic) psychiatry. Mutual distrust and separate defensiveness too often characterize the attitudes of the proponents of both sides. It may well be that social science, effectively introduced into the medical setting, will act as a catalyst for peace. Three points of view instead of two would conceivably generate the more eclectic currents conducive to an atmosphere for the integrative study of illness and health.

Present endeavors to develop a comprehensive theory of behavior, and a general systems theory for science, illustrate that such efforts tend to minimize the separateness of the participating sciences and to blunt the lower-level antagonisms. It is possible that an amalgamation, in a more restricted way, of appropriate biopsychosocial sciences would produce a similar effect in the medical school.

Social science appeals to many psychiatrists who strive for the whole view (man in his environment) since it provides systematic data on the small and large social systems of which each human being is a part. Cultural anthropology in particular has contributed validation of much psychoanalytic theory.

Social science appeals also to some extrapsychiatric medical educators because it offers data and explanations of psychosocial behavior on a conscious, relatively familiar level, understood by (and less threatening to) biologists, pathologists, and medical clinicians and because it is thus more palatable than depth psychology. A number of recent articles and editorial comments by medical educators illustrate a comparatively ready acceptance of social science explanations for human interaction related to health and disease.

In this ready acceptance of social science lie potential problems for the psychiatric teacher, particularly in situations where it ultimately results in the establishment of a basic behavioral science department. Few social scientists are psychodynamically oriented —or individual oriented. Jiao suggests that “the staffing of such a department should include representatives of the disciplines of sociology, anthropology and social psychology, with at least the part time affiliation of medical economics and other social sciences.” Strauss recommends six staff positions distributed among medical sociologists, cultural anthropologists, and experimental and/or social psychologists. Later, statisticians, geneticists, and physiologists would be added.

These suggested administrative organizations, labeled “Behavioral Science” by their proponents, are, within the medical setting, more accurately described as departments of Social and Psychological Science.

In such proposals psychiatry, psychoanalysis, and clinical psychology have no place. The danger here is dilution or even elimination of instruction that we now, with conviction, consider a basic preliminary to medical practice. With the fully developed social science department actively functioning and realizing its undeniable contributive potential, the psychiatrist might or could be faced with the still-unresolved questions (stated at the beginning
of this section] regarding the manner in which growth and development, psychodynamics and psychopathology should be taught.

References for
Chapter IV

6. Ibid.

THE PRECLINICAL TEACHING OF PSYCHIATRY

29. Ibid.
34. Jacob: "Problems and Prospects of the Social Sciences in Medical Education," loc. cit.
THE BEHAVIORAL SCIENCES IN MEDICAL SCHOOLS: CONCLUSIONS AND RECOMMENDATIONS

The Committee, in evaluating the data gleaned by this study, became impressed with a sense of being involved (in 1960) with psychiatric history in the making. The discipline defined as "modern psychiatry" appears to us a development which can be reviewed in the perspective of three identifiable phases.

In the first phase, the psychiatric patient was viewed as an object; the focus of interest was biologic with the accent on observation, description, and classification. In the second, the patient was looked upon as an individual with his own intrinsic economy, his own psychodynamics. In the third and present phase, the patient is beginning to be seen not only as an individual but also as an integral unit of society, in part the product of his environment and in part an agent capable of adapting to and influencing his environment. A fusion of currents from these three phases aptly characterizes responsible modern psychiatry.

How such a fusion can be most successfully effected in our training centers remains unclear. Nor is it clear under what rubric we should appropriately place medical instruction concerning man's bio-psycho-social interrelationships. In our opinion, medical faculties cannot afford to accept uncritically definitions of social or behavioral science inappropriate to the uniquely clinical character of medicine. Biochemistry as taught within the medical setting is a special application of basic biochemistry. In a similar sense, the various professional disciplines concerned with man's social state, past and present, must be appraised for such of their particular contributions as can be meaningfully integrated with other essential components of effective medical education.

We agree that a rigorous science of human behavior amenable to such verification as is possible in mathematics, for example, is not yet and may never be elaborated. However, this fact should neither minimize its stature as a scientific discipline nor lessen its congruence with the training of the complete physician. It does obligate psychiatry to assume a vanguard position in the pursuit of knowledge to determine what is and what is not pertinent to medicine in this area, and how that which is relevant can be conveyed in the most useful way to the medical student.

In the light of the foregoing the Committee submits the following:

1. The current strong trend toward the interdisciplinary study of man, the Science of Human Behavior, will continue to grow as a university-wide responsibility, not confined primarily within the medical schools, whose orientation is toward health and disease.

2. The medical school can and must participate in the quest to enlarge understanding of the forces, meanings, and consequences of human actions and interactions.

3. Meaningful integration in the medical school of knowledge basic to the understanding of human behavior stipulates the addition of social sciences to the existing biological and psychological sciences. Development may then proceed along different lines, depending upon such local conditions as the attitudes of the dean and general faculty, the strength or weakness of the psychiatric department, and the caliber of the nonmedical scientists who are participating members of the department.

4. During this period of our incomplete conceptualizations of a science of human behavior, the Committee recommends a continuing attitude of provisional trial and planned experimentation in teaching medical students a concept of behavioral science. The data obtained in our survey indicate that among differing approaches to a program for teaching this concept, a medical staff tends either (1) to place responsibility for the program upon the psychiatric department or (2) to prefer the establishment of a separate department of behavioral science to conduct the program.

For the time being the committee recommends that such behavioral science material as is taught be included within the curriculum of the psychiatric department, with all participating instructors identifying themselves with the department's goals and methods; and
CONCLUSIONS AND RECOMMENDATIONS

that caution be exercised against prematurely setting up separate behavioral science departments.

5. Effective promotion of a broad, integrative approach to human behavior requires a definite, enlightened acceptance of the principles and policies involved by the school's administration and faculty and their consequent personal commitment to the endeavor.

Practical manifestations of this commitment should be recognizable in (a) assurance of an optimal climate for development, through academic security, for the medical and nonmedical participants; (b) allowance of sufficient time for longitudinal development of the project—without duress to produce early concrete results; (c) appropriation of adequate funds from the school budget; (d) apportionment of reasonable curriculum time for teaching.

6. The Committee urges avoidance of untimely and overextended teaching efforts while the various disciplines are seeking to expand and clarify our knowledge of behavioral science. Until interdisciplinary communication, conceptualization, collaboration, and integration will have become meaningfully realized among the scientists involved, a series of cooperative ventures along research lines might be expected temporarily to receive ungrudging precedence over such major academic courses as we may hope eventually to offer beginning medical students.

The Committee does think, however, that a comprehensive course, judiciously organized and conservatively limited in content, might aid general faculty and student acceptance of those basic concepts of behavioral science which we now agree to be valid. Attempts to impart currently endorsed information should give special attention to teaching competence in all its implications.

7. We are opposed to emphasis in medical school programs on man's social interrelationships at the expense of continued progress in the biological and psychodynamic areas of medical inquiry. We confidently anticipate significant advances in such fields as neurophysiology, psychophysiology, psychopharmacology, and ego psychology.

8. From evidence obtained through this research and detailed in the body of this report, the Committee is convinced that the behavioral science movement in medical schools will become an increasingly important aspect of the medical education basic to the development of the Good Physician.

VI.
SUMMARY

1. This GAP report, prepared by the Committee on Medical Education, is based on a survey of psychiatric department teaching in the first two (preclinical) years of medical school. The survey was conducted for the 1959-60 school year, by site visits and questionnaires, in the 81 American and 12 Canadian four-year medical colleges. Usable data were collected from all but two American and two Canadian schools.

2. Preclinical teaching of psychiatry is centered in individual psychology, strongly influenced by psychodynamic theory. All but one school reported inclusion of some psychoanalytic content in their courses.

3. The core curriculum in the first two years is psychodynamics, normal personality growth and development, and psychopathology.

4. A noteworthy trend, found in 55 per cent of the schools, is the addition to this core material of relevant biological, psychological, and social science data. Such subjects as genetics, neurophysiology, animal psychology, sociology, and anthropology are integrated with the core material. These integrated courses commonly bear such labels as "Human Ecology" or "Behavioral Science."

5. Forty-two per cent of the psychiatric departments teach history taking, interviewing, and psychiatric examination by the end of the second year.

6. About one-third of the schools give some special emphasis to physiological responses relating to emotional states as they occur in everyday life (psychophysiology).

7. Approximately two-thirds of the psychiatric instructors state that the general purpose of their courses is to prepare the medical
student for his general role as a physician rather than to train him for the specific management of psychiatric patients in his practice.

8. Thirty-three categories of professional specialists teach first- and second-year medical students in courses sponsored by psychiatry: clinical psychologists (51 schools), social workers (22 schools), social scientists (22 schools), pediatricians (19 schools). Other teachers in lesser frequency represent such other varied disciplines as general practice, genetics, philosophy, economics, and statistics.

9. All 89 schools teach psychiatry in the first two years, 78 in both years. The average number of curriculum hours is 78 (36 in the first year, 42 in the second year).

10. The lecture is still the most popular teaching method; it is used in 90 per cent of the courses. The small group method is gaining favor and is now part of 62 courses. Live-patient demonstrations, films, tape recordings, one-way vision rooms, and closed-circuit television are often used.

11. For the future, course instructors commonly look toward (a) more nearly multidisciplinary, or integrated, presentation of biology, psychology, and social science; (b) increased curriculum time and staff for small group teaching.

12. Ninety-one of 93 psychiatric department chairmen responded to a query about social and behavioral science. Eighty-seven stated that social science should be part of the preclinical medical curriculum. Sixty-nine would have it taught under the jurisdiction of the psychiatric department. Twenty favor establishment of a separate department of social, or behavioral, science.

13. The present study (1960) is compared with the Ebaugh-Rymer report (1940); significant evolutions in psychiatric teaching during the 20 years include the following:
   a. The former, usual first-year course title of "Psychobiology" (1940) has been changed to "Psychodynamics and/or Personality Growth and Development" (1960).
   b. In 1940, 38 per cent of the schools taught psychiatric courses in both the first and the second year; in 1960, the figure was 90 per cent.
   c. The number of preclinical curriculum hours given the psychiatric department for teaching increased from 20 in 1940 to 78 in 1960.

14. The Committee anticipates that experimentation and change in teaching methods and curriculum organization will continue, and considers it of the first importance that informative accounts of both successes and failures be published. We recommend that a general review and a critical appraisal of trends be diligently repeated in the future at appropriate regular intervals.

15. Much experimentation is in progress in courses labeled "Behavioral Science" or "The Science of Human Behavior." This report directs special attention to the "behavioral science movement" in medical schools and discusses (a) current definitions of behavioral science, (b) historical perspectives of the concept, (c) the developing specialty of medical sociology.

16. The controversial issues of a separate Department of Behavioral Science are illustrated by quoted arguments, pro and con, of psychiatric department chairmen. The Committee points to the probability of special problems for the psychiatric teacher inherent in the creation of such a department.
### APPENDIX

#### Questionnaire: Part I

This set of questions refers specifically to the courses given by your Department of Psychiatry in the preclinical years. One copy should be completed by the instructor in charge for each course given during the first two years of medical school.

* * *

1. Name of course ________________________________________________

2. Number of hours ______________________________________________

3. Year taught ____________________________________________________
   - First year
   - Second year
   - Other (specify) ________________________________________________

   First Semester       Second Semester
   ____________________   ____________________

4. **Instructors**

<table>
<thead>
<tr>
<th>Total</th>
<th>No. of each</th>
<th>No. of hours</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Psychiatrist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Psychoanalytic psychiatrist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(including Institute candidates)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clinical psychologist</td>
<td></td>
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<tr>
<td></td>
<td>Social worker</td>
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<tr>
<td></td>
<td>Sociologist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Neurophysiologist</td>
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</tr>
<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td>Public Health doctor</td>
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<tr>
<td></td>
<td>Other (specify)</td>
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</tbody>
</table>

5. Teaching techniques used: list the number of hours for each.
   - Lectures
   - Teacher demonstrations
   - Live patients

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<thead>
<tr>
<th>Laboratory</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student participation</td>
<td></td>
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<tr>
<td>In small group seminars</td>
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<tr>
<td>With individual patients</td>
<td></td>
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<tr>
<td>As family counsellor or observer</td>
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Assigned reading? ______Yes ______No

6. What is the primary aim or purpose of this course?

7. What is its main content?

8. The varying purposes of psychiatric preclinical courses may be described along a continuum. Below, such a continuum is represented by a line. The polar extreme (A) represents teaching which emphasizes a psychiatric approach to all patients and prepares the student for his general role as a physician. The opposite pole (B) represents teaching designed specifically toward the effective understanding and management of psychiatric patients.

   Where would you place this course in terms of its purpose?

   A ___________________________________________ B

9. Are you generally satisfied with this course as presently constituted?

10. Is there anything you would like to do differently; or what do you hope the future development of this course will be—content, instructors, hours, purpose, teaching techniques, etc.?

#### Questionnaire: Part II

This set of questions, to be filled out by the chairman of your department, is concerned with some general questions about the educational frame of reference and attitudes which apply to your preclinical psychiatric teaching.

* * *

1. In the psychological frame of reference which applies to your preclinical teaching of psychiatry, do you use a *psychodynamic* approach?
APPENDIX

--- Yes
--- No

**IF YES:** Would you say that your guiding educational philosophy is primarily psychoanalytic or primarily multidisciplinary?
--- It is primarily psychoanalytic.
--- It is primarily multidisciplinary.

**IF MULTIDISCIPLINARY:** Does it include psychoanalytic theory?
--- Yes, psychoanalytic theory is included.
--- No, psychoanalytic theory is not included.

**2.** At what time during his educational experience do you believe it is best for a medical student to learn social science (sociology, anthropology, social psychology)?
--- A medical student does not need to be taught social science at all—either before or during medical school.
--- Social science should be taught only in premedical studies, prior to medical school.
--- Medical students should be taught social science both before and during medical school.

**IF YOU AGREE THAT SOCIAL SCIENCE SHOULD BE TAUGHT IN MEDICAL SCHOOL:** Where would you place it in the medical curriculum assuming that you had a free hand in determining the role of psychiatry in the preclinical curriculum, but otherwise considering the conditions which now prevail at your medical school?
--- I would attempt to establish a preclinical program within the department of psychiatry which included social science teaching.
--- I would recommend the teaching of social science in another department of the medical school, such as public health and preventive medicine or pediatrics.
--- I would recommend the teaching of social science in a new department, such as a department of human behavior.

--- Yes
--- No

**IF YES:** What kind of person do you feel should be its chairman? (Check one)
--- a psychiatrist
--- an M.D. who is not a psychiatrist
--- a Ph.D.
--- a highly qualified professional chosen without reference to his degree

**4.** There is the opinion that the competent psychiatrist-educator is fully capable of teaching the medical student what he needs to know about the psychosocial aspects of human behavior, without the collaboration of social scientists. Do you agree with this statement?
--- I strongly agree
--- I agree
--- I disagree
--- I strongly disagree

**5.** To what extent do you find that the subject matter relevant to the basic sciences of human behavior are taught by other departments of your medical school? Describe briefly.
ACKNOWLEDGMENTS

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<td>THE ROLE OF Psychiatrists IN COLLEGEs AND UNIVERSITIES—Revised, Jan. 1957</td>
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<td>21</td>
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<td>.40</td>
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