

It is important to recognize the overdetermined character of the fear of success. It is hardly unique with this phenomenon; all psychological events are overdetermined. Thus the fear of success, far from being a routine expression of the oedipal complex, is usually a final common pathway for several conscious and unconscious conflicts. Consequently, this clinical picture may be seen in patients who are fixated at or regressed to the oral, anal, or oedipal levels of psychosexual development.

We have found it difficult to work through these stalemates in achievement behavior, and they are even more stubborn when they have existed for many years. The behavior of the patient becomes a way of life for him or her and it infiltrates and affects all aspects of existence; furthermore, the patient's friends, family, and colleagues are often collusive in maintain-

ing the inhibited posture. Consequently, it is critical to uncover all the conflictual elements that enter into the fear of success. Our impression has been that psychoanalysis tends to be a highly successful form of treatment for this condition.

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Training Psychiatrists to Work with Community Support Systems for Chronically Mentally Ill Persons

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Community support programs are becoming a major priority in community mental health centers throughout the country. The authors present a training design that integrates principles and skills associated with this model into a 4-year residency training program. The aim of such programs is to keep young psychiatrists involved and in the forefront of the newer approaches to the treatment of chronically mentally ill persons.

The role of the community psychiatrist in community mental health programs is changing. In a pre-

vious report, Shore and associates (1) commented on the need for an integrated residency training experience in community psychiatry and described a partnership between the State of Oregon Mental Health Division, the Oregon State Hospital Residency Training Program, and the Department of Psychiatry at the University of Oregon Health Sciences Center (UOHSC). Briefly, this arrangement allows for the placement of all third-year psychiatric residents in community mental health centers in the state of Oregon. The program funds transportation to and from the training site and also provides for supervision at the training site and at the UOHSC. There is also a weekly 2-hour interdisciplinary seminar in community mental health throughout the third year of residency. The major goal of the program has been to place residents in community mental health programs throughout Oregon so that they might consider community mental health positions once their training is complete. Over the past 7 years this community mental health program has in fact been quite successful in placing psychiatrists in both rural and urban community mental health programs.

In recent months it has become apparent to us that a

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great need exists in Oregon for community psychiatrists trained to work mainly in urban communities that have populations of long-term chronically mentally ill persons, an area of training that our program had not emphasized. Support for this new emphasis is replete in the recent literature; new methodologies for treating this long-term patient group (2, 3) form the basis of an approach to community mental health work that is described under the rubric of community support systems.

Even though fewer physicians are choosing psychiatry as a career (4) and fewer psychiatrists are remaining in community mental health work nationwide (5), we felt it was appropriate to expand our program to attempt to train psychiatrists to work with this underserved population. We hope that psychiatrists will be less likely to become disillusioned and leave community work if their training is tailored to the skills necessary to work with this group.

Most of the community mental health literature suggests that chronically mentally ill persons must retain an indefinite membership in the formal mental health system (6) because they are very likely to relapse if follow-up and monitoring do not occur. For this reason we felt that our psychiatric residents should be required to become proficient in case management, a skill that assumes an assertive long-term relationship with the patient.

Since long-term patients usually lack the capacity to generalize learning from one situation to another (7), skills and behaviors taught to them while they are hospitalized are not necessarily translated to the community. We felt it was necessary for the psychiatric resident to learn to train long-term patients in community living skills in the context in which these skills will be used. We also felt that the chronically mentally ill person needs a comprehensive and continuous array of services and supports to avoid the need for frequent rehospitalization. In addition to providing case management or continuity of care services, we must address a variety of rehabilitative services, network supports, 24-hour emergency psychiatric services, socialization programs, sheltered living arrangements, etc; therefore, we arrange community support training only in sites that provide a wide range of services. Finally, we felt that psychiatric residents need experience not only in the front-line situations described by Fink (8) but also in the planning, community organization, administration, consultation, training, research, and evaluation aspects of developing community support programs. To this end, we link residents in their fourth year of residency to the state Community Support Systems Planning Project, where they will be involved in planning and in statewide training events. Our intent is to add a broad perspective of the planning process from these levels to supplement the experience in local planning and training that our residents have already had.

A FOUR-YEAR PERSPECTIVE

We have integrated community support systems theory and practice into the four-year general residency programs at the University of Oregon Health Sciences Center and at Oregon State Hospital. The first three levels are required of all residents, and the fourth level is optional.

Training Levels 1 and 2

Residents in the first and second years of training receive extra supervision in community psychiatry during their state hospital rotations. This supervision is oriented toward structured placement of the chronic patient back into the community. The concept of case management (as defined by JCAH principles for accreditation of community mental health programs) is introduced, and residents are required to do assessments of selected patients, including psychosocial histories, mental status examinations, social network inventories, role performance assessments, and diagnosis. Residents are expected to develop program-oriented treatment plans and arrange for linking, monitoring, and advocacy for their patients as they leave the hospital and become reintegrated into community support networks. Through their supervision the residents are encouraged to hold planning-linking conferences with various service providers and other support network individuals to facilitate the cooperative development of a treatment program. This kind of supervision, conducted by the Community Psychiatry Training Program faculty, is in contrast to the basic clinical supervision the residents usually receive.

Training Level 3

The curriculum in the required seminar in community psychiatry was expanded to include specific didactic presentations in the third year of residency on the topics of basic social network theory, case management process, deinstitutionalization methodology, community planning and development of supportive and segmented folk networks, and psychosocial rehabilitation. We invite a variety of experts from successful local and national programs for the chronically mentally ill to describe how their programs function. Psychiatric residents are expected to spend a portion of their time working with the chronically mentally ill patients in the mental health center where they choose to do their placement (1) and to assume case management responsibility for some cases.

Training Level 4

Although all of our residents are exposed to community support system concepts and methods during training levels 1, 2, and 3, we anticipate that two or more residents per year will elect to continue this program for one more year.

Faculty from the training program have negotiated

placements with community support systems state office and local demonstration sites. In addition, residents may choose to do special projects in any of the three state hospitals, since all are a part of our training system. Each resident receives 1 hour of supervision per week at the UOHSC and 1 hour of supervision in the field. The supervision is specifically oriented toward the care of the chronic patient in the community. In addition, fourth-year residents participate in a separate community support system seminar that meets throughout the year. This interdisciplinary seminar is designed for the continuing education of professionals working with long-term patients as well as the training of psychiatry residents, social work students, and nursing students with specific interest in long-term patients. At this seminar, which meets monthly at various locations in the community that are part of the community support system for long-term patients (e.g., a church-based socialization center, a group care home project, etc.), the host facility describes its program and the students and staff discuss how the program relates to those described in the scientific literature. The seminar also meets every other week at the Department of Psychiatry to focus on readings and discussions related to the care of the long-term patient; guest experts are invited to lecture periodically. The department-based seminar is limited to psychiatric residents and advanced graduate students in psychology, social work, and nursing.

Educational Objectives

We anticipate that by the end of the rotation in community support systems psychiatry residents who choose a fourth-year elective will have proficiency in the following areas:

Skills. Residents should demonstrate the ability to 1) perform case management functions (assessment, planning, linking, monitoring, and advocacy); 2) perform crisis intervention, crisis support, and crisis care and be able to determine when each should be used; 3) perform social training (teaching appropriate social behaviors to mentally disabled persons); 4) perform task and skill training (teaching survival skills to chronically mentally ill persons); 5) perform sustenance supportive therapies for chronic patients on a continuing basis; 6) work on an interdisciplinary team that plans and provides direct or indirect services for mentally disabled persons; and 7) provide mental health consultation to augmented folk networks, volunteer programs, and citizen advocacy groups for chronically mentally ill persons.

Knowledge objectives. Residents should demonstrate 1) a broad knowledge of the theoretical underpinnings of social psychiatry; 2) an awareness of the system approaches to working with mentally ill persons; 3) a working understanding of principles and processes associated with network intervention; and 4) a thorough understanding of the use of psychopharma-

cologic agents and the psychopharmacological issues that arise when supervision and collaboration with nonmedical staff are involved.

Attitudes. Residents should have 1) an appropriate appreciation of the processes leading to the development of support networks for the chronic patient; 2) an appropriate respect for interdisciplinary mental health team members; 3) a commitment to scientific evaluation of treatment results; 4) a responsibility to patients, their families, and significant others, including agency employees, and appropriate respect for their welfare and opinions; and 5) a sensitivity to and willingness to use a wide variety of opinions and ideas set forth by patients, patient advocates, and community members at large.

DISCUSSION

Methodology in the field of community mental health has changed dramatically since the passage of the Community Mental Health Centers Act in 1963 because of the developing priority of serving the severely disabled, chronically mentally ill patient. It is important that psychiatrists in their training become familiar with the new priorities and the basic skills necessary to serve this population who, more than any other population of mentally disordered persons, has concerned and will continue to concern psychiatrists.

Test and Stein (7) contend that "... treatment of this population is most effective if it takes place in the patient's natural environment." Since most long-term patients essentially have no support network in their natural environment, our trainees will help and encourage them to build such networks and will facilitate and monitor their development so that training in coping skills, social skills, use of leisure time, and involvement in meaningful activities may occur as spontaneously as possible. Cutler (9) points out that long-term patients need not only effective coordinated mental health service segments in their support networks but also social, recreational, and work activities outside of their living situations where they can interact spontaneously and in a natural setting with other persons, some of whom may also be patients and some of whom may be neighbors, work associates, or helpers from the community. They also need an appropriate response from those who live with them in group homes, foster homes, and other special living situations. Our philosophy of case management encourages residents to work with the various segments of the patients' folk networks in order to ensure that each has an assertive natural support system which is alert to his or her needs and crises. Theoretically, once this is accomplished much of the rehabilitation, social training, and vocational training can be mediated through the efforts of members of the various segments of the individual's folk support network.

We recognize that many of our trainees may not be involved throughout their entire career with the everyday aspects of working in the natural environment of chronically ill patients. It is nonetheless important for them to be exposed to community support system training. We also hope that this opportunity will extend into their career experiences. We believe that many of our trainees will go on to clinical, managerial, administrative, and continuing education positions in community mental health work; these are crucial roles that influence the theoretical sanction for the systems approach to the long-term patient. Over the past 3 years more than 80% of our graduates have begun their careers by working in the public sector. The addition of this new focus should enhance their capacity to remain in these settings and to continue to provide a strong base for the emerging methodologies that have resulted in better and more efficient treatment of long-term patients in the community.

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