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EVOLVING CONCEPTS IN PSYCHIATRIC ADMINISTRATION AND MANAGEMENT

Sy Atezaz Saeed, M.D.

Today it is clear that psychiatrists, whether in a hospital position, in private practice, or in a group organization, are doing some administrative work. However, it is not generally realized that we all have some administrative roles and responsibilities. Physicians generally feel that administration is unrelated to their key role—the care and treatment of patients. Institutional administration, specifically in hospitals, is often considered a matter of budgets, red tape, politics, and compromises, a job done by someone else. We usually do not realize that understanding the basic principles of administration and management are useful in our daily professional dealings as physicians, even when we do not have a job solely devoted to administration. This issue of *Psychiatrist Administrator* includes articles that are based on the work presented at a recent workshop. Earlier this year six psychiatrists in the Philadelphia area conducted a workshop about career issues in administrative psychiatry. The psychiatrists included Maryanne Delaney, Shiv Hatti, Barry Herman, Arthur Lazarus, Thomas Newmark, and Michael Vergare. Dr. Lazarus, our Associate Editor and the current president, coordinated the effort to turn some of these presentations into articles for this issue.

Administrative psychiatrists arrive at their leadership positions through many different career paths. They bring, generally, years of clinical knowledge, insight, and an understanding of how the systems work and they typically apply this knowledge and experience to their new role as psychiatric administrator or manager. There is a wide range as regards to how much time they spend in administrative tasks versus serving as clinicians. They face challenges related to both clinical, as well as their administrative roles. Articles such as the ones in this issue capture such knowledge, experiences, insights, and wisdom for our readers. These articles draw our attention to examining how our rapidly evolving health care delivery system is altering the traditional clinical and organizational structures as well as their underlying and supportive processes.

In the first article of the three, Dr. Newmark writes about the multiple responsibilities of a department chair–budgetary issues, oversight of educational programs, and ensuring excellent clinical care, to name a few. In this role, the chair interacts with many people and is on multiple committees. Dr. Newmark offers reflections on importance of networking, leading a meeting, and relating to others. He ends the article by describing effective administrative skills psychiatrists should possess, as well as mistakes they should avoid. In the second article, Dr. Lazarus writes about professional and career issues in administrative psychiatry. He describes the career pathways available to physicians, and discusses relevance of administrative responsibilities to these career paths and the roles physicians choose in their careers. He discusses importance of career events and touches on concepts such as *Caducean Ceiling*, dealing with job loss, networking, and professional conduct. In the last article of the series, Dr. Herman writes about the concept of "Managing Up," a process of consciously working with a supervisor to obtain the best possible results for us, our supervisor, and our organization. He discusses how great organizations rely not only on dynamic leaders but also on "dynamic followers." He submits that often the greatest challenge to effective leadership is in the direct line reporting relationship with a manager or supervisor. Dr. Herman describes how being able to effectively "manage up" may be the most important skill set that one possesses or can acquire to ensure success in any organizational setting. Indeed the skill set required to do so may be very different than that necessary to effectively manage direct reports.

The literature suggests that clinician leadership is increasingly regarded as an essential element in the effective introduction of innovation and improved quality of clinical care by those who manage mental health services. Articles in this issue underscore that clinician leaders require specific skill sets, clear vision, commitment, and a broader view of systems and people.

ARTHUR LAZARUS, MD, MBA

Dear Colleagues:

What are the qualities of a great leader?

I've been thinking about this question lately because I have assumed the presidency of AAPA at a time of great difficulty, a time when we are struggling to achieve a balanced budget and remain a going concern. This is a time that calls for a leader with a clear vision, and I am humbled to know that you see me as fit for the challenge.

Digging into the literature on leadership is like grabbing a fistful of hard candies: many varieties emerge. The book *Built to Last* reminds us that the CEOs of great companies come in a variety of flavors, with no specific leadership style proven to be more effective than any other. This is comforting to know because my style is not "Rambo in Pinstripes," an image often portrayed as necessary for effective leadership.

I subscribe to Dr. Elias Zerhouni's view of leadership. Dr. Zerhouni, director of NIH, says that a leader is someone who possesses a big heart, strong spine, and brains. Of course, it is no surprise that Dr. Zerhouni, a physician, would espouse the medical model.

Rudy Giuliani wrote a book titled *Leadership* in the aftermath of the 9/11 attacks. He stated, "Much of your ability to get people to do what they have to do is going to depend on what they perceive when they look at you and listen to you. They need to see someone who is stronger than they are, but human too."

Harvard Business Review editor Thomas A. Stewart remarked: "There are CEOs who slash and CEOs who fix and CEOs who safeguard and CEOs who build. The great ones do all these things, too, but first of all they love. Passion, commitment, ferocity—the traits of lovers are in these leaders."

Compassion seems to be an important part of leadership. Psychologist David T. Kyle considers compassion to be one of the four "powers" of leadership, along with presence, intention, and wisdom. Compassion also figures prominently in the book *Put the Moose on the Table*, co-written by former Lilly CEO Randall Tobias. The moose symbolizes painful issues no one wants to confront, such as interpersonal conflict or an organization on the verge of bankruptcy. It calls for a compassionate leader who won't avoid disturbing situations or turn his back on colleagues. It has been said that such a leader can even revive a dead moose!

While AAPA is far from dead, I do hope to make it a more vital organization over the next two years. One of my goals is to raise revenue by increasing membership and seeking strategic partners. We have already identified the latter: the American Association of Community Psychiatrists (AACP). Together, AACP and AAPA can now offer membership discounts to individuals who join both organizations. If the number of new members is significant, AACP and AAPA will both benefit.

Strategic partnerships are also being sought with pharmaceutical companies in the form of charitable grants, which truly represent "no strings attached" funding. Recently we received a total of $12,500 from AstraZeneca and Pfizer, and grants from additional drug companies are being pursued.

In terms of making a profit, it is certainly more challenging to work the income side of the equation (increasing revenue) rather than the expense side (lowering costs), and it is important to preserve the many positives that AAPA has to offer, for example, our NewsJournal, regional workshops conducted by AAPA members (see the series of articles in this issue), the APA/AAPA course in administrative psychiatry, the yearly APA/AAPA business luncheon (thanks to Dr. Steven Sharfstein for sharing his thoughts "On Being APA President"), and ready access to other AAPA members who, I might add, comprise an impressive network of leaders in the field of mental health and industry. Hopefully we can expand the quantity and quality of AAPA membership perquisites in the future.

Finally, let it not go unsaid that virtually every great leader has had the benefit of a talented and hard-working team surrounding him or her. I am counting on many individuals to breathe new life and meaning into the mission of AAPA– to promote medical leadership in behavioral healthcare systems. I am grateful to our current Councilors, members of the Executive Council, Committee Chairs, our Executive Director, the AAPA NewsJournal editor, and many other individuals who are listed in the masthead and elsewhere in this volume. Special thanks go to Dr. Shivkumar Hatti, outgoing AAPA President and close friend, who carried the torch so admirably for the past two years.

ADMINISTRATIVE PSYCHIATRY:
REFLECTIONS OF A DEPARTMENT CHAIR

Thomas S. Newmark, MD

The chair of a psychiatry department chair has multiple responsibilities–budgetary issues, oversight of educational programs, and ensuring excellent clinical care, to name a few. In this role, the chair interacts with many people and is on multiple committees. I have been a department chief for over 5 years, and I have been practicing at the same hospital for over 20 years. I am a member of the Finance Committee, Curriculum Subcommittee, Education Committee, Admissions Committee, Board of Trustees, CME Advisory Committee, Ethics Committee, New Jersey Psychiatric Association (NJPA), and the Medical Staff Executive Committee. I am the president of the Medical Staff Committee and chair of the CME Committee and Ethics Committee. Obviously, I spend a lot of time in meetings.

The Importance of Networking

One of the most important aspects of my role is networking. Over the years, I have found that being active in meetings, from the South Jersey Psychiatric Association to the New Jersey Psychiatric Association to the American Psychiatric Association, has benefited my development. I found it very helpful to develop collegial relationships and parlay those relationships into a network of local, state, and national psychiatrists. One way that was very beneficial, for example, was by spearheading our Grand Rounds program for the past 10 years. This has given me an opportunity to develop working relationships with many of the speakers, which total over 400 psychiatrists in the United States. The psychiatrists include many department chairs, program directors, and experts in specialty fields of psychiatry, along with presidents of the APA and other specialty organizations. As Program Director of NJPA, I've had the advantage of meeting the president of the APA at our annual meetings for the past ten years. This has resulted in an excellent educational experience for residents, enabling them to meet leaders in psychiatry. It has also been quite helpful in our attempts to recruit residents. Exposure to leaders has stimulated our medical students and residents to go on to outstanding programs. I encourage anyone who has an interest in administrative psychiatry to develop a personal network. Attend parties and social events. Be active and join committees!

Networking is also important in the hospital. As president of the medical staff consisting of approximately 800 physicians, I make a point to speak with as many staff physicians as possible to further my relationships with them and stay abreast of important issues. My support of other department chiefs and lay hospital administrators is also very important.

Leading a Meeting

One of the most important things I have learned is to always start a meeting on time, even if everyone is not there. Over time, the late stragglers will learn to come earlier, and everybody will be quite appreciative of starting and finishing on time. It is essential to be 100% prepared for a meeting. Preparedness will allow you to have confidence in running the meeting effectively. I use a pocket watch to monitor the time. The watch is affixed to a money clip, so viewing the time is done discreetly. This lessens the urge to look down at my watch or scan the room for the clock. When leading a meeting, you need to learn quickly how to handle long-winded talkers.

Relating to Others

Lastly, I would like to discuss how to relate to others. This invokes Douglas McGregor's Theory X and Theory Y to describe to the behavior of individuals at work.[1] People who subscribe to Theory X assume that individuals are basically lazy and need constant prodding, or else they will not excel at work or be productive. Theory Y stipulates that individuals basically want to do what is in the best interest of the organization, and if encouraged and given the chance, they will almost always rise to the occasion. It assumes that individuals want to take on responsibilities, and that their efforts will be appreciated. It is basically a positive view of individuals. I believe most individuals will respond to Theory Y philosophy. When individuals are encouraged and given the chance, they almost always will rise to the occasion. It is true, however, that some individuals need to be pushed to get work done (Theory X).

Administrative Skills and Mistakes

Tables 1-3 describe effective administrative skills psychiatrists should possess, as well as mistakes they should avoid. A quote from Robert Bolton sums it up best: "Eighty percent of people who fail at work do so for one reason: they do not relate well to people."[2] I have found it very helpful to be open, personable, and friendly, and show that you care for your fellow physicians. Giving them feedback is important. This will almost always lead to success. Caring about others is the most important trait a leader can possess.

Table 1: CHARACTERISTICS OF AN EFFECTIVE PSYCHIATRIC ADMINISTATOR[3]

Above-average intelligence
Energy
Drive
Endurance
Good health
Organization
Determination
Decisiveness
Self-confidence
Responsibility
Good judgment
Integrity
Generosity
Flexibility
Creativity
Resiliency
Empathy
Humility
Friendliness
Sense of humor

Larry Faulkner, MD

Table 2: SKILLS REQUIRED OF AN EFFECTIVE PSYCHIATRIC ADMINISTRATOR[3]

- Develop a strategic vision and plan
- Manage within a budget
- Approach tasks in an organized manner
- Follow tasks through to completion
- Pursue multiple tasks simultaneously
- Delegate authority and responsibility appropriately
- Make timely decisions
- Give others credit for organizational success
- Consider the opinions of others
- Manage conflict constructively
- Recruit competent subordinates
- Be generative in relationships with subordinates
- Inform and support supervisors
- Assess personal strengths and weaknesses realistically
- Accept and give consultation, supervision, and continuing education
- Accept constructive criticism
- Communicate effectively in writing and speaking
- Use varied administrative styles as necessary
- Be a constructive role model
- Participate in organizational social and ceremonial activities
- Be sensitive to political processes

Larry Faulkner, MD

Table-3: TEN ADMINISTRATIVE MISTAKES[3]

1. Misunderstanding responsibility and authority
2. Unwillingness to fulfill a crucial component of an administrative position
3. Inadequate preparation
4. Failure to find a mentor
5. Inability to learn from mistakes
6. Failure to be a positive role model
7. Cultural insensitivity
8. Confusion about the source of power
9. Failure to protect a supervisor
10. Agreeing to work for an incompetent supervisor

Larry Faulkner, MD

References

1. McGregor D. The Human Side of Enterprise, Annotated Edition. New York, McGraw-Hill, 2005.
2. Bolton R. People Skills. Australia, Prentice Hall, September, 1986.
3. Kay, Jerald. Handbook of Psychiatric Education and Faculty Development. Washington D.C., American Psychiatric Press, 1999.

Dr. Newmark is Chief of the Department of Psychiatry and Professor of Psychiatry at Robert Wood Johnson Medical School in Camden, New Jersey.

PROFESSIONAL AND CAREER ISSUES IN ADMINISTRATIVE PSYCHIATRY

Arthur Lazarus, M.D., M.B.A.

Physicians often change careers following graduation from medical school. Specialists, such as psychiatrists, are twice as likely to make career changes compared with primary care physicians.[1] Dr. Leonard Laster, founder and chancellor emeritus of the University of Massachusetts Medical Center, observed that there are essentially five career pathways in medicine:[2]

- Primary Care
- Surgery
- Psychiatry
- Disciplines removed from ongoing care (anesthesiology, pathology, radiology)
- Pursuits distanced from clinical practice (insurance, pharmacy, politics, law, research, administration, informatics, consulting, writing, performing arts, entrepreneurship)

Only a small percentage of physicians choose administration and management as a specialty, but many physicians have administrative responsibilities associated with their clinical practice.

Physicians who make the "plunge" into administration and management, spending at least 50% of their time in administration, tend to disengage from full-time practice over time. The priorities of taking care of patients often compete with the priorities of managing healthcare systems, especially for physicians in the "C" (corporate) suite (e.g., chief executive, chief medical officer, etc.).[3] In addition, physicians may leave practice due to demoralization, burnout, economic dissatisfaction, and spousal and family dissatisfaction.[4]

But physicians may be deceiving themselves if they believe the grass is greener on the management side. Physicians should enter administrative medicine for positive reasons, to have a broad impact on healthcare policy and to ensure quality of care, rather than enter the field by default or as an escape from practice. To become an accomplished medical administrator, physicians must have a working knowledge of management science and a keen interest in managing and developing people. Perhaps psychiatrists, by virtue of their training, are more capable than other physicians to manage people.[5]

Important Career Events

Once a physician decides to pursue a career in management, there are certain events that act as rate-limiting steps in their career development.[6] For example, the decision to specialize in psychiatry may limit employment to the mental healthcare sector. Psychiatrists are frequently passed over for positions requiring a primary care background in the belief that they cannot function as "generalists." Whether or not a physician is a psychiatrist, all physicians who enter the field of management must decide whether to work in a clinical setting (e.g. hospital or community mental health center) or in industry (e.g., insurance or pharmaceutical company). It is difficult to return to a clinical setting once a physician has spent significant time in industry. Finally, it is important to decide whether to pursue a graduate degree in business administration. An MBA degree does not automatically open doors, but it does provide the requisite skills to manage the "medical-industrial complex."[7, 8]

Psychiatrists who enter the field of administration and management will quickly be confronted by a few harsh realities.[9] They will be far outnumbered by non-physician executives, and thus the "playing field" will not be level. They are likely to be viewed as turncoats by colleagues and as outsiders by lay administrators. Physician executives have a foot in two different worlds–one in clinical practice and one in business management–but not 100% in either world. Private practice physicians may make derisive comments, such as, "You have joined the dark side/enemy/ suits." Most assuredly, physician executives will have less autonomy than they had in practice, and they may not have a boss who is a physician. Job security for physician executives is tenuous. On average, HMO medical directors turn over every few years.[10]

Caducean Ceiling

Just as certain minority groups experience a "glass ceiling" that inhibits their career mobility, physicians are likely to encounter several obstacles when attempting to move to a higher level of management, the so-called "caducean ceiling."[11] An online (www.acpe.org) survey of 687 members of the American College of Physician Executives (ACPE) conducted in 2003 revealed that a lack of operational experience prevented more than a third of physicians from attaining greater employment status. Another factor was the lack of a formal education in business management, reported by 23% of respondents. Interestingly, 14% of physicians believed there were no

barriers to their careers, and 6% of physicians had no desire to be promoted to a higher level of management (see reference 12 for suggestions to help improve your chances for promotion). One out of five physicians believed that their career mobility was thwarted by the fact they were physicians!

Another survey[13] of ACPE members conducted in 2000 with 620 physicians sought to determine how many had been involuntarily terminated from a medical management job. Nearly half of them had been terminated within the past 5 years. Reasons included personal conflicts, downsizing, mergers, and financial losses sustained by their organizations. Physicians were also vulnerable to job loss when their immediate supervisors had been terminated. The departure of one's boss often signals impending changes at lower levels of the organization. Physicians who have worked for organizations embroiled in legal investigations and insurmountable litigation have also been engulfed by winds of change.[14]

In many cases, however, physicians in management lose their jobs because of personal failure. Inadequate appreciation of job tasks; inertia in task completion; reluctance to confront issues and people; failure to communicate effectively; lack of involvement in business operations; inability to accept criticism; and setting goals that are not aligned with the organization are common reasons for failure.[15]

In order to ensure alignment between personal goals and organizational goals, it is important for physicians to demonstrate technical proficiency, leadership skills, influential behavior, and "values in action." Physician executives must share their company's vision and mission and contribute to business performance.[16] This requires changing the focus from patients to the organization, which, in turn, requires considerable psychological adjustment, even clashing with traditional patient-centered ethical principles. Former APA president Steven Sharfstein commented, "…the fact that profit-making motives of industry come into conflict with professional ethics is amply documented and should come as no surprise…"[17]

Dealing With Job Loss

Losing a job for any reason requires immediate action.[18] First, agree on the "parting line" with your boss (you may require a letter of recommendation from him or her for your next job). Second, don't blame yourself or the organization for your unemployment, and never "trash" the company to anybody. Third, don't hide from family and friends. The people with whom you are the closest may be your biggest source of comfort until you find another job. Begin searching for a new job right away. Don't panic and accept the first job offer unless it appears to be a very good fit. On the other hand, don't be overly specific and demanding in your search.

Networking with colleagues and job recruiters is likely to lead to more job opportunities than perusing the classified advertisements. There will also be more opportunities if you are willing to relocate for a new position. In fact, studies have shown that physician executives typically require a willingness to move between organizations and across organizational types to advance their careers.[19]

The time between jobs provides an excellent opportunity to update your CV, reassess your strengths and weaknesses, and obtain or reinvest in critical core competencies.[20] Practice rehearsing for job interviews, specifically by formulating answers to questions you are likely to be asked during a job interview. Companies seeking the services of physician executives typically employ performance-based interviewing methods to assess a candidate's skills.[21] Examples of questions you may be asked are:

· What strategies have you used in the past to build consensus on teams?

· Can you convey unpopular decisions to subordinates and senior leaders? Give an example from your past. Were you able to persuade anyone to your point of view?

· What was the most difficult personnel (or budgeting) challenge you ever faced, and how did you handle it?

· What was the most successful project you led? Specifically describe your role.

Make sure you conduct yourself professionally at all times, treating everyone with respect and kindness, especially people responsible for arranging your interviews. Personal interactions (soft skills) will figure prominently in hiring decisions.[22]

Good luck!

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*Arthur Lazarus, MD, MBA, is senior director of clinical research for AstraZeneca Pharmaceuticals in Wilmington, Delaware. He is associate editor of **Psychiatrist Administrator** and President of AAPA. His opinions are not necessarily those of AstraZeneca, its management, agents, or employees.*

References:
1. Jennett PA, Kishinevsky M, Bryant H, Hunter KL. Major changes in medical careers following medical school graduation: when, how often, and why. Academic Medicine 1990;65(1):48-49.
2. Laster L. Life After Medical School. New York, Norton & Company, 1996.
3. Rogers M. Wearing two hats. Health Leaders 2003;6(1):69-70.
4. Tilden N. Six reasons physicians leave a job. Unique Opportunities 2001;11(2):38-44.
5. Penzer WN. Clinician turned administrator: drawing upon clinical experience for managerial expertise. Administration and Policy in Mental Health 1989;17:105-109.
6. Lazarus A. Defining events in the careers of physician executives. Physician Executive 2005;31(5):36-39.
7. Hillman AL, Nash DB, Kissick WL, Martin SP. Managing the medical-industrial complex. New England Journal of Medicine 1986;315:511-513.
8. Lazarus A. MD/MBA: Physicians on the New Frontier of Medical Management. Tampa, FL, American College of Physician Executives, 1996.
9. Lyons MF, Cejka S. Getting a firm grip on the realities for physician executives. Physician Executive 1994;20(6):8-12.
10. Lazarus A. Medical director musical chairs. Physician Executive 2001; 27(4):22-25.
11. Weber DO. 'Caducean ceiling' blocks docs from CEO posts. Physician Executive 2002;28(5):6-9.
12. Lazarus A. Are you ready for that promotion? Physician Executive 2003;29(6):34-37.
13. Kirz H. Congratulations…you're fired! Physician Executive 2000;26(4):20-25.
14. Lazarus A. Can you recognize the winds of change? Physician Executive 2007;33(5):30-33.
15. Peters RM. When Physicians Fail as Managers. Tampa, FL, American College of Physician Executives, 1994.
16. Lazarus A. Reality check: is your behavior aligned with organizational goals? Physician Executive 2004;30(5):50-52.
17. Sharfstein SS. Comments on "presidential address: advocacy to leadership" (Dr. Sharfstein's reply). American Journal of Psychiatry 2007;164(2):346.
18. Lazarus A. What threatens psychiatric administrators' job security? Psychiatric Services 2002;53:1018-1022.
19. Kindig DA, Dunham NC, Chun LM. Career paths of physician executives. Health Care Management Review 1991;16(4):11-20.
20. Lazarus A. Cultivate your core competencies. Physician Executive 2002;28(3):34-38.
21. Lazarus A. Preparation is key to successful job interviews. Physician Executive 2004;30(3):48-50.
22. Lazarus A. Soften up: the importance of soft skills for psychiatrist executives. Psychiatrist Administrator 2004;4(1):19-23.

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MANAGING UP: DYNAMIC FOLLOWING IN AN ORGANIZATIONAL SETTING

Barry K. Herman, M.D., M.M.M.

Great organizations rely not only on dynamic leaders but also on "dynamic followers." Often the greatest challenge to effective leadership is in the direct line reporting relationship with a manager or supervisor. Being able to effectively "manage up" may be the most important skill set that one possesses or can acquire to ensure success in any organizational setting. The skill set required to do so may be very different than that necessary to effectively manage direct reports. Managing up is the process of consciously working with a supervisor to obtain the best possible results for you, your supervisor and your organization. This is not about political maneuvering or sycophantic behavior. Rather, it is a deliberate effort to bring understanding and cooperation to a relationship between individuals who often have very different perspectives.

An alternate title to this article could be, "How Executive Coaching Saved My Job." This article briefly recounts the author's own difficulties in acclimating to a large corporate environment. Soon after assuming a medical director position at a pharmaceutical company six years ago, I experienced significant challenges in the relationship with my boss. Because I was unable to resolve our conflicts by myself I took advantage of my company's offer to make use of a personal executive coach over a one-year period. The result of this undertaking was a highly successful outcome which included developing an effective and productive work relationship with my boss and being rapidly promoted within my group. I believe this would not have occurred in the absence of my coaching experience.

A Market for Coaches

There has been a virtual explosion in the executive and organizational coaching market over the past several years. The very nature of corporate life is a complex, fast-paced and often pressured environment where executives and senior managers may derive enormous value from personalized, skilled help delivered in a structured and safe one-on-one situation. Skilled executive coaching can offer this. While there are no regulatory agencies which oversee the licensing and professional conduct of "coaches," the numbers have rapidly increased. The breadth of backgrounds from which they come has also expanded enormously. Retiring executives, HR directors, academics and management trainers have been joined by engineers, senior police officers, teachers, clinical and occupational psychologists, counselors and psychotherapists. My coach (recommended by my company's HR Department) was a Stanford-trained clinical social worker with a business degree who had extensive experience working with many different types of organizations. This article will not focus on the various types of coaches and coaching that are currently available, but rather will offer a brief overview of my personal experience and how I conceptualized the coaching process.

Managing Up

Before turning to my coaching experience, there are some fundamental concepts essential for effectively "managing up." In order to manage effectively, one must first be able to manage oneself. This involves various capabilities, from self-awareness (how one's personal style affects others, and the ability to make adjustments); receptivity to constructive criticism (and the ability to respond positively and effectively); the ability to develop and maintain positive work relationships; and projecting an image of trust, fairness and reliability. Many of these capabilities fall into what are now commonly referred to as "soft skills." Business schools and organizations are paying increasing attention to topics such as teamwork, leadership, and communication in recognition that these traits are necessary for success in the corporate suite.

Managing a supervisor involves understanding his or her management style. This includes assessing the emotional, cognitive, and personal style (including idiosyncrasies, quirks and pet peeves) of your boss. It is important to understand where your boss fits into the organizational structure and how decisions get made that impact you. Subordinates must ascertain their supervisor's own goals, and determine where the points of intersection with their own lay. This concept of alignment of one's own professional goals with those of your boss and with the organization's strategic plan is arguably the most critical factor for success. Developing a personal "action plan" that is aligned with your organization's strategic plan can be enormously helpful.

Conflict in any relationship is inevitable, and conflict per se is not necessarily a signpost for trouble. However, the capacity to manage conflict is essential for managing, either up or down. It is important when trust erodes in a

relationship with your supervisor to "diagnose" and to act quickly. This can present a very stressful scenario. It is important to maintain one's own composure and to manage strong emotions. Understanding the nature and source of conflict requires active listening and considering that the presenting problems may run deeper. In this situation openly acknowledging the existence of conflict and trying to set up regular meetings with your boss may result in resolution. However, if conflict with a boss persists or escalates, outside help may be necessary because of the dire consequences of ignoring it.

A not uncommon phenomenon in corporate settings, and one which I encountered, is a supervisor who is threatened by a subordinate's superior competencies and/or has immediate and powerful personality clashes resulting in seemingly irresolvable conflict. This can present a vexing scenario resulting in considerable anxiety and stress, and may place one's career and/or career advancement in jeopardy. It almost ended for me what would have been a very short-lived career in the pharmaceutical industry. Supervisors have the power to prevent personal and professional advancement in a corporate structure. They can overtly and covertly subvert and contaminate relationships with teammates and with other internal stakeholders. They can assign high profile projects and initiatives to other team members, thereby limiting one's visibility and influence. They can employ tactics such as ultra micromanagement and focus on minor performance issues to the extent that significant performance successes are overlooked or devalued. They also rate your annual performance and determine important things like raises, bonuses, and other perquisites. This author, faced with escalating conflict and many sleepless nights, sought help in executive coaching, but not without considerable skepticism and trepidation.

Overcoming Blind Spots

I would like to briefly share my experience with the coaching process. I believe that in my case the ultimate goal of this endeavor was to "learn to observe the observer that you are." The process involves challenging "blind spots" about self-perception. You become powerfully aware of how you are perceived by others and how you interact with the world. More importantly, you are able to develop the power and leverage to change and to take action with a new "world view." I must mention that although there are many similarities, working with a coach is not the same as psychotherapy. Despite much skepticism about the potential for coaching to help my situation I was willing to give it a try.

The Initial Phase of Coaching: "Assessing Reality"

I would characterize my work with a coach over the course of a year as having four overlapping phases. I would call the first phase, "Assessing Reality." The initial work consisted a several hour face-to-face meeting to describe my current work situation and also to review my work history. There were many probing questions about how I perceived the difficulties with my boss. Popular corporate techniques now routinely include personality assessments and peer feedback. The use of tools such as 360-degree assessments from direct reports, team members and supervisors (current and past) can provide invaluable feedback as well as provide a baseline for measuring improvement. I filled out an emotional intelligence inventory; it took about an hour. More importantly my coach interviewed by phone co-workers, direct reports, and supervisors (past and present, including my current boss). I was encouraged to select individuals with whom I perceived both positive and less than positive relationships. I spoke with or sent notes to all of them asking for their help in participating in this process. Some also filled out a survey, the Hay Group ECI (emotional competence inventory). My coach then reviewed my own self-perceptions with the perceptions of me described by others. The results were shocking—there were significant discrepancies between how I viewed myself and how others perceived me. Although it was a bitter pill to swallow, being confronted with this "reality" motivated me highly to commit to the coaching process.

Emotional Intelligence

Let me interject a few comments about "emotional intelligence" (EQ). This term has become hugely popular and has invaded the corporate landscape. It encompasses the area of "soft skills" referenced above. It describes abilities distinct from, but complementary to, cognitive intelligence - those capacities typically measured by IQ. Simply stated, the idea about EQ is that it is the ability to understand your own emotions and those of others, and being able to use this information to bring about the best outcome for all concerned; knowing where emotions come from and being able to manage your own and those of others; knowing what emotions mean and what information they are providing; being able to work well with others as well as alone, and being able to combine cognitive knowledge with emotional knowledge and use them in tandem. Cognitive intelligence involves abilities such as logic, reason, reading, writing, analyzing and prioritizing. Research in this area suggests that one's IQ is fixed and

static; however, emotional intelligence can be developed and improved throughout life. There is a mounting body of evidence that that the higher one goes in an organization, the more important EQ can be. For those in leadership positions, emotional intelligence skills account for close to 90 percent of what distinguishes outstanding leaders from those judged as average.

The Second Phase: Agreeing on Goals

I would characterize the second phase of coaching as "Agreeing on Goals." It involves clearly defining what you hope to accomplish in your work with your coach. It might be as simple as wanting to keep your job. But other goals can be outlined such as increasing your visibility and influence in the organization, improving work-life balance, or achieving promotion and career advancement. In my case, I simply wanted to reduce the level of conflict that was present, and to develop an effective, productive relationship with my boss. I was largely successful in achieving this goal, and in the process many other positive results materialized.

The Third Phase: "A Plan for Action"

The third phase is developing a "Plan of Action." This involves a commitment to an ongoing framework for working with your coach. In my case I had weekly telephone sessions of one hour in length. We worked on ways in which I could be become more aware of my own "blind spots." The focus of the work was on behavior, not on feelings; what I would do and how I would do it in various real scenarios. In particular, efforts were concentrated on ways in which I could align my goals with those of my boss. I would be given regular "homework assignments," mostly focused on my interactions with my boss, and with my coach's support we would review the results and make adjustments as necessary. In the process my coach became my trusted confidante, my advocate, and more importantly, a source of objective feedback. Over the course of the year I would meet with my coach for face-to-face meetings of 2-3 hours in length on a quarterly basis. This was important to review progress and to drill down on persistent difficulties. As the year of working together came to a close, select co-workers agreed to complete another survey.

The Fourth Phase: "Reinvent Yourself"

I would characterize the final phase as "Reinventing Yourself." This involves being able to change your own "world view." I found this to be a gradual process. Under stress one tends to revert back to old behaviors and perceptions. Ultimately I found myself able to take action with a "new story" about myself and about others. Internally this involved a different and more realistic quality of self-perception. Externally it led to more effective behavior in the work setting. At the end of the year, a final face-to-face meeting with my coach was held, and at my request I invited my boss to join us, to discuss his perceptions about our current work relationship and to compare my final 360-degree evaluation with the initial one. This was an invaluable experience, both for me and for my boss, and helped to solidify the enormous gains in trust and respect that strengthened over the year.

Conclusion: "Fold 'Em" or Stand Pat

In some instances, even with one's best efforts, attempts to manage up are unworkable. There are times when it is probably best to "fold 'em" and to move on. Leaving one's job and an organization can be scary, but it can also lead to tremendous opportunities for success. There are several tell-tale signs of when one should consider leaving a job: when your personal action plan deviates from the organization's strategic plan; when it is impossible to align your goals with those of your boss; when you find that you are no longer learning in your job; and finally, when you dread going to work every day. Not every story has a happy ending like mine. I was very fortunate to work at a company that valued and offered executive coaching to its employees. I was also lucky to work with a great coach. I believe that a "good fit" with a coach is as crucial to success in a coaching relationship as it is with a mental health practitioner in a therapeutic relationship. For me, the most revelatory aspect of my coaching experience was to realize that managing up is a skill that can be learned.

Barry Herman, MD, MMM, is Senior Director, Neurosciences, Pfizer, Inc. Worldwide Pharmaceutical Operations. He is Treasurer of AAPA and a Distinguished Fellow of the APA. The views expressed by Dr. Herman are not necessarily those of Pfizer, Inc. or its agents.

References and Recommended Reading

1. Dobson, Michael & Dobson, Deborah Singer (1999) *Managing Up!: 59 ways to build a career-advancing relationship with your boss.* New York, NY: American Management Association.

2. Goleman, Daniel (1998) *Working with Emotional Intelligence.* New York, NY: Bantam Books

3. Hathaway, Patti & Schubert, Susan D. (1992) *Managing Upward: Strategies for Succeeding with your Boss.* Boston, MA: Thompson Learning.

4. O'Neill, Mary Beth (2000) *Executive Coaching with Backbone and Heart: A Systems Approach to Engaging Leaders with Their Challenges,* San Francisco: Jossey-Bass

5. Osborne, Christina (2003) *Managing Your Boss.* New York, NY: DK Publishing.

6. Patterson, Kerry; Grenny, Joseph; McMillan, Ron & Switzer, Al (2002) *Crucial Conversations: Tools For Talking When Stakes Are High.* New York, NY: McGraw Hill.

ETHICS COLUMN

WHO SHOULD BE ABLE TO DEVELOP AND USE DSM-V?

In response to Lazarus[1] and Russakoff [2]

I very much appreciated that Drs. Lazarus and Russakoff took the time and effort for their commentaries on last issue's column[1,2]. In essence, I suggested DSM-V should be designated for use by psychiatrists only[3]. They disagreed.

In order to continue this discussion, I'd like to make a rebuttal of sorts and then continue on to other DSM-V ethical topics, as suggested by Dr. Lazarus. Allow me to start from the end of Dr. Russakoff's commentary. In discussing scope of practice, he ends with the quote: "The question may not be money but the answer often is." In that regard, is DSM as much about the money as it is about patients? Probably not, but my cynical side can not help but notice the huge sales of DSM-IV that a cookbook format and open policy of use has allowed. Maybe our APA is contingent on future sales for financial viability. If so, that may be a Faustian deal. Unfortunately, I know from prior leadership positions in hospitals, clinics, and managed care systems that "the answer often is" money, even if it looks like something else.

As to the contention that the DSM is for patients and there is no proof that other disciplines can't be as skilled as psychiatrists, I would again argue that it is derelict not to know if there are real differences. Since this is an American Psychiatric Association project, then it is our responsibility to know if other disciplines are as skilled in making diagnoses as us. The fact that they were involved in doing structured interviews has little to do with real life diagnostic interviews, which are very rarely like research-based structured interviews. To reverse this role question, would we presume to be as competent to provide and deliver psychological testing? That is the diagnostic expertise of psychologists! Though too lengthy and expensive for everyday practice, such testing can be a component of a difficult diagnostic process.

The hypocrisy for me comes in having a DSM loaded with medical references, as DSM-IV is, but then assuming that those without medical training are just as skilled as those who have had the education. If they are as skilled, let's go ahead and stop fighting psychologists from prescribing medications. Psychologists as an organization certainly think they are as skilled. In his Presidential Address (Twenty-First Century Ethical Challenges for Psychology, American Psychologist, July-August, 2007, p.375-383), Gerald Koocher predicts – and is preparing psychologists for – the "demise of psychiatry". Do we really want to help them along?

I would also suggest that from the research that I am familiar with, that as a whole, primary care physicians are in general poor psychiatric diagnosticians, but for opposite reasons. They are well-trained in the medical aspects, but miss the psychiatric perspective too often. The best example is mistaking panic attacks for cardiac symptoms.

To be ethical about these usage issues, we need the data. There is plenty of time to do so.

As Dr. Lazarus pointed out, there are other ethical questions in the development of DSM-V. The most prominent is potential conflict of interest in the contributors. The solution to date is to make that conflict of interest overt and to try to choose "experts". Here, too, I do not think that is enough. I'm afraid that what constitutes "experts" in diagnostic concepts is not the same as "expert" clinicians. The latter is who represents those who use DSM. In many situations, being an expert in knowledge does not make you an expert in skills. For instance, experts in drug studies may not have an everyday, real life practice, let alone also being subject to pharmaceutical company conflict-of-interest. I would suggest, then, that we need real life, everyday "master clinicians" heavily "embedded" in the DSM process, just like journalists have been in the armed forces in Iraq. They can be observers who can bring actual clinical life into the ongoing deliberations.

How would these clinicians be ethically chosen? The choice here should be local, given that knowledge of clinical expertise – given our current dearth of outcome studies – is a local phenomenon. The APA district branch should choose. Finally, to return to the influence of money, these master clinicians should be paid for their time, at least whenever their time is not covered by a salary.

References

1. Lazarus, Arthur. Commentary on who should be able to use DSM-V? *Psychiatrist Administrator*: Vol. 7, Number 1, 2007, pp 14.
2. Russakoff, L. Mark. Commentary on who should be able to use DSM-V? *Psychiatrist Administrator*: Vol. 7, Number 1, 2007, pp 15.
3. Moffic, H. Steven. Who should be able to use DSM-V? *Psychiatrist Administrator*: Vol. 7, Number 1, 2007, pp 11.

WELCOME NEW MEMBERS!

May 2007
Conseulo Cagande, M.D., Camden, NJ
Jonathan Nehrer, M.D., Mentor, OH
Tanveer Padder, M.D., East Meadow, NY

August 2007
Elizabeth Joseph, M.D., Springfield, IL
Robert L. Oldham, M.D., Richmond, VA
Stephen Signer, M.D., San Diego, CA

LITERATURE SCAN

The *Literature Scan* is our regular column that reviews recent literature of interest to administrators in behavioral health care systems. The column covers a period of approximately 6 months. Papers are selected on such topics as administration, consumer satisfaction, delivery of health care, education, efficacy, ethics, evidence-based practice, leadership, and management. The daily demands of administration and practice often leave little time for browsing journals. It's our hope that this column may fill the gap.

Ellman MS, **Rosenbaum JR**, **Bia M**. Development and Implementation of an Innovative Ward-Based Program to Help Medical Students Acquire End-of-Life Care Experience. *Academic Medicine: Journal of the Association of American Medical Colleges*. 2007 July; 82(7):723-7.

The authors of this article developed and implemented a new ward-based, end-of-life care experience for third-year medical students at Yale University School of Medicine in 2005. The primary objectives of the program are to improve students' comfort and skills in communicating with and assessing patients facing the end-of-life and to reflect on their experiences. Students interview hospitalized patients, families, and caregivers; assess specified end-of-life plans; reflect on the experience; then prepare a report for presentation at a case conference facilitated by a multidisciplinary faculty. Many of the students interview patients while rotating on psychiatry consults, and the case conference occurs during the psychiatry clerkship. An assessment of the personal impact of the exercise on the students who completed the program in 2005 and 2006 revealed students' recognition of the complexity of patients' reactions to dying, students' appreciation of the value of the clinicians' presence, and students' personal reflections. The experience suggests that a hands-on end-of-life exercise is possible and will be well received in the acute inpatient setting. Key features for success include separate, dedicated faculty for the case conference (which is integrated into a single clerkship), emphasis on student self-reflection, and a requirement that the written component become part of the student's portfolio.

Fortney JC, **Pyne JM**, **Edlund MJ**, **Williams DK**, **Robinson DE**, **Mittal D**, **Henderson KL**. A Randomized Trial of Telemedicine-Based Collaborative Care for Depression. *Journal of General Internal Medicine*. 2007 Aug; 22(8):1086-93.

The objective of this study was to evaluate a telemedicine-based collaborative care model adapted for small clinics without on-site psychiatrists. They discuss how evidence-based practices designed for large urban clinics are not necessarily portable into smaller isolated clinics. Implementing practice-based collaborative care for depression in smaller primary care clinics presents unique challenges because it is often not feasible to employ on-site psychiatrists. Their results found that collaborative care can be successfully adapted for primary care clinics without on-site psychiatrists using telemedicine technologies.

Kallert TW. Priebe S. . Kiejna A. Rymaszewska J. Nawka P. Ocvar L. Raboch J. Starkova-Kalisova L. Koch R. Schutzwohl M. Are Day Hospitals Effective for Acutely Ill Psychiatric Patients? A European Multicenter Randomized Controlled Trial. *Journal of Clinical Psychiatry*. 2007 Feb; 68(2):278-87.

The authors of this article describe how acute psychiatric day care has been proposed as an alternative to conventional inpatient care, yet the evidence of its effectiveness is inconsistent and based only on single-site studies in three countries. The aim of this comparative multicenter randomized controlled trial was to establish the effectiveness of acute day hospital care in a large sample across a range of mental health care systems. The trial was conducted from December 2000 to September 2003 in five European countries. They found that day hospital care is as effective on clinical outcomes as conventional inpatient care and more effective on social outcomes.

Kolodny A. Psychiatrists as Administrators: The Perspective of a Mental Health Department Psychiatrist. *Psychiatric Quarterly*. 2007 Sept; 78(3):193-8.

This paper was presented and adapted from the American Association of Psychiatric Administrators Annual Membership Luncheon Speech at the American Psychiatric Association in Toronto, Canada on May 23, 2006. The author talks about three experiences from his work for the New York City Department of Health and Mental Hygiene and points out how psychiatrists working as administrators are uniquely able to meet community mental health and

substance misuse needs. The author goes on to describe how public health interventions employed by psychiatric administrators reduce morbidity and mortality from opioid and methamphetamine misuse.

Levy KN, **Edell WS**, **McGlashan TH**. Depressive Experiences in Inpatients with Borderline Personality Disorder. *Psychiatric Quarterly*. 2007 June; 78(2):129-43.

The authors of this study investigated the quality of dependent and self-critical depressive experiences in a hospitalized sample of depressed, depressed borderline, and borderline non-depressed inpatients. Subjects were administered structured diagnostic interviews for axis I and axis II along with the Symptom Checklist-90-Revised Depression Scale and the Depressive Experiences Questionnaire. Authors concluded that there were no differences between the three groups in overall levels of impairment or severity of depression. The authors go on to explain that phenomenologically, however, depressive experiences were quite different. They describe subjects with borderline personality disorder, with and without a diagnosed depressive disorder, scored higher than subjects with depression only on the measure of anaclitic neediness. Further analyses revealed that anaclitic neediness was significantly associated with interpersonal distress, self-destructive behaviors, and impulsivity. Also, the authors' findings suggest the importance of considering phenomenological aspects of depression in borderline pathology.

Malone D, **Newron-Howes G**, **Simmonds S**, **Marriot S**, **Tyrer P**. Community Mental Health Teams (CMHTs) for People with Severe Mental Illnesses and disordered Personality. *Cochrane Database of Systematic Reviews*. 2007 July 18; (3):CD000270.

The closure of asylums and institutions for the mentally ill together with government policies underlines the rationale behind care in the community. An example of this is reducing the number of hospital beds for people with severe mental illnesses in favor of providing care in a variety of non-hospital settings. The authors of this article examine how the major thrust towards community care has been the development of community mental health teams (CMHT). Their objective was to evaluate the effects of CMHT treatment for anyone with serious mental illness compared with standard non-team management. After extensive searching and analysis of information from the Cochrane Schizophrenia Group Trials Register (March 2006) and

Journal of Personality Disorders coupled with data collection, the authors concluded that community mental health team management is not inferior to non-team standard care and is superior in promoting acceptance of treatment. It may also be greater in reducing hospital admission and avoiding death by suicide. In addition, the authors conclude that the evidence for CMHT based care is insubstantial considering the massive impact the drive toward community care has on patients, health care providers, clinicians and the community.

Miller E. Variations in the Official Prevalence and Disposal of the Insane in England Under the Poor Law, 1850-1900. *History of Psychiatry*. 2007 March; 18(1):25-38.

Miller explores how in the latter half of the nineteenth century, the majority of those recognized as insane were pauper insane. Miller explains how the local poor law officials and magistrates determined who was regarded as one of the pauper insane and what happened to them. This paper shows that there was considerable variation across England in the proportion of the population regarded as insane. Miller states that although most of the insane were committed to an asylum, a substantial minority were kept and made to labor in the workhouse. Moreover, there was also considerable variation in the numbers dealt with in this way. Miller states that contrary to views expressed at the time and more recently, areas with higher levels of industrialization did not have higher rates of insanity. In fact, the trend was definitively in the reverse direction. Miller maintains the factors that influenced the poor law authorities to retain the insane in the workhouse did not appear to be the additional expense of asylum care or the availability of beds in local asylums. The management of the insane in the workhouses was generally poor, with the majority of the insane retained in the workhouse being idiots and imbeciles rather than lunatics, although some workhouses contained considerable numbers of the latter.

Okasha A. Mental Health and Violence: WPA Cairo Declaration—International Perspectives for Intervention. *International Review of Psychiatry*. 2007 June;19(3):193-200.

The author presents this article in two sections. In the first section, the author presents a comprehensive review which highlights the psychological consequences suffered by populations living in war zones such as the worrying prevalence of fear, panic, depressions, behavioral disturbances and PTSD. The author emphasizes how the most vulnerable groups include women, children, the

disabled and the elderly. Further information concludes that the loss and destruction of homes, loss of male heads of households to death or captivity, and displacement and exposure to the dangers of sexual abuse and rape, (almost always associated with war crimes), leaves women and especially mothers, at high risk of hopelessness and depression. The level of depressive symptoms in the mother was found to be the best predictor of her child's reported morbidity. Furthermore, the author would have us recognize that the devastation of families and the breakdown of the home structure deprive the elderly and the handicapped of the family care. In the second section of the article, the author summarizes the efforts done by the World Psychiatric Association (the Association addresses the consequences of war and collective violence in the different regions of the world). The author suggests a comprehensive professional intervention program, involving several world organizations involved in health and education. The author also indicates the special importance of the role of key religious institutions, is to highlight the peaceful values carried by all religions and to replace the currently dominant messages of conflict and rejection of the "other".

Sarwer DB, Brown GK, Evans DL. Cosmetic Breast Augmentation and Suicide. *American Journal of Psychiatry*. July; 164(7):1006-13.

This study assessed the unexpected relationship between cosmetic breast implants and suicide that has been found in six epidemiological investigations completed in the last several years. Epidemiological studies were reviewed and the results found that across the six studies, the suicide rate of women who received cosmetic breast implants is approximately twice the expected rate based on estimates of the general population. However, the first study of this issue suggested that the rate of suicide among women with breast implants was greater than that of women who underwent other forms of cosmetic surgery. In addition, the largest and most recent investigation in this area found no difference in the rate of suicide between these two groups of women. Concluding the study, the authors suggest that the higher-than-expected suicide rate among women with cosmetic breast implants warrants further research. Additionally, women interested in breast augmentations who present a history of psychopathology, or those who are suspected by the plastic surgeon of having some form of psychopathology, should undergo a mental health consultation before surgery.

Solhkhah R, Passman CL, Lavezzi G, Zoffness RJ, Silva RR. Effectiveness of a Children's Home and Community-Based Services Waiver Program. *Psychiatric Quarterly*. 2007 Sep; 78(3):211-218.

The object of this study is to show how there exists limited alternatives to residential treatment or hospitalization for children with serious emotional disturbances. The authors explain that community-based interventions are intended to offer less restrictive and expensive options than traditional treatment. One such program is New York State's Home and Community-Based Services (HCBS) Waiver Program. From 1996 to 2002, 169 children were enrolled in the Manhattan HCBS. All children spent at least one month on the wait list. Using the wait list as a control group allowed a comparison of the HCBS intervention. Results indicated that the HCBS program appears to be a clinically and cost-effective method of maintaining children in their community.

Wheeler K. Psychotherapeutic Strategies for Healing Trauma. *Perspectives in Psychiatric Care*. 2007 July; 43(3):132-41.

The purpose of this article was to demonstrate how the Adaptive Information Processing Model (AIP), originally developed by Shapiro (2001), provides a model for understanding how trauma affects the brain and how healing occurs. There is evidence that the effects of trauma are thought to be much broader than the diagnosis of PTSD as well as overlap with many other diagnostic categories. The author specifies that recent physiological research supports the complexity of neurobiological responses to childhood stress and trauma. The outcome from the Treatment Hierarchy, AIP model, and evidence-based treatment framework provide the context and a compass for holistic PMH-APRN practice for working with traumatized patients.

The *Psychiatrist Administrator* is the official publication of the American Association of Psychiatric Administrators (AAPA). Established in 1961, AAPA is the premiere educational, networking, and support resource for psychiatrists interested in administration and management. The AAPA promotes medical leadership and medical excellence in behavioral healthcare systems, including services for mental illness, substance use disorders, and developmental disabilities.

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IPS Symposium

What Youth Want from Their Psychiatrists
Thursday, October 11, 2007
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Dr. Charles Huffine is bringing a group of youth involved in advocacy issues nationally and locally to discuss "What Youth Want from Their Psychiatrists." This Symposium will be of interest to psychiatrists treating adolescents and who administer programs for teens. There will be ample opportunity for dialogue with this group of thoughtful young people. This discussion stems from a growing movement of youth empowerment in mental health, a new factor in movement toward a more recovery oriented system of care.

Forum on Transforming Psychiatry
Wes Sowers, M.D.
Friday, October 12, 2007
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Workshops:
Developing Consumer Provider Dialogues
Wes Sowers, M.D., Thursday, October 11, 2007, 2 p.m. - 5 p.m.

Treatment Planning and Person Centered Care
Wes Sowers, M.D., Saturday, October 13, 2007, 1:30 p.m.

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