Residency Program
Doctor of Medicine (MD)
Curriculum (Phase-B)

Psychiatry

Bangabandhu Sheikh Mujib Medical University
Dhaka, Bangladesh

Contents

1. Introduction:

Name of the Program	:	Doctor of Medicine in Psychiatry, MD (Psychiatry)
Phase	:	B
Duration of the Program	:	Three academic years
The Program consists of	:	Phase B (Specialty Part) Three years residency training and course

1.1 Overview of the specialty:

Psychiatry as a specialty deals with mentally disordered patients. It deals with the assessment, diagnosis and management of psychiatric disorders. The patients are treated on the basis of bio-psycho-social model. The psychiatrist, in accordance with his medical professional responsibilities, occupies a central position in a multidisciplinary team whose members contribute their special competences to the common goal.

By the end of the eighteenth century it was recognized that the study of mental alienation was part of medicine. However, mental diseases were of such a nature that it was not possible to treat the 'insane' in the same conditions as patients affected by other diseases. Their most obvious manifestations had social consequences. According to the prevailing philosophical view, the mentally ill were deprived of free will by their illness. In practice, they were unable to participate in the normal life of the society and were often considered as potentially dangerous. Because of this they had generally been confined in 'madhouses' of various kinds. Philippe Pinel, a French psychiatrist constitutes a turning point. He is known worldwide as the physician who 'liberated the insane from their chains'. As a result, we are now treating our patients in general hospital psychiatry unit.

In most countries, psychiatry is now practiced in the community rather than in institutions and it has converted patients from passive recipients of care to active participants with individual needs and preferences. Psychiatrists are now involved in the planning, provision, and evaluation of services for whole communities. Care in the community has also drawn attention to the many people with psychiatric disorder who are treated in primary care, and has led to new ways of working between psychiatrists and physicians. At the same time, psychiatrists are working now more in general hospitals, helping patients with both medical and psychiatric problems.

This is worth mentioning that in treating mentally disordered patients biological, psychological, and social factors interact and much stigma is attached to mental disorders. But we should keep in our mind that scientific treatment in this field exists and very much effective. With the advent of new generation drugs and researches prognosis of psychiatric disorders became much better now-a-days.

Advances in genetics and in the neurosciences have already increased knowledge of the basic mechanisms of the brain and are beginning to uncover the neurobiological mechanisms involved in psychiatric disorder. Striking progress has been achieved in the understanding of Alzheimer's disease, for example, and there are indications that similar progress will follow in uncovering the causes of mood disorder, schizophrenia, and autism. Psychological and social sciences and epidemiology are also essential methods of investigation in psychiatry. Although the pace of advance in these sciences may not be as great as in the neurosciences, the findings generally have a more direct relation to clinical phenomena. Moreover, the mechanisms by which psychological and social factors interact with genetic, biochemical, and structural ones still continue to be important however great the progress in these other sciences.

Regarding psychiatric disorders, mostly the major psychiatric diseases come forward in discussion, presentation even in different social and medical concern. But the prevalence and existence of other psychiatric problems (also known as: The minor psychiatric disorders) are much higher in all set up, all around the world, that not been properly recognized. These minor disorders deserve to get sufficient concentration in the academic curriculum to improve quality mental health service and making quality psychiatrists.

The field of psychiatry itself can be divided into various subspecialties. These include: Adult psychiatry, Child and adolescent psychiatry, Intellectual disability psychiatry, Developmental psychiatry, Geriatric psychiatry, , Addiction psychiatry, Forensic psychiatry, Neuropsychiatry, Consultation-liaison psychiatry , Social psychiatry, Cross-cultural psychiatry, Community psychiatry, psychotherapy, Biological psychiatry, Psychiatric epidemiology, Psychosomatic medicine, Psychopharmacology etc.

1.2. Psychiatry residency Program:

All the selected Residents in the Program will act and named as resident. Their job description shall be as per job description of a resident of the university. The residents must at all times participate in clinical placements that offer appropriate experience, namely direct contact with and supervised responsibility of patients. Training placement will be made as block that consists of three months. All training placements must include direct clinical care of patients. The Residents will undergo the residency training in wide spectrum in psychiatry. General adult psychiatry is at the core of basic training although all residents are expected to gain experience

in the specialties of psychiatry. The Residents will also undergo residency training in Medicine relevant to psychiatry, other disciplines relevant to hospital liaison psychiatry etc. The training scheme must provide an overall balance of hospital and community experience. The Program must ensure that the rotation plan for an individual trainee enables them to gain the breadth of experience required. Trainees will need to monitor the scheme through their portfolio and will be monitored themselves by the scheme through its quality management processes. The designated supervisor with the aim of ensuring high quality training will carry out the evaluation of performance of a trainee periodically. In addition; residents will receive theoretical knowledge on customized ways during this residency-training period to make the training sensible and meaningful.

Components for structured training:

A. Working with patients in ward
B. Morning session/ journal club/ topic discussion/ case presentation/ grand round/group discussion/ research related discussion etc.
C. Working in out patient department
D. Encouragement of group learning, self directed learning and sharing session with trainers and other trainees.
E. Ensure of protected study time
F. Community orientation: sending trainees to different outreach centres for community orientation.
G. The training will be assessed regularly and there will be also end-block assessment. Satisfactory performance is required in above components for appearing at the summative assessment.

2. Goals and Objectives:

2.1: Overall goals:

- To produce psychiatrists who would able to meet and respond to the changing healthcare needs and expectation of the society.
- To develop psychiatrist who possess knowledge, skill, and attitudes that will ensure that they are competent to practice psychiatry safely and effectively.
- To ensure that they have appropriate foundation for lifelong learning and further training in their specialty and/or subspecialties.
- To help them to be critical thinkers and problem solvers when managing mental health problems in the community.

2.1. Program objectives:

The candidates in the program shall achieve the diverse competencies/objectives are as followings:

- **Clinical expertise:** to assess cases, establish diagnoses, formulate and implement treatment plan, work in a team and proper documentation.
- **Health advocacy**: to apply appropriate determinants consequences of mental health, mental health promotion and prevention.
- **Academic perspectives**: to create a life-long Program for continuous medical education, read, interpret and apply new findings, integrate and apply new knowledge and technology.
- **Collaborative capacities:** to establish treatment plan, work efficiently with other health care professionals and work collaboratively with relevant agencies.
- **Administrative capacity:** to develop cost effective

treatment plan, and mental health services, utilize resources effectively and conduct multidisciplinary work.

- **Effective communication:** to establish therapeutic alliance with patients and relatives/caregivers, educate patient, families, teachers, other health and social service professionals, and public and communicate effectively with teachers, prison health care staff, law and law enforcing personnel.
- **Professionalism:** to abide by ethical principles and profession; respect patient rights and broader human rights; support patient autonomy and dignity and respect patient patient's culture, beliefs and values.

3. Phase-B Admission requirements:

Resident who has successfully completed Phase-training and passed Phase-A Final examination are eligible for enrollment in the Phase-B Program.

4. Phase-B curriculum structure:

The training is designed to develop both the generic and specialty-specific attributes necessary to practice independently as a consultant psychiatrist. The aim is to trained individuals to provide the highest standard of services to the patients with mental health problems.

4.1. Phase B: Specialty Training in Psychiatry:

In-depth specialty-specific educational and training Program in this phase will make the resident competent and prepare them for the specialty qualification. It will provide educational

Program covering the specialty of Cardiology and its subspecialties, Biostatistics, Research Methodology and Medical Education along with rotation specific clinical training.

The curriculum of psychiatry covers three broad areas:

The residents shall undergo through active and integrated learning process in the following three areas to acquire intended learning outcomes that have been set to achieving the Program objectives:

A. Knowledge
B. Skills
C. Attitudes demonstrated through behavior

A. Knowledge:

- The knowledge of Psychiatry includes psychiatric symptoms and syndromes, psychological aspects of medical disorders and psychosocial issues. Psychiatric symptoms, syndromes and their treatment are to be learned in the context of an integrated biological, psychological and social approach.
- Knowledge about--diagnosis, aetiology, comorbidity, complications, management, prevention of Specific conditions like: Delirium and Dementia, Alcohol and Drug Abuse and Dependence, Schizophrenia, Depression and Bipolar Affective Disorder, Post Traumatic Stress Disorder, Acute Stress Disorder and Adjustment Disorder, Anxiety Disorders and Obsessive Compulsive Disorder, Somatoform Disorder, Hypochondriasis and Psychological Factors Affecting Medical Conditions, Eating Disorder, Sleep and Sexual Disorders, Personality Disorders, A conceptual understanding and their influence on physical and mental disorders etc.

- Knowledge about special areas of importance:-
  - Recovery – an understanding of recovery principles with people who have mental disorders.
  - Pharmacology – treatments of major and minor mental disorders including side effects of treatment.
  - Psychotherapy – basic principles of interpersonal and cognitive behavioural psychotherapies and psycho-education in the treatment of mental disorders.
  - Rehabilitation – concepts of long term management of people with long term mental illness.
  - Risk assessment –Recognition and basic management of dangerousness to self or others.
  - Ethical issues – general principle and their application to psychiatry including confidentiality, competency, informed consent, autonomy and beneficence.
  - Legal issues – basic knowledge about Mental Health Act.

B. Skills:

Communication skills:-

- Learn to take a formal psychiatric history including incorporating information from other sources
- Be able to take a drug and alcohol history
- Examine all dimensions of the mental state with the expectation that it will be used regularly in the assessment of patients
- Develop a basic understanding of the strong emotional relationship between patient and doctor especially within the realm of psychiatric illness and have the competence to use this to facilitate good communication in the interest of the patient

- Appreciate the importance of forming a therapeutic alliance and the role of empathy
- Be able to engage and interview a patient and their caregiver including any specific cultural issues
- Be able to engage and negotiate treatment with often frightened or resistant patients in non psychiatric settings
- Be able to engage and examine a patient whose mental state is such that compulsory treatment under the mental heath act may be necessary
- Be able to undertake these tasks in a community or hospital setting
- Use principles of recovery in working with patients and their families
- Share informations with the patient and family including the implications of diagnosis and benefits and disadvantages of treatment
- Understand how to adapt assessments for different developmental stages.

Information evaluation skills:-

- Select the crucial pieces of information for making a differential diagnosis
- Evaluate the role of the personal and social factors in the patient's presentation.
- Formulate a management plan including when to refer for specialist assistance.

- **Treatment skills:-**
- Encourage adherence to treatment, explore, and eliminate barriers to this.
- Basic prescribing skills especially for psychiatric disorders commonly encountered by non-psychiatrists.

- Recognize adverse effects of treatment and distinguish them from illness.

Learning skills:-

- Sustain self-directed independent learning such that the student will keep up to date with new advances in psychiatry and psychological aspects of medicine throughout their professional life.

Teamwork skills:-

- To cooperate with medical colleagues and other healthcare workers.
- To be aware of patient and family organizations and other community services that support and promote mental health.

C. Attitudes:

It is important that residents develop appropriate attitudes. These attitudes need to be encouraged during the teaching of psychiatry and other disciplines. It is important that teachers model these attitudes and that students have the ability to internalize them. Internalizing occurs in the way that students work with patients and members of staff.

Residents are expected to:

- recognise that the profession of medicine involves life-long learning
- show capacity for critical thinking and constructive self-criticism
- tolerate uncertainty and acknowledge the opinion of others
- work constructively with other health professionals

- recognise the value of good doctor-patient relationships
- appreciate the value of the developmental approach to clinical problems emphasizing the stage of the life cycle and longitudinal perspective of the illness

4.2. Expected outcome at the completion of Phase-B:

- **Residents are expected:** to perform specialist assessment of patients and documents relevant history and examination on culturally diverse patients to include:
  - Presenting or main complaint
  - Past medical and psychiatric history
  - Systemic review
  - Family history
  - Socio-cultural history
  - Developmental history
- to demonstrate the ability to construct formulations of patients' problems that include appropriate differential diagnoses.
- to demonstrate the ability to recommend relevant investigations and treatment in the context of the clinical management plan. This will include the ability to develop and document an investigation plan including appropriate medical, laboratory, radiological and psychological investigations and then to construct a comprehensive treatment plan addressing biological, psychological and socio-cultural domains.
- to do the assessment of risk, knowledge of involuntary treatment standards and procedures, the ability to intervene effectively to minimize risk and the ability to implement prevention methods against self-harm and harm to others. This will be displayed whenever appropriate, including in emergencies.

- based on full psychiatric assessment, residents are expected to demonstrate the ability to conduct therapeutic interviews; that is to collect and use clinically relevant material. The doctor also demonstrate the ability to conduct a range of individual, group and family therapies using standard accepted models and to integrate these psychotherapies into everyday treatment, including biological and socio-cultural interventions.
- to demonstrate the ability to concisely, accurately and legibly record appropriate aspects of the clinical assessment and management plan.
- to develop the ability to carry out specialist assessment and treatment of patients with chronic and severe mental disorders and to demonstrate effective management of these disease states.
- use effective communication with patients, relatives and colleagues. This includes the ability to conduct interviews in a manner that facilitates information gathering and the formation of therapeutic alliances.
- to demonstrate the ability to work effectively with colleagues, including team working.
- develop appropriate leadership skills.
- to demonstrate the knowledge, skills and behaviours to manage time and problems effectively.
- to develop the ability to conduct and complete audit in clinical practice.
- to develop an understanding of the implementation of clinical governance.
- to develop and utilize the ability to teach, assess and appraise.
- to develop an understanding of research methodology and critical appraisal of the research literature.

- to ensure to act in a professional manner.
- to develop the habits of lifelong learning.

5. Teaching and learning methods:

The bulk of learning occurs as a result of clinical experiences (experiential learning, on-the-job learning) and self-directed study. The degree of self-directed learning will increase as trainees become more experienced. Teaching and learning occurs using several methods that range from formal didactic lectures to planned clinical experiences. Aspects covered will include knowledge, skills and practices relevant to the discipline in order to achieve specific learning outcomes and competencies. The theoretical part of the curriculum presents the current body of knowledge necessary for practice. This can be imparted using lectures, grand teaching rounds, clinico-pathological meetings, morbidity/mortality review meetings, literature reviews and presentations, journal clubs, self-directed learning, conferences and seminars.

6. Phase B Program contents:

Residency vs Learning Modules:

During the entire training period, residents will receive theoretical knowledge to facilitate their learning in customized fashion. Followings are the modules that give an indication of the areas need to be covered to facilitate comprehensive training and will be set in both formative and summative assessment. However, knowledge on recent developments is very essential and will be incorporated in the modules.

Phase B of the Program has two major components:

a) Residency training and

b) Learning modules

The prorgamme contents are fulltime residency training along need-based updated theoretical knowledge mentioned in the designed learning modules that run side by side through the entire duration of the Program.

7. Residency training for Phase B:

Phase-B residency Program consist of three years: 3rd year, 4th year and 5th year. The training requirements shall be as follows:

Third Year: Advanced training in Psychiatry:-

This is one-year training placements in the Department of Psychiatry where the trainee is given a role matching his/her seniority and experience. Residents will get the opportunity to work in a multidisciplinary team, which includes psychiatric nurses, occupational therapists, recreational therapist, psychologists and social workers, and the trainee should, particularly have the chance to chair clinical meetings and case reviews. Liaison with other hospital specialists and with general practitioners, including domiciliary consultations, need to be available. Training and supervision in the use of electroconvulsive therapy (ECT) must form part of advanced training Program. The trainer will be involved in the teaching and supervision of residents, the monitoring of the use of ECT and audit.

Experience in emergency psychiatry is of increasing importance with a growing emphasis on community and domiciliary care. Special emphasis will be given in managing violent and agitated patients, patients with attempted suicide, drug overdosing and intoxication, stuporus patients in general emergency and psychiatric emergency setup. Residents will be able to understand and get specific information about variations of sexual identity, behaviors, different determinants

of sexual orientation and psychological problems related to sexual orientation. Different documented information and instruction regarding gender identity, sexual dysfunction, abnormalities of sexual preference (paraphilias) would be provided. They will be able to handle different ethical problems arises during diagnosis, treatment of disorders of sexuality and gender. In addition, resident will get experience working in disaster psychiatry, prenatal psychiatry, different clinics of the Department of Psychiatry (e.g. traumatic stress clinic, pain clinic, addiction clinic, sleep clinic, sexual dysfunction clinic, dementia clinic, self- harm clinic, eating disorder clinic, autistic clinic, learning disability clinic, hyperactivity clinic, OCD clinic, conversion disorder clinic, first episode psychosis clinic etc.), behaviour therapy instruction, forensic consultations, ethical issues in psychiatry, a substance misuse placement, work in psychiatric emergency care unit, a community–domiciliary care service. The proportion of in-patient, out-patient, day care and community–domiciliary care will vary. Likewise, the special interest sessions will change from time to time, thus helping the development of wide clinical experience and therapeutic skills. These different commitments will be carefully timetabled each week and subject to the same conditions for training (e.g. supervision and assessment).

Forth year: Training in Adult (General & Community) Psychiatry:-

This will be full one year residency training in Adult Psychiatry in the Department of Psychiatry. General adult psychiatry will be core of the training along with adequate exposure in Community Psychiatry. Training placements will offer experience in hospital and/or community settings. Therefore, in this period, residents will also be placed in community

psychiatry services centers including chronic long stay psychiatric services (e.g. Mental Hospital) for the period of one month.

Experience gained in general adult psychiatry must include properly supervised in-patient and outpatient management, with both new and follow-up patients, and supervised experience of emergencies and 'on call' duties. Resident will work with functionalized teams, of which the supervisor/trainer is a member. During their rotation, a trainee must document experience in all of the below:

- assessment of psychiatric emergencies referred for admission
- assessment and initial treatment of emergency admissions
- day-to-day management of psychiatric in-patients
- participation in regular multidisciplinary case meetings
- prescribing of medication and monitoring of side-effects
- administration of electroconvulsive therapy
- regular participation in psychotherapy case allocation meeting
- use of basic psychological treatments
- use of the mental health legislation
- assessment of new out-patients
- continuing care of longer-term out-patients
- psychiatric day hospital
- community mental health team-joint assessments in the community with other professionals
- crisis intervention
- domiciliary treatment

In addition, residents will complete learning module of General Adult Psychiatry in customized ways in this period.

Fifth Year: Training in Specialties in Psychiatry

This will be full one year residency training in subspecialties in psychiatry. The residents will be rotated in different subspecialties in psychiatry including Child and Adolescent Psychiatry, Psychiatry of Intellectual Disability, Rehabilitation Psychiatry, Geriatric Psychiatry, Substance Misuse Psychiatry, Forensic Psychiatry, and Psychotherapy. Such training placements will be in the existing specialty services of the Department of Psychiatry. Some placements will be made in other training centers where such specific specialty services exist. Basic contents of the specialty training are as follows:

Child and Adolescent Psychiatry:

This will be a full time placement in child and adolescent psychiatry unit of the department of psychiatry combined with a placement in learning disability psychiatry. Trainees should play an active part in patient care and not be expected to adopt a passive observer role. The placement will include extensive community experience, with both medical and psychological approaches to treatment.

Psychiatry of Intellectual Disability:

This will be combined with a placement in child and adolescent psychiatry. Residents should receive sufficient exposure to gain awareness of the nature and scope of the problems with an emphasis on integrated psychiatric and psychological treatment rather than basic physical care. Trainees must get experience of community facilities as well as hospital care.

Rehabilitation Psychiatry:

Attachment to a rehabilitation team with particular emphasis on the care of individuals with severe chronic disability is recommended. Such experience should involve not only in-patient care but also community facilities, including day centres, hostels, supervised lodgings and sheltered workshops.

Geriatric Psychiatry:

It constitutes a separate attachment within the rotational training scheme. It is important that residents gain experience in treating both the acute and chronic functional disorders of older people, in addition to the assessment and management of organic illnesses. This should include both hospital and community experience and work in the multidisciplinary team. Residents should gain experience of pharmacological and psychological treatments, including the drugs used to treat cognitive and behavioural symptoms in dementia and related disorder.

Substance Misuse Psychiatry:

Resident will receive appropriate experience in this area. There will be a full-time or part-time placement where a specific service exists for the treatment of alcohol and/or drug dependence.

Forensic Psychiatry:

Some experience may be gained in general adult psychiatry but a specialist attachment in forensic psychiatry services of the department of psychiatry will be required. Apart from the experience of the provision of psychiatric care in secure settings, it is valuable for trainees to accompany consultants to

prisons, hospitals, secure units, remand centres and other establishments. Residents will prepare shadow court reports for discussion with their consultants. Specific instruction is needed in the principles of forensic psychiatry, detailed risk assessment and management, and medico-legal work.

Psychotherapy:

Trainees must receive theoretical and practical instruction in a full range of psychotherapeutic treatments as set out in the curriculum. Residents must gain theoretical knowledge, supervised clinical experience of various approaches in psychotherapy, and should be familiar with all commonly used treatments. Training will have formal attachment to a specialist psychotherapy unit of the department of psychiatry under supervision of a consultant psychotherapist. There basic requirements are: developing interview skills, psychotherapeutic formulation of psychiatric disorder, a minimum of three short-term cases, each using a different psychotherapeutic model, one long-term individual case, using any model, some experience either of group psychotherapy or couple, family or systemic therapy and parenting. Use of the designed logbook and specific assessment records is essential to ensure that each trainee fulfils the requirements in psychotherapy training during the rotational training scheme.

In addition, residents will complete learning module of Specialties in Psychiatry in customized ways in this period.

7.1. Training rotations for the Residents in Phase-B

Total duration: 36 months

Phase- B consists of 6 Blocks. These Blocks are as follows:

Block	Specialty	Duration (months)
1	Advance Psychiatry	6
2	Advance Psychiatry	6
3	Adult Psychiatry	6
4	Adult Psychiatry	6
5	Specialties in Psychiatry	6
6	Specialties in Psychiatry & Examination	6

Of the 6 blocks placement in Psychiatry, 2 Blocks will be for training in Advance Psychiatry,2 blocks will be for training in Adult (General and Community) Psychiatry, and the rest 2 blocks for training in Child and Adolescent Psychiatry, Psychiatry of Intellectual Disability, Psychotherapy, Substance Misuse Psychiatry, Geriatric Psychiatry, and Forensic Psychiatry. Last 3 months of Block 6 will be kept for eligibility assessment and Phase B Final Examination.

7.2 Learning Modules in Phase B:

- Adult (General, Community & Rehabilitation) Psychiatry
- Specialties in Psychiatry(Child and Adolescent Psychiatry, Psychiatry of Intellectual Disability, Substance Misuse Psychiatry, Geriatric Psychiatry, Forensic Psychiatry and Psychotherapy)

Monitoring and Evaluation of Phase B Training:

Form of training must be comprehensive and structured. Resident shall maintain the training log book and designed portfolio duly signed by the competent person/persons under supervisor/supervisors. Residents are expected to achieve

necessary clinical skills to integrate the physical and psychiatric assessments/findings.

The formative (continuous) evaluations of residents will be based on

- successful completion of the log book
- completing portfolio frame work
- supervisor's report and course co-coordinators report

In addition, summative assessment of training will be held accordingly.

knowledge, Skills, Attitudes - Clinical competencies in Phase B:

Major competency- assessments

- Establishing and maintaining therapeutic relationships with children, adolescents and families
- Safeguarding Children
- Undertake clinical assessments of children and young people with mental health problems
- Managing emergencies
- Paediatric psychopharmacology
- Psychological therapies in Children and Adolescents Psychiatry
- Assessment and treatment of Children and Adolescents Neuropsychiatry
- Psychiatric management of children and adolescents with learning disabilities
- Paediatric liaison services
- Working with Networks
- Medico-Legal Aspect of Child & Adolescent Psychiatry
- Inpatient and outpatient Child and Adolescent Psychiatry

- Intellectual Disability Psychiatry
- Substance misuse
- Psychotherapy
- Geriatric mental health
- Rehabilitation

Major Competency - Management

- Managing a budget
- Managing risk
- Handling complaints
- Involving service users
- Evidence based practice
- Applying good practice standard
- Monitoring and analysing outcomes
- Audit

Competencies for Child and Adolescent Psychiatry:

1) Building trust and respect with child, adolescent and families:		
Knowledge	**Skills**	**Attitudes demonstrated through behaviours**
•Attachment theory •Basic psychodynamic theory •Basic systemic theory	•Observing confidentiality, even with young children when it does not jeopardize safety •Share information, involving children, young people and parents in decision making and obtaining consent from the appropriate person •Being able to combine staying in touch with the patient's feelings with reflecting what is going on •Tolerating uncomfortable feelings •Staying aware of the patient's level of anxiety •Judging when the patient is ready to consider a new	•Courtesy, compassion and sensitivity to the patient's needs •Sympathy for human frailty and a non-judgmental behaviour •Shows sensitivity to family, cultural and social circumstances

	perspective on their difficulties •Talking about the patient's difficulties in a respectful and thoughtful fashion •Maintaining a therapeutic alliance with patients who are very resistant to looking at their difficulties in new ways	

2) History taking and interviewing using developmental approach in Children and Young people (from parents, child and adolescent):

Knowledge	Skills	Attitudes demonstrated through behaviours
•Awareness and knowledge of range of disorders presenting in childhood and adolescence & associated signs & symptoms	•Use of developmentally appropriate communication skills to elicit history from children across the age range and developmental span, and from parents, including	•Shows sensitivity behaviour to cultural and ethnic issues and beliefs •Non-judgmental •Aware and sympathetic behaviour towards the anxiety and fear felt by children & adolescent subject to examination

•Knowledge of major diagnostic classificatory systems (ICD; DSM) •Legal framework of informed consent as applicable in child and adolescent practice •Range of appropriate investigations for psychiatric disorders in children and adolescents, including alcohol and substance misuse •Appropriate investigations for major causes of learning disability •Appropriate physical and laboratory monitoring for patients on medication	those with learning difficulties •Obtain consent appropriately •Physical examination of children and adolescents (putting child at ease, appropriate developmental approach) with appropriate chaperoning •Recognition of acute medical illness	

Competencies for Psychiatry of Intellectual Disability:

1) Psychiatric care in Intellectual Disability:

Knowledge	Skills	Attitudes demonstrated through behaviours
•Demonstrate an understanding of the multidisciplinary and holistic approach to the psychiatric care of people with ID •Understand the principles of life span issues that affect people with ID and how that influences the management of transitions •Demonstrate a knowledge of the principles of clinical supervision and their	•Competently make diagnoses of both organic and functional illnesses and the assessment of complex needs, leading to the formulation and implementation of appropriate management plans in ID •Competently assess and manage: :patients with epilepsy :patients with ASD :patients needing secure care :patients with dementia associated with ID :challenging behaviours associated with ID	•Display willingness and availability to give clinical supervision to colleagues at all times (NB: this competency applies across all the intended learning outcomes and subjects of this domain)

practical application (NB this competency applies across all the intended learning outcomes and subjects of this domain)	•Offer psychiatric expertise to other practitioners to enhance the value of clinical assessments (e.g. through clinical supervision) to which the psychiatrist has not directly contributed •Elicit information required for each component of a psychiatric history; in situations of urgency, priorities what is immediately needed; and gather this information in difficult or complicated situations	

Competencies for Substance Misuse Psychiatry:

1) Explaining Adversity of Alcohol Misuse:

Knowledge	Skills	Attitudes demonstrated through behaviours
•Demonstrate an understanding of the effects of alcohol and illicit drugs on health and psychosocial wellbeing •Be aware of the link between risk and substance misuse •Demonstrate an understanding of support services and agencies •Demonstrate an understanding of legislation with regard to illicit drugs •Demonstrate an understanding of the role of specialist drug and alcohol teams •Demonstrate knowledge of	•Offering advice on the effects of alcohol and illicit drugs on health and psychosocial wellbeing •Work with other agencies, including those in the non-statutory sector •Demonstrate ability to make a detailed assessment of cognitive function and detect presence of substance misuse related brain disorder •Make assessments of substance misuse disorder in criminal justice settings • Make assessments of substance misuse	•Provide non-judgmental help and support •Ability to establish and maintain working relationships and understand the needs of families and careers •Demonstrate sensitivity to multi-cultural diversity in substance misuse practice

investigations available and appropriate use in assessment and diagnosis (including ECG interpretation) with reference to QT interval prolongation •Demonstrate in-depth knowledge of psychosocial and pharmacological management and treatment of: :cannabis use disorders :benzodiazepine use disorders :stimulant use disorders :alcohol use disorders :opiate use disorders : nicotine use disorders etc. •Knowledge of the full range of providers of substance misuse services and	disorder in in-patient settings Assess gambling disorders •Understand and apply specific assessment skills required for pregnant women Understand and apply specific assessment skills required for special groups e.g. LD, adolescents, older adults •Make assessments of mental capacity especially with reference to intoxication •Ability to induct and manage opiate dependent patients on to oral replacement therapy •Demonstrate competence in management of	

their role within local and national treatment systems •Demonstrate understanding and clinical application of specific psychological treatments e.g. Motivational Enhancement Therapy, Relapse Prevention •Demonstrate in-depth knowledge of psychosocial and pharmacological management and treatment of severe mental illness and personality disorders in substance misusers •Understand the concepts related to the stages of Change model and tailor interventions accordingly	in-patient treatment of substance misuse disorders •Apply specialist treatments, e.g. injectable medications •Demonstrate competence in managing patients with polydrug dependence •Ability to conduct motivational interviews •Ability to work closely with colleagues in the Multi Disciplinary Team (MDT) and external statutory/non-statutory agencies	

Competencies for Old age Psychiatry /Geriatric Psychiatry:

1) Assessment and Management of Older psychiatric Patients:

Knowledge	Skills	Attitudes demonstrated through behaviours
•Demonstrate a knowledge of the principles of clinical supervision and their practical application (NB this competency applies across all the intended learning outcomes and subjects of this domain) •Demonstrate an understanding of community assessment and	•Offer psychiatric expertise to other practitioners to enhance the value of clinical assessments (e.g. through clinical supervision) to which the psychiatrist has not directly contributed •Elicit information required for each component of a psychiatric history; in situations of urgency, prioritise what is immediately needed; and gather this information in difficult or complicated situations •By the completion of training, psychiatrists will be able to identify psychopathology	•Display willingness and availability to give clinical supervision to colleagues at all times (NB this competency applies across all the intended learning outcomes and subjects of this domain) •Contribute to the delivery of services that respect diversity, taking account of issues of ageing in a multi-cultural society •Maintain good professional attitudes and behaviour when responding to situations of ambiguity and uncertainty

management and work effectively in a variety of settings e.g. outpatient, day patient, residential and inpatient facilities with older patients	in all clinical situations, including those that are urgent and/or complex •Assess and diagnose patients with multiple and complicated pathologies Take a history from patients and others that include factors relevant for diagnosis and management of an older patient •Make a mental state examination with detailed assessment of cognitive function Use appropriately investigations in old age psychiatry, including neuropsychology and neuroimaging •Make a basic physical examination be competent in the diagnosis and management of physical illness at a basic level and consider this	

	when planning individual management. Also recognise and manage the complex interaction of mental and physical problems in old age •Independently assess and manage patients with mental illnesses including uncommon conditions, in emergencies •Demonstrate expertise in applying the principles of crisis intervention in emergency situations •Make care plans in urgent situations where information may be incomplete •Make an emergency plan for the management of older patients at immediate risk	

Competencies for Forensic Psychiatry:

1)Clinical history :

Knowledge	Skill	Attitudes demonstrated through behaviours
•Links between psychopathology, victimisation, mental disorder, behaviour and crime Criminology of offences relevant to forensic psychiatry and diversity •Services for special groups of forensic patients •Safety policies and procedures relating to patient consultation	•Situations of urgency, prioritise what is immediately needed; and gather this information in difficult or complicated situations	•Display willingness and availability to give clinical supervision to colleagues at all times (NB this competency applies across all the intended learning outcomes and subjects of this domain

2) Patient examination, including mental state and physical examination:

Knowledge	Skills	Attitudes demonstrated through behaviours
•Psychopathology and phenomenology relating to risk Demonstrate a knowledge of the principles of clinical supervision and their practical application (NB: this competency applies across all the intended learning outcomes and subjects of this domain)	•Tailoring the examination to the purpose, setting and context Assessment of safety of environment for patient consultation and examination Undertake mental state and physical examination and investigations sensitively in accordance with patients diversity needs. By the completion of training, psychiatrists will be able to identify psychopathology in all clinical situations, including those that are urgent and/or complex Assess and diagnose patients with multiple and complicated pathologies	•Display an awareness of complex needs

3) Diagnosis :

Knowledge	Skills	Attitudes Demonstrated through behaviours
•Impact of legal context on patient evaluation	•Assessment of behavioural abnormalities which increase risk	

4) Formulation:

Knowledge	Skills	Attitudes demonstrated through behaviours
•Understand the balance between the primary duty of care to patients and protecting public safety and take proper account of this in professional decision-making Philosophy of retribution, incapacitation, deterrence	•Collation and integration of information from clinical, risk and legal evaluation into a detailed formulation •Psychodynamic formulation	•Recognising the contribution of MDT members and other agencies in assessing patients, incorporating patient perspective

Competencies for Psychological therapies:

1) Applying psychological Treatment:

Knowledge	Skills	Attitudes demonstrated through behaviours
•Apply contemporary knowledge and principles in psychological therapies	•Display the ability to provide expert advice to other health and social care professionals on psychological treatment and care •Demonstrate the ability to conduct a range of individual, group and family therapies using standard accepted models and to integrate these psychotherapies into everyday treatment, including biological and socio-cultural interventions. •Plan psychotherapeutic treatments on the basis of individual	•Continue to practice and develop a range of treatment skills

	formulation predicting probable consequences of treatment and its interaction with other factors in the patient's life •Demonstrate an understanding of mental disorders and how psychodynamic, cognitive behavioural, systemic and integrative therapy theories and models may be applied in practice showing a sensitive appreciation of application of more than one model applied across the full range of psychiatric disorders •Demonstrate awareness of current	

	evidence-based treatment guidelines and their range of application. Ability to critically evaluate summary guidance in the light of the methods used •Demonstrate an understanding of the factors affecting the appropriate choice of therapist for a patient becoming able to combine published evidence with extensive personal experience in making reasoned choices •Demonstrate mastery of the theory, technique and application of a recognised	

	form of psychotherapy (psychodynamic; cognitive-behavioural or systemic) Validated competence in delivery of the treatment (when initiating, sustaining and ending episodes of care). Able to develop a treatment model to meet the needs of specific situations and to use experience gained to enhance the knowledge and skills of other therapists •Demonstrate mastery across a broad range of clinical conditions, within a range of common clinical	

	settings; out-patient, in-patient, day settings and across more than one modality (individual, group, family) •Demonstrate competence in the theory and technique of two other recognised forms of psychotherapy •Demonstrate core skills of the chosen approaches and appreciate scope of their application and by applying those skills from these models within integrative packages of care Demonstrate skills in monitoring the process of therapy appropriately •Employs watchful	

	sensitivity throughout each session, prompting action based on informed comparisons •Able to review entire progress of a treatment accurately •Demonstrate a range of appropriate leadership and supervision skills including: Coordinating, observing and being assured of effective team working Setting intended learning outcomes :Planning :Motivating :Delegating :Organising :Negotiating :Example setting :Mediating / conflict resolution :Monitoring performance	

Rehabilitation Psychiatry:

1) Assessment of Patents who needs rehabilitation:

Knowledge	Skills	Attitudes demonstrated through behaviours
•Understand the range of potential risk behaviours (e.g. risk of physical aggression/self harm, physical aggression/ vulnerability to aggression from peers in inpatient settings, self-neglect/fire-setting) Understand the epidemiological factors which may increase risk of harm to others in populations with long term	•Evaluate through information obtained from patients, their families and other relevant sources, the patient's strengths, disabilities, risks and vulnerabilities •Apply in practice the principles of assessment of disability associated with primary and secondary impairment and tertiary handicap •Demonstrate in clinical practice the use of structured tools used in the assessment of psychosis,	•Understand the individual as a person with a narrative and how they conceptualise their illness in relation to this •Understand how this affects their self esteem, sense of autonomy and motivation •Help professionals from different backgrounds to understand and use psychotherapeutic concepts in managing this patient group •Provide psychotherapeutic assessment and specific evidence based interventions for people with

severe mental disorders, how these overlap with factors in the general population and how these factors may interact (e.g. social deprivation, substance misuse, adverse early life experience) •Understand the various aspects of mental health legislation including those aspects which relate to courts/Criminal Justice System Understand the range of structured risk assessment	disability, social function, quality of life and to monitor change •Assess change in social function and predict capability to move between settings •Contribute a psychotherapeutic perspective to the multidisciplinary assessment and management of patients with severe and enduring mental illness •Use high level communication, negotiation and liaison skills with other stakeholders, including primary care, general adult, forensic and substance use	chronic, disabling and complex mental health problems •Ensure that care plans are consistent with the patient's strengths and level of function and that access to interventions is not precluded by disability •Maintain a strategic focus on the provision of work, leisure, social and educational services for patients with severe mental illness •Maintain a strategic focus on the provision of work, leisure, social and educational services for patients with severe mental illness

tools available including their strengths (e.g. structured way of collating factors which may contribute to risk which may then contribute to development of formulation) and weaknesses (e.g. predict risk in populations only, not individuals and do not cover important areas of risk assessment/formulation including situational and victim factors) •Understand the psychological effects of	services, Criminal Justice System, prisons and Probation Services and other independent providers as appropriate to develop flexible, integrated and comprehensive services •Sustain optimism that instills hope for recovery in individuals and those around them •Balance the risks of disengagement from services with the potential benefits of challenging unwillingness to face issues or progress •When crisis arises, recognise the	

chronic illness on interpersonal relationships and intrapersonal structures •Describe local and national protocols, laws, benefits and policies relating to mental health service provision in hospitals, residential work, educational settings and other social settings. The pharmacologic al management of psychosis resistant to conventional regimes such as NICE and BNF guidelines	dynamics in the individuals environment which may contribute and address them sensitively in so far as possible to avert the crisis •Attend to the practical needs of the patient, including housing, benefits, education, work and activities of daily living •Attend to social and leisure needs •Employ evidence based psychological approaches for treatment of disorders resistant to pharmacological intervention # Identify strengths and	

•Know how to ensure the development of a variety of care settings which allow individuals to pick the least dependent and restrictive and the most socially inclusive environment appropriate as close to where they want to live as possible	tensions in the relationship of patients with their families and careers and address appropriately •Assess and manage risk as part of a comprehensive package of recovery-based support for people with severe mental illness/complex needs within a wide range of settings from inpatient services to the community •Provide comprehensive adapted rehabilitation Programs for service users with cognitive deficits associated with severe mental illness/co-morbid	

8. Assessment:

The assessment for certification of the MD degree of the University is comprehensive, integrated and phase-centered attempting to identify attributes expected of specialists for independent practice and lifelong learning and covers cognitive, psychomotor and affective domains. It keeps strict reference to the components, the contents, the competencies and the criteria laid down in the curriculum. Assessment includes both **Formative Assessment and Summative (Phase final) Examinations.**

8.1. Formative Assessment:

Formative assessment will be conducted throughout the training phases. It will be carried out for tracking the progress of residents, providing feedback, and preparing them for final assessment (Phase completion exams).

There will be Continuous (day-to-day) and Periodic type of formative assessment.

- **Continuous (day-to-day) formative assessment** in classroom and workplace settings provides guide to a resident's learning and a faculty's teaching / learning strategies to ensure formative lesson / training outcomes.
- **Periodic formative assessment** is quasi-formal and is directed to assessing the outcome of a **block placement** or **academic module completion**. It is held at the end of Block Placement and Academic Module Completion. The contents of such examinations include **Block Units** of the Training Curriculum and **Academic Module Units** of the Academic Curriculum.

8.1.1. End of Block Assessment (EBA):

End of Block Assessment (EBA) is a periodic formative assessment and is undertaken after completion of each training block, assessing knowledge, skills and attitude of the residents. Components of EBA are written examination, structured clinical Assessment (SCA), medical record review, and logbook assessment. Unsatisfactory block training must be satisfactorily completed to be eligible for phase final examination

8.1.2. Formative assessment for Academic modules for Biostatics and Research Methodology and Medical Education to be done in the first nine months of Phase B training. Residents getting unsatisfactory grade must achieve satisfactory grade by appearing the re-evaluation examination to be eligible for the Phase B Final Examination.

8.2. Summative Examination:

Assessment will be done in two broad compartments.

a) **Compartment A:** Consist of 3 (three) components.
   1. Written Examination (Consisting of 2 papers).
   2. Clinical Examination (One long and four short cases).
   3. SCA and Oral (10 stations SCA, Oral one board consisting of 2 examiners).

Every Resident must pass all the 3 components of compartment-A separately. Candidates will be declared failed if he/she fails in one or more component (s) of the examination. He/she then have to appear all the 3 components in the next Phase B Final Examination.

b) **Compartment B:** Thesis and Thesis defense.

8.2.1. Written Examination:

Two Papers: Contents of written papers listed in Annexure II

Question type and marks:

- Two Papers (Paper I and Paper II); 100 marks each; Time 3 hrs for each paper. Pass marks-60% of total of 2 papers.
- **Each paper will consist of Two Groups:**
- **Group A:**
  - 10 short questions (5 marks each)
  - These will assess the knowledge of different level and its application
- **Group B:**
  - 5 scenario based problem solving questions (10 marks for each).
  - The questions should focus to assess the capability of handling clinical problem independently and comprehensively as a specialist.
  - Suggested format:–
    - A scenario followed by question(s).
    - Questions may include diagnosis, differential diagnosis, investigation plan, treatment, follow up and patient education.

8.2.2. Clinical Examination: Long case and Short case:

- There will be one long case and four short cases.

i) **Long case: Marks-100**
  - Directly observed
  - Two examiners for each examinee.
  - History taking and examination by the examinee →30min.
  - Discussion on the case 20 min.(presentation 6min, crossing 6x2min and decision 2min).

  - Examiners will not ask any question nor stop the examinee in any way during history taking and physical examinations.
  - Discussion should be done preferably as per structured format and proper weightage on different segments of clinical skills.

ii) **Short cases : Marks-100**
  - Four in number
  - Time 20-30 min. (Time will be equally divided for each short case)
  - Crossing should be done with proper weightage on different segment of clinical skills.

iii) **Pass marks: 60% of total of Long and Short Cases**

8.2.3. Structured Clinical Assessment (SCA): Marks-100

- 10 stations : 5 min each

8.2.4. Oral Examination: Marks-100

- One board consisting of 2 examiners.
- 20 minutes (9+9+2).

8.2.5. Pass marks in SCA and Oral: 60% of total (SCA and Oral.)

8.3. Thesis Evaluation:

- **Marks: Thesis writing-200; Defense-100: Marks for acceptane-60% of total.**
- To be evaluated by 3 (three) evaluators:- 2 subject specialists and one academician preferably involve in research and teaching research methodology.
- Among the subject specialists one should be external.
- Evaluators should be in the rank of Professor/Associate Professor.

- Supervisor will attend the defense as an observer and may interact only when requested by the evaluators.
- Thesis must be submitted to the controller of Exam not later than 27 months of enrolment in Phase-B.
- Thesis must be sent to the evaluators 2 (Two) weeks prior to assessment date.
- Evaluation will cover Thesis writing and its defense.
- For thesis writing evaluator will mark on its structure, content, flow, scientific value, cohesion, etc.
- For defense – Candidate is expected to defend, justify and relate the work and its findings.
- Assessment must be completed in next 3 months.
- Outcome of the assessment shall be in 4 categories – "Accepted", "Accepted with minor correction", "Accepted with major correction" and "Not Accepted".

8.3.1. Description of terms:

- **Accepted:** Assessors will sign the document and resident will bound it and submit to the Controller of Examinations by 10 days of the examination.
- **Accepted with minor correction:** Minor correction shall include small inclusion/exclusion of section; identified missing references, correction of references and typographical and language problem. This should be corrected and submitted within 2 weeks.
- **Accepted with major correction:** Task is completed as per protocol with acceptable method but some re-analysis of result and corresponding discussion are to be modified.
- To be corrected, confirmed by Supervisor and submit within 3 (Three) weeks.
- **Not Accepted:** When work is not done as per protocol or method was faulty or require further inclusion or confirmation of study.

- To complete the suggested deficiencies and reappear in defense examination during its next Phase Final Examination.
- Candidate has to submit his/her thesis and sit for examination and pay usual examination fess for the examination.

8.3.2. Residents must submit and appear Thesis defense at notified date and time. However non- acceptance of the Thesis does not bar the resident in appearing the written, clinical and oral exam.

8.4. Qualifying for MD/MS Degree:

On passing both the compartments, the candidate will be conferred the degree of MD/MS in the respective discipline. If any candidate fails in one compartment he/she will appear in that compartment only in the subsequent Phase-B exam.

9. Supervision and Training Monitoring:

Training should incorporate the principle of gradually increasing responsibility and provide each trainee with a sufficient scope; volume and variety of experience in a range of setting that include inpatient, outpatient, emergency and intensive care. All elements of work in training rotation must be supervised with the level of supervision varying depending on the experience of the trainee and the clinical exposure. Outpatient and referral supervision must be routinely including opportunity to personally discuss all cases. As training progress the trainee should have the opportunity for increasing autonomy, consistent with safe and effective care for the patient. Trainee will at all time have a named supervisor, responsible for overseeing their education.

Supervisor - are responsible for supervision of learning throughout the Program to ensure patient and laboratory safety, service delivery as well as the progress of the resident with learning and performances. They set the lesson plans based on the curriculum, undertake appraisal, review progress against the curriculum, give feedback on both formative and summative assessments as well as sign the logbook and portfolio. The residents are made aware of their limitations and are encouraged to seek advice and receive help at all times.

Course Coordinator –of the department coordinates all training and academic activities of the Program in collaboration with the Course Manager.

Course Manager - collaborates Course Coordinator of the department to coordinates all training and academic activities of the Program.

Course Director – of each faculty directs guides and manages curricular activities under his/her jurisdiction/authority and is the person to be reported to for all events and performances of the residents and the supervisors.

10. Curriculum Implementation, Review and Updating:

Supervisors and residents both are expected to have a good knowledge of the curriculum and should use it as a guide for their training progamme. Since Psychiatry has historically been rapidly changing specialty the need for review and up-dating of curricula is evident. The curriculum is specifically designed to guide an educational process and will continue to be the subject of active redrafting, to reflect changes in both Psychiatry and educational theory and practices. Supervisors are encouraged to discuss the curriculum and to feedback on content and issue regarding implementation at Residency Course Director. Review will be time tabled to occur annually for any minor changes to the curriculum. The curriculum will be reviewed with input from the different Subspecialties of Psychiatry

11. Syllabus for the Phase B:

Residency Program of Doctor of Medicine in Psychiatry

Paper-I: SAQ in Comprehensive Psychiatry

- Group-A: Adult Psychiatry
- Group-B: Specialties in Psychiatry

Paper I: Group-A: Adult Psychiatry
(General Adult Psychiatry, Community Psychiatry and Rehabilitation Psychiatry)

a) General Adult Psychiatry:-

I. Introduction to Psychiatry: concepts of mental illness, criteria of abnormality. Disease, illness and sickness. Different models of defining mental disorders. History of Psychiatry.

II. Phenomenology and Psychopathology: signs and symptoms of psychiatric disorders. Concept of psychopathology and its approaches, defense mechanism.

III. Psychiatric assessment: psychiatric interview, interviewing techniques. Multidisciplinary approaches of assessment. Record keeping.

IV. Classification in psychiatry: history of classification and its needs. Types of classifications- categorical and dimensional. Diagnostic grouping, knowledge of ICD and DSM classifications and diagnostic systems. Cross cultural variation.

V. Psychiatric epidemiology: cross cultural differences and time trends.

VI. Aetiology of psychiatric disorders: approaches to aetiology and its development, different models and theories. Contribution of biological, psychological and psychodynamic factors to psychiatric aetiology. Importance of multifactorial aetiology.

VII. Treatment approaches: general approaches of psychiatric treatment including application of multidisciplinary team approaches. Role of psychiatrists in treatment, condition of the various treatment processes involved.

VIII. Preventive psychiatry: types of preventive activity - improvement quality of life, activities to differential levels. Preventive approaches to high-risk group. Mental health education.

IX. Psychiatric services: different models of service. Liaison approach. General hospital services- inpatient, outpatient and day hospital. Primary care psychiatry and referrals. Mental hospital and its present state. Community psychiatric services. Specialized services such as educational, social and economic rehabilitation. Therapeutic communities and support groups.

X. Psychiatric morbidity and its effects on family, society and economy.

XI. Aetiology, presentation, clinical course, outcome and prognosis of psychiatric disorders with the special emphasis of the following: Schizophrenia: development of ideas about schizophrenia, epidemiology, aetiology, classification, diagnostic criteria, course and prognosis,

treatments. Other psychotic disorders: overview, schizotypal disorders, delusional disorders, acute and transient psychotic disorders, schizoaffective disorders, Psychotic disorder due to general medical conditions. Atypical psychotic disorders, culture-bound psychotic disorders.

XII. Mood disorders: depressive disorders - epidemiology, aetiology, classification with different perspectives, clinical presentation and diagnostic criterias, course and prognosis, assessment and management.

XIII. Bipolar disorders: epidemiology, aetiology, types, clinical presentation and diagnostic criterion of different episodes, course and prognosis, treatments.

XIV. Other mood disorders:

XV. Anxiety disorders: overview, normal and pathological anxiety including their aetiology, classification. Specific anxiety disorders including phobic anxiety disorders, OCD, panic disorder, generalized anxiety disorder, anxiety disorder due to general medical conditions, substance induced anxiety disorder, mixed anxiety and depressive disorder.

XVI. Stress related disorders: overview, reaction to stress. Acute stress disorder, post -traumatic stress disorder, adjustment disorder, their aetiology, clinical features and diagnosis, course and prognosis and management. Other reaction to stress.

XVII. Somatoform disorders: epidemiology, aetiology and types. Detailed knowledge on somatization disorder, undifferentiated somatoform disorder, hyporhondriacal

disorder, dissociative (conversion) disorders, body dimorphic disorder.

XVIII. Other somatoform disorders.

XIX. Factitious disorders: overview, epidemiology, clinical features and diagnosis, treatment. Other neurotic disorders: neurasthenia, depersonalization - derealization disorder. Other specific neurotic disorders. Chronic fatigue syndrome. Cardinal psychological features of cerebral disorders: Acute and chronic organic reactions, focal cerebral disorders.

XX. Specific disorders: head injury, cerebral tumors, epilepsy, intracranial infections,cerebraovascular disorders, dementias and pseudodementias, delirium and cognitive disorders, vitamin deficiencies, toxic disorders, movement disorders and other disorders affecting the nervous systems. Culture bound syndromes.

XXI. Sexuality and gender identity disorders: normal sexuality, psychosexuality, sexual and gender identity and sexual behaviour, normal sexuality, psychosexuality, sexual and gender identity and sexual behaviour. Sexual dysfunctions including sexual desire disorder, sexual arousal disorder, orgasmic disorder with special emphasis on premature ejaculation, Sexual pain disorder - vaginismus, dysperunia.

XXII. Substance induced sexual dysfunction; culture bound sexual disorder - Dhat syndrome. Paraphilias. Gender identity disorders - epidemiology, aetiology, description, course and prognosis of transsexualism.

XXIII. Sleep disorders: normal sleep patterns, regulation, and function and sleep-wake rhythm. Classification of sleep disorders, dyssomnias, insomnias and hypersomnias. Parasomnias -nightmare disorders, sleep terror disorder, sleep waking disorder. Sleep disorder related to another mental disorder. Other sleep disorders including sleep disorders due to general medial conditions, and substance induced sleep disorders.

XXIV. Impulse control disorders: overview. Impulse control disorders not elsewhere classified, intermittent explosive disorders, pathological gambling, kleptomania, pyromania, Trichotillomania and others.

XXV. Eating disorders: epidemiology, aetiology, presentation, diagnosis, course, prognosis and treatment of anorexia nervosa, bulimia nervosa and obesity.

XXVI. Personality disorders: development of abnormal personality, Epidemiology, aetiology, presentation, diagnostic criteria, course, prognosis and treatment of different types of personality disorders with special emphasis on antisocial personality disorder.

XXVII. Other conditions related to psychiatry and psychiatric disorders: relationship problems, abuse of adult, bereavement, malingering, phase of life problem, age-related cognitive decline, academic and occupational problem, nonadherence to treatment for mental disorder.

XXVIII. Psychiatric emergencies epidemiology of suicide, deliberate self-harm and its treatment. Organic and functional psychiatric emergencies and their

management. Violence and assaultative behavior, their causes and treatment. Emergency psychiatric interview.

XXIX. Biological therapies:

XXX. Drugs: Psychopharmacology (reference Phase-A).

XXXI. Clinical psychopharmacology and therapeutics: basic guidelines of presenting psychotropics including typical and atypical antipsychotics, antidepressants, mood stabilizing agents, sedative-hypnotics for specific psychiatric disorders. Monitoring, management of adverse effects, drug interactions.

XXXII. Prescribing psychotropic in general medical conditions: specially in stroke, epilepsy, Parkinson's disease, cardiovascular diseases, hepatic and renal impairment.

XXXIII. Electroconvulsive therapy (ECT): mechanism of action, indications, contraindications, clinical guidelines, technique of administrations, adverse effects.

XXXIV. Other biological therapies: light therapy, psychosurgery, chronotherapy, placebo and others.

XXXV. Psychological therapies:

XXXVI. General considerations: development and perspectives of psychotherapies and classifications. Indications for the use of counseling and psychotherapy.

XXXVII. Specific psychotherapy for the management of psychiatric disorders (details have been given in Paper - II: Psychotherapy section).

XXXVIII. Social therapies:

XXXIX. General considerations: Development of social treatment and community care, major theoretical

influences, principles of community care, different methods of social treatments including therapeutic communities and milieu therapy.

XL. Community psychiatric care: primary care, acute specialized care, long-term care.

XLI. Rehabilitation: provision for rehabilitation for psychiatric disorders with special emphasis on schizophrenia, mental retardation, substance use related disorders.

XLII. Social work: values of social work. Interventions - casework and counseling, working with the family and volunteers, group work. Social work contribution to the multidisciplinary team; collaboration with other agencies; effective collaboration. Evaluation of social treatment and its future.

b) Community Psychiatry:-

I. Concept of community psychiatry: evolution, historical trend, custodial care, mental hygiene movement, deinstitutionalization, and disease prevention in psychiatry,

II. Prevention in psychiatry: public health model - primary secondary and tertiary prevention,

III. Community mental health care services: (please refer to General Adult Psychiatry section. Psychiatric services) Community mental health centers: philosophy, objectives, care facilities, consultation, care of chronically ill and participatory community care.

IV. Manpower development: development of clinical and para-clinical staff, training, utilization of existing manpower, and peer review of efficiency.

V. Economics of psychiatry, cost shifting, cost analysis, sources of financing, prospective, payment, insurance, unfavorable provisions for psychiatric patients.

c) Rehabilitation Psychiatry:

I. Provision for rehabilitation for psychiatric disorders with special emphasis on schizophrenia, mental retardation, and substance use related disorders.

Paper-I: Group-B: Specialties in Psychiatry

(Child and Adolescent Psychiatry, Psychiatry of Intellectual Disability and Psychotherapy, Substance Misuse Psychiatry, Geriatric Psychiatry, Forensic Psychiatry)

a) Child and Adolescent Psychiatry:

I. Classification and epidemiology of child and adolescent psychiatric disorders.

II. Interviewing: with children and adolescents, with parents and family.

III. Assessments, physical examination, medical investigations, psychological tests, multiaxial diagnosis.

IV. Aetiology of child psychiatric disorders: genetic influences, chromosomal abnormalities, brain disorders, individual and family factors, social and environmental influences.

V. Prevalence, aetiology, presentation, treatments and outcome of clinical syndromes and conditions in child and adolescent psychiatry including pervasive

developmental disorders, specific developmental disorders, hyperkinetic disorder, oppositional defiant and conduct disorders, emotional disorders specific to childhood, anxiety disorder, depression, somatoform disorder and its variants, stress related disorder, obsessive compulsive disorder, tics disorder, feeding and sleeping disorders, attachment disorders in infancy and childhood. Enuresis and encopresis, school refusal, selective mutism, preschool problems.

VI. Psychiatric aspect of somatic disease & disorders, psychosomatic disorders, epilepsy and psychiatry

VII. Family conflict and problems, school and peer factors. Disorders of adolescence, suicide and deliberate self-harm, anorexia and bulimia nervosa, substance use disorders, schizophrenia and allied disorders,

VIII. Continuities of childhood psychiatric disorders into adult life.

IX. Approaches to treatment: basic range of treatment methods -description, indications and contraindications for different treatment interventions, outcomes. Indications for in patient and day patient care.

X. Child psychiatric services: general description. Basic information on different agencies involved in the care of children and their functions. Residential homes brostal and penal institutions.

XI. Legal aspects of child care: child protection, child abuse. Rights of the children adolescents. Role of the psychiatrist.

b) Psychiatry of Intellectual Disability:

I. Evolution of concept of learning disability and Learning Disability Psychiatry.

II. Current status of learning disability- broad and narrow view.

III. Learning disorders: epidemiology, aetiology, clinical features, diagnoses and treatment of Reading disorder, Mathematics disorder, Writing disorders, other learning disorders.

IV. Mental Retardation: Nosological evolution and present nomenclature. Classification, epidemiology, aetiology (Genetic, perinetal and acquired factors), clinical features, diagnosis, assessment(psychiatric interview, physical examination, neurological examination, laboratory tests, hearing and speech evaluation, psychological assessment), comorbid psychopathology, treatment and prevention.

V. History and development of learning disability services. Multidisciplinary team approach and role of child and adolescent psychiatrist, Learning disability psychiatrist and general psychiatrist in the team. Liaison among educational, health and social agencies. Special education and community services for learning disabilities.

c) Psychotherapy:

I. Development of psychotherapy, common factors in psychotherapy.

II. Psychoanalytic psychotherapy: development of psychoanalytic concepts of Freud, the Neo-Freudians,

Anna Freud, Klein and Winnicott. An understanding of classical psychoanalysis and its components. Psychodynamic psychotherapy.

III. Indications of expressive, brief, long term and supportive psychotherapy.

IV. Behaviour therapy: development of behaviour therapy, classical and operant conditioning. Dielectic behaviour therapy. Social skill training, assertiveness training. Understanding of systematic desensitization graded and cue exposure, flooding, extinction, token economies and other techniques. Functional analysis of behaviour. Formulate a treatment plan and use measurements to assess changes.

V. Cognitive therapy: development of cognitive therapy and principles of cognitive treatment. Cognitive model for depression and other non-psychotic disorders. The importance of schemas, negative automatic thoughts and maladaptive assumption. Strategies and techniques of cognitive therapy. Cognitive analytic therapy.

VI. Family therapy: development of family therapy. Understanding of family system, subsystem, family rules, homeostasis, family life cycle framework, genogram. Different models of family therapy: dynamic, structural strategic, systemic, psycho educational and behavioural. Parenting techniques. Goals of treatment.

VII. Marital (couples) therapy: types, indications, contra-indication, goals, and processes of marital therapy.

VIII. Group therapy: therapeutic factors in groups. Types of

groups and group therapy. Understanding mechanisms, techniques of therapy in small and large groups. Inpatients group therapy, Therapy groups including self-help groups.

IX. Special considerations: interpersonal psychotherapy (IPT), counseling. Crisis intervention, multi-systemic therapy, EMDR, meditation, hypnosis, abreaction, psychodrama, biofeedback, and computer based psychotherapeutic Program, combined psychotherapy and pharmacotherapy.

X. Evaluation of psychotherapy: efficacy, difficulties in defining outcome, understanding of effect, size and meta-analysis, specific and nonspecific effects of psychotherapy.

XI. Psychotherapy: science, humanistic, philosophy, religion and spirituality - common elements and differences.

d) Substance Misuse Psychiatry:

i. Overview: terminology- substance abuse, dependence, withdrawal, intoxication. Classification of disorders associated with the use and abuse of alcohol and other psychoactive substances.

ii. Epidemiology and basic pharmacology: alcohol, cannabis, the stimulants (amphetamine, cocaine, caffeine, pemoline etc.), hallucinogens, inhalants, nicotine, solvents and nitrites, opiates, phencyclidine, sedatives, hypnotics and other anxiolytics (benzodiazepine and barbiturates).

iii. Classification, aetiology, presentation and diagnostic criteria, comorbidity, assessment and treatment of substance use related disorders. Personality aspects of drug additions.

iv. The interaction of substance and alcohol use with psychiatric disorders. Substance induced psychiatric disorders.

v. Strategies for prevention of substance abuse. Role of different agencies. Drug control act and regulations.

vi. Assessment and management of non substance additive and related syndromes.

vii. Arguments for and against the various types of prescribing and treatment modalities.

viii. Substance misuse related medical, psychiatric and social complications and their impact on public health.

ix. Social reintegration and rehabilitation.

e) Geriatric Psychiatry:

i. Old age: neurobiology of aging. Psychology of aging - psychodynamics, cognition and age, importance of loss.

ii. Socio-economic factors in old age: attitudes status of the elderly, retirement, income, accommodation, socio-cultural differences.

iii. Psychopharmacology of old age.

iv. Psychological aspects of physical diseases: particular emphasis on possible psychiatric sequelae of cerebrovascular diseases, renal disease, Parkinson's disease, sensory impairments. Emotional reaction to illness and to chronic ill health.

v. Mental disorders of old age: special emphasis on dementia disorders, delirium, depressive disorders, schizophrenia, delusional disorders, substance use disorders, sleep disorders, anxiety disorders, bereavement and adjustment disorders.

vi. Deliberate self-harm and suicide in old age.

vii. Psychiatric aspects of personality in old age.

viii. Assessment of a referral in old age. Use of home visits.

ix. Service provision: principles of service, multidisciplinary work, social services and voluntary agencies. Institutional care of the old, community care, terminal care of the elderly. Hospice concept.

x. Medico legal issues in geriatric psychiatry: elder abuse. Management of property. Testamentary capacity, driving.

f) Forensic Psychiatry:

i. Relationship between crime and psychiatric disorders: knowledge of the range of offences committed by mentally disordered offenders. Specific crime and their psychiatric relevance particularly homicide, other crimes of violence, sex offenses, arson, shoplifting and criminal damage. The relationship between specific illness and crime.

ii. Mental disorders and offending in special groups: young offenders, females, substance misuse and crime offenders with brain damage, epilepsy, deafness and other physical disabilities. Special syndromes, morbid jealousy erotomania, factitious disorders.

iii. Psychiatry and the criminal justice system: an outline of the procedure of arrest, prosecution and sentencing. Role of Police in arrest of mentally disordered offenders, the assessment of defendants at police stations, false confessions.

iv. Psychiatric defenses: fitness to plead, autism and deafness, criminal responsibility, diminished responsibility, infanticide, amnesia and automatism. Psychiatric disposals after conviction.

v. Psychiatry and the courts: witness of fact, expert witness, writing reports, giving evidence, principles of assuring a defendant for the court and preparing psychiatric court report in a criminal case.

vi. Facilities and treatment: elements of forensic psychiatric services, their relationship to each other. The use of security in the treatment of psychiatric patients and the arguments for and against seclusion. The long term management of patients on restriction orders. Care in the community for previous violent patients.

vii. Offending behaviour and its management.

viii. Dangerousness: concept, definitions and situations where assessment is required.

ix. Problems of predictions.

x. Psychiatry in prisons: prevalence of psychiatric disorders in prison populations, suicide in prisoners, psychiatric treatment in prison settings.

xi. Victims: the psychological sequelae of victimization, especially anxiety states, anger and aggressive behaviour. Compensation and other medico-legal issues.

xii. Civil matters: Psychiatric disorders and civil rights including marriage, divorce, custody of children and management of property and affairs.

xiii. Ethics in psychiatry: ethical principles, professional codes, patient - therapist sexual relationship, informed consent, involuntary treatment, privilege and confidentiality, hospitalization, right to treatment, impaired physicians, physicians in training, claim for psychiatric damage. Abortion.

xiv. Mental Health Act.

MD Residency Phase B Examination

Paper-II: Scenario Based Problem solving situation in Comprehensive Psychiatry

- Group-A: Adult Psychiatry (General Adult Psychiatry, Community Psychiatry and Rehabilitation Psychiatry)

- Group-B: Specialties in Psychiatry (Child and Adolescent Psychiatry, Psychiatry of Intellectual Disability, Psychotherapy, Substance Misuse Psychiatry, Geriatric Psychiatry, Forensic Psychiatry)

10.1 Academic curriculum of Generic Skills, Medical Statistics, Research Methodology and Medical Education

a) Generic Skills:

b) Medical Statistics:

Basic concepts: definition, importance, uses in medical science and limitations, Concepts of scale of measurement, sampling methods, frequency and probability distributions, summary statistics and graphs, tables, outlines, plots Types of data - categorical, ordinal, continuous. Descriptive and inferential statistics: tests of significance, non-parametric and parametric tests, estimation and confidence intervals. The advantage of confidence intervals over p values. Specific tests: t-test. Chi-square test, Mann-Whitney U, confidence intervals for difference between means proportions, mode, medians. Brief introduction of other methods, factor and cluster analysis. Ideas of reliability and validity. Sensitivity, specificity and predictive values of research measures. Bias, particularly-cross-cultural biases. Diagnostic agreement measured by kappa and intra-class correlation. Data analysis: inputting,

editing, listing, exploring and analyzing data. Presenting results, Inferring the cause and effect relationship, Confounding factors. Analyses: meta analysis, survival analysis, analysis of covariance, regression and correlation. Research methodology: Candidates should be able critically to examine the design, methodology, results and appraisal of published research, with reference to following areas: Principles and criteria for literature reviews, meta-analysis, Concepts of incidence, Prevalence and population at risk, z test. Sampling techniques, case identification, and case registers mortality and morbidity statistics, Measurements in psychiatry, their advantages and limitation. Research methodology, study design, generation of hypothesis, hypothesis testing, and designing research proposals (type of research study will emphasize on epidemiological surveys and clinical trials and Data analysis and statistics).

c) Research Methodology:

- Residents should be able critically to examine the design, methodology, results and appraisal of published research, with reference to following areas:
- Principles and criteria for literature reviews, Meta - analysis, concepts of incidence, prevalence and population at risk.
- Sampling techniques, case identification, and case registers mortality and morbidity statistics.
- Measurements in psychiatry, their advantages and limitation.
- Research methodology, study design, generation of hypothesis, hypothesis testing, and designing research proposals (type of research study will emphasize on epidemiological surveys and clinical trials).

- Data analysis and statistics.
- In addition, Residents have to do an original research work relevant to psychiatry. For this purpose, they have to complete the followings:

d) Medical education

These will be covered in the first 9 months of Phase B. Courses will be conducted in modular format organized by the respective department in collaboration with the Basic Science Faculty. The assessment will be done as part of formative assessment and will be held jointly by teaching staff offering the course. Residents failing to achieve satisfactory level shall have another three months to recover.

10.2. Immunology and Genetics:

To be covered throughout the 33 months in appropriate clinical context. Formative and summative assessment will be taken along with clinical curriculu

Annexure 1:

Clinical Training Rotations:

Block 1							
Months	1st	2nd	3rd	4th	5th	6th	
Educational Program	Introduction to Psychiatry including Adult, Child & Adolescent, Forensic, Substance Misuse, Old Age. Rehabilitation Psychiatry, Learning disability and Psychotherapy. **Basic Courses:** Biostatistics, Research Methodology, Basic of Medical Education						E O B A
Clinical Training Rotations	• Inpatient, Outpatient and Psychiatric emergency • Drug De-Addiction Centers, Pabna Mental Hospital. • Adult,Forensic and Geriatric Psychiatry, Psychiatric Sex Clinic, Psychotherapy, ECT						
Thesis Work	**Protocol development/Submission/IRB clearance**						

Block 2							
Months	7th	8th	9th	10th	11th	12th	
Educational Program	Introduction to Psychiatry including Adult, Child & Adolescent, Forensic, Substance Misuse, Old Age. Rehabilitation Psychiatry, Learning disability and Psychotherapy. **Basic Courses:** Biostatistics, Research Methodology, Basic of Medical Education						E O B A
Clinical Training Rotations	• Inpatient, Outpatient and Psychiatric emergency • Autism Centers, Child Guidance Clinics, Geriatric Care Hospitals/Old Homes, Primary care/Community care placements • Adult, Forensic, Geriatric, Psychiatric Sex Clinic, Psychotherapy,ECT						
Thesis Work	**Patient enrolment, intervention and data collection**						

Block 3							
Months	13th	14th	15th	16th	17th	18th	
Educational Program	Adult Psychiatry, Liaison Psychiatry, Community Psychiatry, Psychiatric Emergency						E O B A
Clinical Training Rotations	• Inpatient, Outpatient and Psychiatric emergency • Placement in Psychotherapy Division • Placemcent in Emergency department • Adult,Forensic and Geriatric Psychiatry, Psychiatric Sex Clinic, ECT						
Thesis Work	**Patient enrolment, intervention and data collection**						

Block 4							
Months	19th	20th	21st	22nd	23rd	24th	
Educational Program	Adult Psychiatry, Liaison Psychiatry, Community Psychiatry						E O B A
Clinical Training Rotations	• Inpatient, Outpatient and Psychiatric emergency • Adult, Forensic, Geriatric, Psychiatric Sex Clinic, Psychotherapy, ECT						
Thesis Work	**Patient enrolment, intervention and data collection**						

Block 5							
Months	25th	26th	27th	28th	29th	30th	
Educational Program	Child & Adolescent, Forensic, Substance Misuse, Old Age. Rehabilitation Psychiatry,Learning disability and Psychotherapy						E O B A
Clinical Training Rotations	• Inpatient, Outpatient and Psychiatric emergency • Placement in Child & Adolescent Psychiatry Division • Forensic, Geriatric, Psychiatric Sex Clinic, Psychotherapy, ECT						
Thesis Work	**Data processing and Analysis**						

Block 6							
Months	31st	32nd	33rd		34th	35th	36th
Educational Program	Child & Adolescent, Forensic, Substance Misuse, Old Age. Rehabilitation Psychiatry, Learning disability and Psychotherapy			E O B A	Eligibility Assessment and Phase B Final Examination		
Clinical Training Rotations	• Inpatient, Outpatient and Psychiatric emergency • Forensic, Geriatric, Psychiatric Sex Clinic, Psychotherapy, Child and Adolescent Psychiatry,ECT						
Thesis Work	**Report writing and Submission**						