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By Joel Yager, M.D., and Jonathan F. Borus, M.D.

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Announcements

Association for Academic Psychiatry
1991 Annual Meeting

The 1991 Annual Meeting of the Association for Academic Psychiatry will meet from Wednesday evening March 7 through Saturday March 10 at the Hyatt Regency Westshore located on Tampa Bay in Tampa, Florida.

Our keynote speaker, Dr. John F. Greden, Professor and Chairman of the Department of Psychiatry at the University of Michigan, will address solutions for "A Crisis for Educators in Academic Psychiatry: Earn-As-You-Go Pressures Versus Teaching." The 1991 Psychiatric Education Award recipient, Dr. J. Thomas Ungerleider, Professor of Psychiatry at UCLA, will present a session demonstrating the creativity of his interactive program for teaching medical students about substance abuse.

Other workshops at the 1991 meeting will explore inpatient teaching, resident pregnancy and maternity issues, residents as teachers, geriatric psychiatry teaching, mentoring, reconciling academic careers with "life," supervision, managed care in academic psychiatry, effective teaching techniques, junior faculty issues, tenure tracks for teaching, how to get into print, how to review manuscripts and books, how to get started in research, and promotion issues.

A new format to be introduced this year will be collegial consultation about teaching problems. As is our tradition, a wide variety of free university sessions will be held for members to meet in small groups to discuss other pressing or impassioned issues. This year's "AAP Evening Out" will be our own private tour and dinner at the Salvador Dali Museum.

For further information contact: Mary O'Laughlin, Department of Psychiatry, Mount Auburn Hospital, Cambridge, MA 02238. Phone: (617) 499-5198.

American Association of Directors of Psychiatric Residency Training—Midwinter Meeting

The 1990 midwinter meeting of the Association of Directors of Psychiatric Residency Training will celebrate the Association's twentieth anniversary and will take place January 17–20, 1990 at Lowes Ventana Canyon Resort in Tucson, Arizona.

Allan Tasman, M.D., will be the Program Chairman for this year's event, entitled "Back to the Future—Our Twentieth Anniversary."

Mark your calendars now for this exciting anniversary meeting of the AADPRT. This year's meeting promises to be special in many ways. Highlights include:

- A special lecture by James H. Shore on "Order or Chaos: Subspecialization and American Psychiatry"
- Important new information from APA, RRC, and ABPN
- Over 45 educational workshops presented by leading educators on a wide range of vital topics
- Special sessions for new training directors, residents, and child psychiatrists
- Time to meet and get reacquainted with fellow training directors and enjoy the marvelous southern Arizona environment and the luxurious accommodations at the Ventana Canyon Resort
- Sunday morning breakfast panel on "Resident Recruitment: Problems and Prospects"
- A Western Cookout Dinner and a Mexican Fiesta
- A special AADPRT trip to the Arizona-Sonora Desert Museum, rated as one of the most outstanding botanical and zoological gardens in the world

Registration packets were mailed to AADPRT members in October, 1990. If you are not a member, but would like to attend, please contact: AADPRT Executive Office, Institute of Living, 400 Washington Street, Hartford, Connecticut 06106. Telephone: (203) 241-6855.
The American Association of Directors of Psychiatric Residency Training

Salutes the Selection of the

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Bruce A. Wright, M.D.
University of Pittsburgh/Western Psychiatric Institute

We look forward to their active participation in the AADPRT 1991 Mid-Winter Meeting and their ongoing commitment to the pursuit of excellence in psychiatric education and their future involvement in AADPRT.
In Appreciation

This issue marks the end of Academic Psychiatry’s second year. We would like to pause to express our great appreciation to the many people whose hard work and dedication have supported the rejuvenation of this journal.

As Editors we are most grateful for the sustained devotion of the members of our Editorial Board, who alone undertook all of the careful reviews for the first six issues and have been deeply involved in major policy decisions about the journal’s new format, sections, and focus. We express our particular appreciation to Drs. Robert Cancro, George Ginsberg, and Gene Usdin, who will be completing their Editorial Board terms at the end of 1990. We feel fortunate that Drs. Arnold Cooper, Stephen Scheiber, and Gordon Strauss have been selected by the journal’s Governance Board to follow in their footsteps. We are delighted with the expert Reviewer Panel assembled during the past year; our review process is already benefiting from their wisdom and constructive insights. The below listing of the names of our Editorial Board and Reviewer Panel members is a small sign of our gratitude to them.

Deep appreciation is also owed to our sponsoring organizations and publisher. The renewal of Academic Psychiatry was only possible through sponsorship by the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry. The intellectual and financial support of their members has been critical to the rejuvenation of the journal. We have also had superb cooperation and the highest level of professionalism from both Board and staff of our publisher and partner, American Psychiatric Press, Inc. Their willingness to unstintingly support the publication of a high-quality journal devoted to the community of academic psychiatrists has been vital.

Finally, we thank you, our contributors and readers, for investing your time and ideas in Academic Psychiatry. Your support invigorates our efforts and makes our work worthwhile.

Jonathan F. Borus, M.D.  William H. Sledge, M.D.
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Academic Psychiatry

Journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry

EDITOR
Jonathan F. Borus, M.D.

DEPUTY EDITOR
William H. Sledge, M.D.

FEATURES
Regular and special overview articles present empirical research and critical analyses of important topics in psychiatric education and academic psychiatry.

A “New Ideas” section details descriptions of innovative programs, curriculums, teaching strategies, techniques, and technologies in use by colleagues across the country.

Commentary provides readers with the opportunity to get an insightful view of emerging trends and pressing issues in academic psychiatry.

Letters to the Editor provides a forum for lively debate of published articles.
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*By Daniel J. Anzia, M.D., and John La Puma, M.D.*

Toward a New Alliance:

*Psychiatric Residents and Family Support Groups*

*By James G. Barbee, M.D., et al.*
IN APPRECIATION

In Appreciation

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Milton Viederman, M.D.

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Special Article

A Survival Guide for Psychiatric Residency Training Directors

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This paper catalogues the inevitable problems that beset training directors and describes coping strategies designed to improve the likelihood of the training director’s survival and the quality of his or her life. The difficulties of the job include picking residents, struggling to assure that the faculty provides decent teaching programs, contending with repetitive bureaucratic details, being overloaded by numerous tasks, and warily watching as residents who somehow squeaked through the program are sent off on their own. Offsetting the hassles are the exciting jobs of picking residents, guiding the faculty in setting up teaching programs, keeping a complicated program running, mastering numerous challenges, and watching with satisfaction as new, competent psychiatrists graduate.

The role of training director can be short-lived or life-long. Some occupants have had enough of it in a year or two, recognizing that they are not well suited for the position (or giving their departments enough time to make the assessment for them); others, competent enough at the job, use it as a stepping-stone to take them either up or away from the academic ladder. For many it’s a way station between residency and something else—practice, full time research after grants are obtained, or a different administrative or clinical role in an academic department.

In some departments the position is a tag-on to other major responsibilities, a burdensome administrative appendage. In most departments, however, it is recognized as consisting of enough work and responsibility to merit a full-time or nearly full-time position. In past years up to one-third of psychiatry chairmanships were said to have been filled by previous training directors; however, currently these jobs are more likely to go to faculty with stronger basic research credentials than most training directors garnered. Most training directors hold this job for three to five years, although long-time survivors are not uncommon.

As veteran training directors with many years in the role, our aim in writing this paper was to provide a survival guide for those who find themselves directing training programs and to enhance their durability (should they so choose), quality of life, and effectiveness regardless of how long they endure. As prerequisite, only some types of people are likely to do the job well.

From our vantage points, personality traits that contribute to enjoying and being successful at this position include liking and being able to get along well with most peo-
ple (including hypersensitive, narcissistic, and rigid personalities); being nurturing, even toward occasionally entitled and surly types; wanting to be loved, admired, feared, and ridiculed; having integrity; enjoying overstimulating, if not frankly chaotic, environments; being able to attend to detail or finding others who can; enjoying authority, but being able to take direction both from those below as well as from those above one in the chain of command; identifying with the struggles of both residents and faculty; being able to tolerate organizational as well as clinical ambiguity; having an interest in educating others as well as oneself; having a comprehensive psychiatric perspective; being politically and socially adept; and having a willingness to work long hours, nights, and weekends.

THE HASSLES OF EVERYDAY LIFE

The training director is the middleman par excellence (1). Like the charioteer in the ancient parable being pulled in all directions by a team of unruly horses, the training director needs to harness and gain some measure of control over the many challenging forces pulling him hither and yon, so that all can work together in an organized way toward a common goal. We will describe the many “horses” pulling (or on occasion, charging directly at) the training director. Although training directors must make personal decisions about which horses are most demanding, all need care.

Residents

As the major focus of the program, residents require considerable attention. First, their selection. If a program is lucky, there are enough of the types you want when they’re needed. But, even in the best of programs the likelihood of a timely abundance of applicants for picking and harvesting is remote. Something always happens to upset the best laid plans: residents fall in and out of love (with partners only sometimes in the same city as your program), or experience sudden changes in their family, health, gravid state, or other circumstances of life that thwart their training plans and the program’s schedules. Applicants who wouldn’t have even been considered on Match List Submission Day suddenly look more attractive in June when a spot unexpectedly opens up and service pressures mount.

Most residents, individually and collectively, are excellent and fun. However, the occasional “disturbed and disturbing resident” (2) can upset the equilibrium of any residency program. Residency is frequently a difficult time that tests the adaptive capacities and character of those going through the ordeal. Part of the training director’s role is to help residents become acquainted with their particular ways of handling things. The following types of problematic residents bear particular mention:

Dr. Goading Complainer. We all know that residents have a lot to complain about; no system is perfect and everyone involved in the training business should be dedicated to identifying real problems and doing whatever can be done to solve them. All residents’ complaints should be taken very seriously. Within this context, some residents are consummate complainers, often without a legitimate cause. “Goading” has learned at an early stage that the best defense is a good offense. He enjoys keeping the authority figures off balance through criticism and hopes that by taking charge of the talking agenda there won’t not be enough time left for careful scrutiny of his own work and shortcomings.

Dr. Phantom. Within the loose and permissive structure of many programs, the Phantom manages to find all the cracks to slip between: getting out of rounds, patient assignments, presentations, etc. He may sometimes be found in the local moonlighting parlor during the day.
Dr. Shaky. Dr. Shaky lacks the self-confidence necessary to make independent medical decisions and requires far more hands-on supervision throughout training than 95% of residents, not necessarily because he lacks knowledge, but because he lacks conviction about using that knowledge. The good news is that he’s extremely careful about checking with faculty before instituting major therapy with which he is inexperienced. The bad news is that he’s extremely careful about checking with faculty before instituting anything.

Dr. Know-It-All. Dr. Shaky’s counterpart, Dr. Know-It-All, was blessed, it seems to him, by being born knowing everything he ever needed to know, or being able to intuitional knowledge PRN, better than with a direct line to MEDLARS. You can’t tell him anything. More precisely, you can tell him whatever you want to, but it will matter little. Knowing it all, he usually makes himself scarce in supervision situations.

Dr. Radical. Dr. Radical seems ready to throw over the bastions of whatever seems to be established practice in favor of a revolutionary new idea. Most often—but not always—he appears as a particularly flamboyant incarnation of Dr. Know-It-All, spouting off half-baked ideas. The real challenge for discerning training directors and faculty is to distinguish between true creative innovation and fuzzy-minded balderdash. The truly creative radical is usually able to make a good case for his innovative notions, bolster them with scholarly support, and convince at least some of the more open-minded faculty of their merits.

This non-exhaustive review of problematic resident types would not be complete without recognizing that hassles related to the resident group as a whole are common as well. Organized residents can be one of the most creative and energizing forces in a training program, and their contributions to problem identification and problem solving should be valued and appreciated as perhaps the most potent force available to the training director who senses the need for change. However, during any change process, stirred passions within the residency group may occasionally mimic the Chinese Cultural Revolution, with various faculty members wearing the dunce cap. The principle of seeking out the kernel of truth in the attack, siding with the reasonable aspects of the house staff’s perspective, and joining forces with them to solve mutually agreed upon problems always pays off.

Chairmen

Without a great working relationship with and the complete endorsement of the department chairman, the training director’s job is ultimately undoable. The best chairman is one who values training, holds residents and their work in esteem, gives you what you need, leaves you alone, backs you up when necessary, meets with the residents as you direct, and facilitatively mentors your career. The presence of such a chairman may account for the longevity of training directors in some places; the presence of one of the types of chairmen described below may account for training directors’ brief tenure elsewhere.

Dr. Overinvolved Mother. Hovering, overinvolved, and overinvested in the training program rather than in the other aspects of the chairmanship, Dr. Overinvolved Mother may often compete with the training director for the affection of the residents and the day-to-day authority over their activities. In many cases he was once a training director, and he may be secretly sorry that he left the job.

Dr. Splitter. Dr. Splitter invites end runs of the residents and faculty around the training director and may set up the training director to take the blame for problems beyond the latter’s control.
Dr. Low Priority for Education. A politician-administrator-money maker-scientist who has little interest in training, Dr. L.P. may even mean well, but he just doesn’t quite know how to support training or the residents, especially when other people and priorities grab his attention. He sees training as something to get done with as little trouble as possible in order to get on to the really important stuff—politics, administration, making money, and research.

Teaching Faculty

In addition to the devoted, talented, flexible and cooperative faculty who are eager to teach, you are sure to encounter the following types.

Dr. Excuse. For fully understandable and excellent reasons (that come in a wide assortment of shapes, sizes, and colors) Dr. Excuse, the galaxy’s expert in difficult personality disorder (DPD), can never quite deliver even an off-the-cuff, “wing it,” seminar what/when/how you ask him to teach. He is always out of town/writing a grant/preparing to be site visited/detoxifying from a site visit/doing a site visit/meeting with potential donors or a foundation president, etc. As a result, you settle on asking Dr. Always Available to teach DPD, and as usual Dr. Available comes across with an excellent seminar that took him many weekends to prepare.

Dr. My Way or the Highway. Blessed direct recipient of the Word of God, Dr. My Way (genetically related to Dr. Know-It-All, but they would both deny it) mixes equal doses of authority and rigidity, often earning him a resident diagnosis of DPD. Unintentionally, Dr. My Way usually alienates most potential converts to his point of view, except for a few of the more timid, easily impressionable residents who are in awe of authority figures and cannot bring themselves to believe that universities can actually promote people with thought disorders to high academic posts.

Service Chiefs

Service chiefs who understand residents’ needs and view training as a joyful enterprise are worth their weight in platinum. However, in addition to such people, you might also encounter the following two types of service chiefs.

Dr. Simon Legree. Driven to produce, Dr. Legree sees the residents assigned to his service as cannon fodder in the wars on mental illness/meeting admissions and discharge quotas/getting his research done. His motto is “Pile it on, there ARE 24 hours in a day, and you learn ONLY by taking care of patients, including your 67th demented patient this week.”

Dr. Can-You-Just-Take-Care-of-This-One-Thing? This service chief has the residents’ best interests and training at heart, but somehow always manages to come up with one little thing he’d like the resident to do at exactly the time that core curriculum seminars are scheduled.

Schedules and Assignments

Schedules and assignments are both the joy and the bane of the training director’s life. Although some details are often delegated to an administrator or chief resident, the complexities are the meat and potatoes of “directing”: How many residents are assigned which services and for what lengths of time? How will unforeseen gaps and unfilled positions be handled—i.e., with whose blood, sweat, and tears? For some reason, no one has given training directors unlimited rabbits (residents) to pull out of hats, nor dictatorial authority over house staff and faculty. Therefore, getting all parties to agree, even begrudgingly, or not agree but to live with changes in schedules and assign-
mements is an essential part of the training director’s role. Old hands realize that its always wise to have those people who will have to live by the schedules take a major role in producing and implementing them, to whatever extent that is peacefully possible.

Institutional Quagmires

Some institutional problems are so mired in bureaucratic difficulties that they defy the most sympathetic administrators. The training director may find himself dealing with such entangled issues as health and maternity leave, moonlighting policies and policing, assuring safety and security for residents in emergency rooms and around the hospital grounds, and assuring adequate medical coverage and consultation for medically ill psychiatry patients on general psychiatric units. Many of these thorny issues involve systems and policies beyond the control of the training director and, at times, the chairman. Although hours and hours of meetings may occasionally yield gratifying solutions (or creative temporizing) for such difficult problems, many have a way of resurfacing, like gophers in a lawn, after they presumably were settled. The astute observer learns to identify and avoid getting entangled in uncontrollable, unmanageable, and uninfluenceable situations. Life is simply too short.

Routines and Rituals

The residency education office is like a farm, working a predictable 12-month calendar that tells when to plant (Match List Day), when to fertilize (most of the time), when to weed (occasionally), and when to harvest (June). During applicant interview season many training directors and other faculty interview enough medical students to fill a walk-in clinic several times over, and they may start to feel like a broken record. When one determines in the first two minutes of the interview that the applicant is a dud, having a variety of time-saving techniques is critical. Our favorite is to stop asking questions, tell the applicant that the information in the folder is complete, and invite him to ask questions of you; this ordinarily cuts the interview time in half.

The interviewing and selection aspects of the job will appeal to those with show business aspirations, because like actors in a Broadway hit they will hear themselves giving the same speeches (with very little alteration) and telling the same jokes in numerous performances for years on end.

Funding

The first responsibility of the training director is to assure that there are adequate resident stipends for the program. Short of selling one’s first born, there are few barriers to these negotiations. Many training directors prepare for their interdepartmental and intradepartmental swim with sharks (the specific species are squalus deamus, squalus hospital directorus, and squalus chairmanus), piranhas, and other denizens of the deep by such toughening up exercises as training for iron man competitions, being kicked out of a Wall Street firm for being too unethical, or graduating with honors from the Jimmy Hoffa Graduate School of the United Auto Workers’ Continuing Education Program.

After the question of stipends is settled, and assuming that the residency program must somehow make do with the number of positions allocated to it, the direct and indirect costs of running a program often exceed the available bucks: there’s often not enough administrative or secretarial support, and often fewer dollars than needed for such niceties as training materials, tapes and recording equipment, resident travel to meetings, social events, weekend retreats of residents and faculty, baby presents, graduation dinners, weddings, etc. Training directors should use all manners of influence, salesmanship, and benign coercion to nego-
tiate at least some separate budget for residency education from involved departments, hospitals, and other facilities.

**Academic Pressures**

In university-based residencies, training directors are under pressure as academic faculty to get grants, produce scholarly work and research, and publish. While, as below, we recommend that the training director take a lead role in educational research, developing a noneducational research focus along with running a training program may be more prime-time programming than many training directors can stand.

**Overload**

Psychiatric training directors (and other academic psychiatrists) probably have the highest prevalence of Overextended Personality Disorder (OPD) of any known group. OPD is THE Yuppie disease of the '70s, '80s, and '90s and will be the subject of an upcoming paper by Drs. Yager and William Sledge. This syndrome results from having too many REALLY IMPORTANT things to do (administration, clinical care, teaching, research, and family life) that require a 72- to 96-hour day to do properly. Adding some personal time (for exercise and the bathroom, for example) requires extending these estimates even further. Objective measures include incoming phone calls per hour and number of phone calls returned per minute of free time. Predisposing factors to the development of OPD include being stimulus seeking, stimulus bound, taking things seriously, and being a people pleaser.

**SURVIVAL STRATEGIES**

Various training directors have employed a diverse set of coping strategies. These survival techniques, including prioritizing, bridge building, triaging, delegating, and carefully scheduling and managing time, should be useful for many other faculty members as well.

**Prioritize.** The first order of business is scheduling regular meetings with oneself to define and redefine one's own values and priorities. The training director must regularly reassess the desirable mix of self- versus other-directed administration/teaching/clinical care/research/family/personal time and activities, recognizing that these will shift over time with one's personal and family life-cycle stages, evolving professional interests, manifestation of latent talents, shifting levels of altruism and ambition, mood swings, sleep deprivation, season of the year, blood glucose level, and hormone shifts. It is wise to prepare "rough budget estimates" allocating time to each area, with zero-based budgeting on at least a yearly basis. Some of these meetings may profitably be held with someone else in the room, such as a supportive spouse or empathic therapist.

**Communicate.** An open communications style with residents and faculty pays off handsomely in both satisfaction and efficiency. In addition to frequent, regularly scheduled meetings with various resident groups and participation in central faculty and staff activities, enjoying non-work-focused social occasions with both residents and faculty increases the sense of family and togetherness that makes work a more enriching place for all. Take a resident (or all the residents) to lunch; or even, take your chairman to lunch! These activities will maximize your awareness of fast-moving developments and build the necessary interpersonal bridges that facilitate effective problem solving.

**Keep a broad perspective.** The more all-embracing and inviting one's professional view, the better one's chances of helping house staff and faculty feel valued. To avoid unwittingly contributing to professional splitting,
learn to appreciate the positive contributions of each point of view in psychiatry, and of clinical work, research, teaching, and administration, while at the same time feel free to be direct and constructively critical. One’s perspective should be broad enough to include the possibility of making mistakes and being wrong: one of the most valuable lessons a training director can teach residents by example is to accept justified criticism rather than raising a defensive shield.

Delegate. As a rule, after briefly assessing the various issues that come his way, the training director should delegate as much of the work as is reasonable to others in the nearby vicinity. With the good fortune of highly competent people around to help, this can go well; without good administrative help the training director is in big trouble. With a good “kicker file” and calendar in place, a large number of recurring activities, reports, and requirements may be handled almost entirely by a competent staff.

Involving other faculty. A la Tom Sawyer, wise training directors have employed various strategies to meaningfully involve other faculty in painting the residents’ fence. These have included appointing separate faculty to be responsible for the curriculum development and content of each year of training, having autonomous residency selection and evaluation committees chaired by other faculty members under the auspices of the main residency education or training committee, and delegating responsibility for regularly scheduled individual feedback sessions with residents regarding their progress and evaluations to individual faculty preceptors (training supervisors) (3). Organized (and disorganized) resident groups are also important friends, often offering the most constructive advice.

On a national level, resources available for informational, emotional, social, and philosophical support and advice include the major national organizations such as the American Association of Directors of Psychiatric Residency Training, the Association for Academic Psychiatry, and the American Psychiatric Association, the Handbook of Residency Training Directors (4), and the telephone.

Appoint associate training directors. Particularly in the larger, more complex programs, or where the training director has other institutional and national responsibilities, an associate training director should be appointed. It’s essential to have enough faculty-level authority available on-site to care for the multiple, often immediate needs and demands of the program. In addition, since the administrative burden on the training director can leave little time for other professional activities, it’s important to divide the work AND the rewards.

Use basic time-management techniques. Time-management consultants suggest dividing work into three piles. Pile A needs immediate attention, Pile B can wait a day or two or until the weekend, and Pile C can wait until I get to it, IF I get to it (5). When you need to go into BASIC survival mode (I just can’t do it all, or I’ll get sick), it’s amazing how much can wait, at times indefinitely, if it has to. Studies show that physicians who do basic time management lead more satisfying professional and personal lives than those who don’t (6,7). Several good references are readily available (5,8,9,10).

Just Say No. Having a large Nancy Reagan anti-drug sign posted above the telephone may stimulate inhibiting neurons for a few milliseconds before one agrees to take on the next irresistible offer/project/request to lecture elsewhere/write a book/join an important regional, statewide, or national committee extended in one of the training director’s deluge of incoming calls.

Have a slush fund. Slush funds make the world go round. Depending on local zeit-
geist, good connections with your pharmaceutical representatives, hospital auxiliary and volunteer associations, professional practice plan discretionary funds, and beneficent donors can yield contributions to your “Friends of Psychiatric Education” checking account that provide the oil to keep the program’s engine going, elevating the ride from third class to something a bit higher.

Do yourself a favor. Favors come in all sizes, shapes, and flavors: supervise a favorite resident; teach a stimulating course (and update/change what you teach often enough so that you don’t go stale); or challenge yourself with a new area of scholarship or research every few years (including systematic studies of aspects of residency education that seem particularly vexing, since research is an excellent defense against impotence, and who knows, maybe we’ll all learn something) (11). Most important, take some time off once in a while to smell the flowers before you get geriatric anosmia.

References
2. Garetz FK, Raths ON, Morse RH: The disturbed and the disturbing psychiatry resident. Arch Gen Psychiatry 1986; 33:446–447
5. Lakein A: How to get control of your time and your life. New York, Peter H. Wyden, 1973
Regular Articles

Interrater Reliability in Evaluating Trainee Interviewing Skills

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Merril MacD. Allen

The reliability of the evaluative judgments by psychiatric faculty of physician-trainee interviewing skills was studied. Three methods were included: global rating scales, data checklists, and a time-allocation form. Data were obtained during a training workshop for psychiatric instructors in the U.S. The authors found low interrater reliability with all three methods. The study findings were replicated at a second workshop with Canadian faculty. The authors outline some recommended modifications of observational systems that may help improve both the accuracy and reliability of ratings of trainee interviewing skills. The use of more accurate quantitative techniques is briefly reviewed.

The ability of a physician to provide effective medical care is dependent upon the utilization of good interpersonal skills, including medical interviewing (1-4). Despite their importance, the amount of teaching and evaluation of these skills varies considerably from one U.S. medical school to another. For example, in a 1978 nationwide National Library of Medicine (NLM) survey regarding interpersonal skills instruction, Kahn et al. found that only 69% of the reporting programs employed some form of direct observation of the student with a patient (5). Few schools required formal demonstration by students of proficiency in medical interviewing skills.

In the United States, the licensing authorities have been even less willing to undertake the task of evaluating these skills. For about 70 years, we have had two tracks to medical licensure in the United States: 1) licensing procedures under direct responsibility of individual states; and 2) the three-component examination administered by the National Board of Medical Examiners (NBME).

Beginning in 1922, the NBME employed a three-part examination, the third segment of which was taken shortly after graduation from medical school (6). The Part III examination included patient demonstrations and, up until the late 1950s, included trainees conducting medical interviews. This practice was officially abandoned in approximately 1965 in favor of an exclusive reliance on paper-and-pencil techniques. The reasons included a combination of poor interrater reliability by physician examiners, the growing number of examinees, and logistical difficulties associated with finding enough suitable patients for the examinees to interview and examine (7).

The Federation Licensing Examination (FLEX) was first administered in 1968 and was designed to replace the multiple examinations produced by individual states (8).
Over the next decade, FLEX examination was adopted by virtually all states. Since its inception, it has been based heavily on NBME procedures and, as a result, also does not include observation of examinees with patients. In the past several years the NBME has had a task force and an assigned staff which, together, have been directed to develop means of assessing clinical skills for certification and/or licensure (9). Perhaps assessment of medical interviewing skills will be readopted by the NBME and/or state licensing authorities in the next decade.

Evaluation of medical interviewing as part of U.S. graduate training in the medical specialties is similarly deficient. With two exceptions, none of the American Board of Medical Specialties member boards includes assessment of medical interviewing skills as part of specialty certification. The two exceptions are the American Board of Internal Medicine and the American Board of Psychiatry and Neurology (ABPN). In its Part II oral examination, the ABPN requires candidates to evaluate psychiatric or neurological patients. In recent years, ABPN evaluation of psychiatric candidates has included one examinee-patient encounter observed by two examiners who separately complete two global rating scales; and a second examination of the candidate after viewing a videotape of an interview of one additional patient. Our findings of low reliability coupled with the reports cited below regarding predictive validity raise troublesome questions about use of global rating scales and only two candidate examination sessions for important pass-fail judgments.

The lack of confidence in our methods of assessing medical interviewing skills in an accurate and reliable manner may be the major reason why medical schools, licensing authorities, and specialty boards have been reluctant to require trainees to demonstrate minimal performance standards for this aspect of clinical competence. If physician trainees are to be required to demonstrate a certain level of proficiency in medical interviewing, the evaluation of these skills should be carried out in an accurate, reliable, and valid manner. The ethical reasons are self-evident. The legal reasons reflect the growing practice of individuals who have been dismissed from medical school to sue the medical school for reinstatement; and for individuals who have been denied medical licensure to sue the responsible agency (10).

The NLM survey cited above showed that the use of global rating scales was the most popular evaluation instrument for those programs employing direct observation. Their continued popularity contrasts sharply with the results of several previously published studies which have demonstrated that the use of global rating scales typically results in poor interrater agreement (7,11–13). The latter is a form of reliability and refers to the reproducibility of the observer’s judgments (i.e., if two raters view the same sample of behavior, how similar will the resulting ratings be). For example, in 1969 Hess (12) reported that the reliability of one global rating scale ranged from 0.57–0.71. (Perfect agreement between two separate raters would yield a correlation of 1.00.)

Another type of reliability is accuracy, which is defined as a comparison between an observer’s ratings and an established criterion (14). Assurance of an observer’s accuracy is preferred over interrater reliability; if an observer’s assessments are sufficiently accurate (i.e., are reliable when judged against a well-defined standard), there is much less need to document interrater reliability. So far, the published reports regarding global rating scales have focused on interrater reliability and have not attempted to deal with the problem of accuracy. This omission may reflect 1) a failure to appreciate the difference between interrater reliability and accuracy or 2) an underlying realization of the difficulty of devising criteria for global rating scale characteristics that have not been sufficiently well defined.

In view of the continued popularity of global rating scales in evaluating medical
interviewing, the authors undertook a study with two research goals: 1) to redetermine the reliability of global rating scales and 2) to compare the reliability of the global ratings scales with several other direct observation interview assessment techniques. The study focused on trainee interviewing skills that, although not synonymous with interpersonal skills, represent a major clinical task for which interpersonal skills play a very important role.

The opportunity to accomplish these research goals came about as the result of a workshop that was sponsored jointly by the American Psychiatric Association (APA) and the NBME to help psychiatric instructors improve their teaching and evaluation skills. The workshop was held in Philadelphia and included 94 psychiatrist participants, all of whom were junior or mid-level medical school faculty members. One of the three workshop sessions focused primarily on the evaluation of trainee interviewing and interpersonal skills. Two years after this APA/NBME workshop, the authors replicated this study in Montreal with a group of 65 Canadian participants. However, only the APA/NBME workshop results will be reported in total since there was a substantial agreement of findings between the two sites.

Both the U.S. and Canadian workshops were designed to provide each participant with an opportunity to use the following three assessment techniques: 1) a global rating scale containing commonly employed evaluative statements that are familiar to most instructors (e.g., explains purpose of the interview to patient); 2) a modified version of a patient-specific data checklist designed to measure the information obtained by the interviewer (15); and 3) a time-allotment form designed to generate data that would resemble that provided by interaction analysis (16,17). Although most instructors are rarely, if ever, asked to make quantitative estimates of trainee behavior, many evaluative judgments by instructors depend upon inferences similar to the quantitative estimates required with the time-allotment form (e.g., an instructor's judgment that a medical student talked too little and was therefore too passive during an interview).

METHODS

The 94 Philadelphia participants were drawn from 21 northeastern and mid-Atlantic states. On the first day of the workshop the 94 participants were divided into three groups, each group rotating through each session separately. In this report, the three groups have been treated as one. The authors used three videotape segments showing the initial 3.5 minutes of three different interviewer-patient encounters. Interview-specific rating forms were prepared. Each form included the following three sections.

Section I—Data checklist. The authors employed a patient-specific checklist which typically focuses on the patient's current problem(s) and includes a list of topics which instructors feel a trainee should obtain with a given standardized patient; the observer is required to specify if certain elements of the clinical history were requested and/or actually obtained by the interviewer. A criterion scoring for each of the three checklists (one for each videotape) was based on multiple viewings of the videotapes by the project staff. For each interview, the workshop participants were asked to indicate whether the information in each data checklist element had been elicited during the interview. Analyses consisted of determining the percent of correct responses by each participant (accuracy).

Section II—Global rating scale. This section contained ten generic statements which had been selected from typical global ratings forms recently in use by U.S. medical schools. For each of the ten global statements (e.g., explains purpose of interview), the par-
participants were asked to indicate which of five phrases best applied to the interviewer. Four of the phrases ranged from "highly characteristic" to "highly uncharacteristic"; the fifth phrase was "does not apply." For purposes of analysis, we combined the original five phrases into three categories: characteristic, uncharacteristic, and inapplicable. Analyses consisted of determining the variability of responses among the group (an indirect measure of interrater reliability). No attempt was made to determine the accuracy of these responses.

Section III—Time allotment form. The participants were asked to estimate the percent of interview time spent in various types of interviewing activities (e.g., the amount of time used in talking to the patient). Analyses of this section included: 1) summarizing the participants' time estimates for the interview behaviors; and 2) comparing the mean of the pooled judgments with the data generated by using the 1981 version of the NBME-designed Interaction Analysis System for Interview Evaluation (ISIE-81) to summarize these same behaviors (18–20). ISIE-81 includes 29 mutually exclusive categories of behavior (e.g., the trainee asks the patient a direct question about a medical problem). While watching a videotape of a trainee-patient interview, a trained observer records every two seconds into a microcomputer the behavior which best characterizes the last two seconds of the interaction.

Hartman has summarized some of the issues involved in selecting a reliability statistic (14). The authors employed Scott's coefficient, which provides a mechanism of determining differences in frequency of responses (21). Some investigators would argue in favor of a statistic that determines raw interval-by-interval agreement, such as that provided by the widely employed Cohen's kappa (16); this approach would make the ISIE analyses far more costly. In addition, the use of a 29-category system (in comparison to two- or three-category systems) makes the assessment of interval-by-interval agreement less advantageous. The interrater reliability of trained ISIE coders is approximately 0.72–0.82; mean intrarater reliability is 0.84 with 62% of the values in a series of 59 reliability checks falling between 0.85 and 0.95 (19). In this study, ISIE-81 data were used as a standard against which the accuracy of the participants' ratings on the time allotment form could be estimated.

At the beginning of the interview skills session, instructions for using the color-coded, patient-specific forms were reviewed with the group before the first videotape was shown. The participants then watched the first of the three 3.5-minute videotapes, completed the appropriate form, and repeated the process with the second and third interviews. The three sections of the rating form were kept in the same order for all three interviews. At the first two interview skills sessions there were a few late arrivals who did not complete the evaluation of interview 1 and/or interview 2; as a result, the sample size changes from a low of 89 to a high of 94.
Throughout each session, the participants watched each videotaped interview in a very attentive manner and appeared to be highly motivated to provide an accurate assessment of the three interviewers' skills.

Two years later, the study was replicated at a Montreal workshop with 65 psychiatric educators. Two of the original videotapes were shown, each extended to eight minutes. Unless otherwise specified, the data and analyses described below refer to the initial Philadelphia workshop.

RESULTS

Data Checklists

Figure 1 illustrates the scoring distribution reflecting participants' accuracy in handling the three sets of ten data checklist questions for each of the three patients. A wide range of responses was obtained. For example, with interview 1, 19 of the 89 instructors were 100% accurate in identifying data that were discussed; however, 10 of the 89 instructors achieved only 60% or less accuracy. The Montreal findings were similar.

Global Rating Scales

Participants exhibited great variation in global ratings. In ratings of interview 1, there was a moderate degree of consensus for rating scale statement 12 ("Takes initiative to prevent uncomfortable silences"); 82% of the participants felt statement 12 was characteristic of the trainee interviewer. However, for rating scale statement 14 ("Uses questions to clarify what the patient means") for interview 2, there was poor agreement: only 50% of the observers felt that statement 14 was characteristic of the interviewer. For all three interviews, statement 18 ("Takes cognizance of patient's affect"), statement 19 ("Responses indicate a professional awareness of meaning of patient's problems"), and statement 20 ("Gives evidence of empathic understanding of patient's communications") all showed poor agreement. In the Montreal replication, there was similar variability in judgments made by the 65 Canadian participants.
Time Allotment Forms

The participants' accuracy in estimating the amount of time taken up by certain types of interaction are shown in Figures 2 and 3. These judgments showed the least consensus; for example, the participants' estimates of interviewing talk time for interview 1 ranged from 15–80% (Fig. 2). Estimates of the amount of affective focus for interview 1 (Fig. 3) reflected even less agreement, ranging from 0–95%. The Montreal replication resulted in similar findings.

DISCUSSION

Findings

Our results demonstrate serious problems in trying to get faculty to make reproducible judgments about trainee interviewing skills. The poor reliability associated with the use of global rating scales in this study corroborates previous reports; this finding is especially disturbing because of the widespread popularity of global rating scales and their continued use for specialty board certification (5).

Similar difficulty in achieving accurate and/or reliable judgments of complex trainee tasks have been seen in evaluating trainees' psychotherapy skills (22), in assessing medical student patient case reports (23), and in undertaking diagnostic evaluation of psychiatric patients (24). For example, Liston et al. arranged for 13 experienced psychiatrists to evaluate psychotherapy interviews of six residents, using a global rating form (22). The authors found that the agreement among the resulting judgments was uniformly low.

Brevity of Tapes

Was the brevity of the interview segment (i.e., only 3.5 minutes) a significant factor in our failure to obtain reliable and accurate instructor ratings? We think not. In considering this question, it is important to distinguish between the concept of interrater reliability, accuracy (both defined above), and other attributes of observational techniques such as predictive validity. We were unable to find any evidence in the literature that interrater reliability is enhanced by lengthening the observation time. Examples of high interrater reliability for very brief periods of observation can be seen during televised Olympic ice skating and diving competitions. Moreover doubling the length of the observation period during the Montreal replication resulted in no improvement in reliability or accuracy of instructor ratings.

Predictive validity refers to the extent to which performance during a given test situation will help predict performance in another situation (e.g., in a second testing situation or while carrying out unobserved routine clinical responsibilities). Published reports provide substantial evidence that as far as diagnosis-related behavior is concerned, predictive validity is greatly affected by the number of encounters one observes (25). For example, in a review of published studies regarding the evaluation of trainee problem-solving skills, McGuire concluded that judgments made on the basis of observation of a trainee with a single patient with one type of problem would fail to provide an accurate prediction as to how the same trainee would perform with another patient having a different type of clinical problem (25). The studies which McGuire summarized suggested that an observer must review many encounters (e.g., 9–12 encounters) of the physician trainee with patients who have a variety of clinical problems in order to predict reliably the trainee's overall problem-solving skills. The measures of problem-solving skills in the papers cited by McGuire tend to focus on the trainees asking crucial diagnosis-related questions, and did not focus on other aspects of medical interviewing skills.

Our own unpublished data tend to support McGuire's conclusions and also suggest
that diagnosis-independent interviewing performance (e.g., the relative balance of open-ended versus direct questions and the ability to use empathic responses) tends to be moderately consistent across cases.

In observing performance, reliability and predictive validity cannot always be clearly separated. For example, although correlations in performance from one clinical encounter to another reflect predictive validity, the same data can be viewed as test-retest reliability (10). The study reported herein focused on interrater reliability and accuracy, not on predictive validity.

RECOMMENDATIONS

Global ratings. The use of global ratings should be abandoned unless the user can document adequate interrater reliability of the system (i.e., the combination of a rater and rating form which, when used together, provide accurate and reliable ratings). Liston et al. expressed similar misgivings about the use of global rating forms in evaluating resident psychotherapy skills (22).

Multiple ratings. One approach that might make global ratings sufficiently reliable would be to have several observers evaluate each encounter and combine the independent ratings of performance into a single score. Hollifield et al. demonstrated that combining independent judgments of five instructors for a given trainee-patient encounter provided good reliability with judgments made by the same group reviewing the same taped interviews six months later (26). Such an approach would probably be viewed as entirely too demanding of faculty time for a medical school or residency training program to undertake on a regular basis.

Training of faculty. Olympic judges obtain considerable on-the-job training through years of experience at lower levels of competition; and repeated opportunities to compare their own ratings with the ratings of many of their colleagues. Would similar training of faculty result in acceptable levels of accuracy and reliability? In the case of data checklists, the fact that a substantial number of faculty were very accurate suggests that with training, other faculty might be able to bring their accuracy up to an acceptable level. Although faculty raters could be given the option to replay the tape to improve the accuracy of their ratings, it seems unlikely that they would observe interviews lasting 20 minutes or more for a second time. One of the advantages of data checklists is that although faculty input is essential in their design, one need not use expensive faculty time to collect checklist data. In the case of global ratings, the potential results of training are unclear. Hinz reported that following careful training of faculty observers, he was able to get faculty pairs to reach 75% agreement and concluded that sources of inconsistency were inherent in the use of global rating scales (11). McLeod recommended that global assessment of student case reports be abandoned and be replaced by a standardized assessment instrument (23).

Use of standardized patients. Another approach would be to employ standardized (simulated) patients and have the latter evaluate trainee interviewing skills. The term standardized patient (SP) refers to individuals who are trained to simulate a given patient's clinical problem (the medical history and/or physical examination findings). The SP rating forms are typically a hybrid of global judgments and checklists. Although published reports have claimed that SPs can provide reliable judgments about interviewing skills, many of these reports have contained relatively little detail about interrater reliability (27,28).

Design new qualitative instruments. Our study suggests that thorough field testing of a large number of rating statements might make it possible to collect a series of state-
ments which, in the hands of the typical instructor, would provide reliable data. A more promising approach may be seen in development of anchored rating scales in which each point on a scale is defined behaviorally.

Quantitative measures. Over the past two decades, the authors have undertaken a number of studies employing quantitative methods of evaluating interviewing skills (29). Our efforts have been directed primarily toward the use of interaction analysis, the ISIE-81 system, and two forms of data checklists: patient-specific checklists (see above) and generic checklists. A generic checklist includes a list of topics about which a group of instructors feel the trainee should inquire for a given type of patient (e.g., the data base which a trainee should acquire in the initial evaluation of most adult ambulatory patients) and tends to pay relatively little attention to the patient’s present illness. Generic checklists assess thoroughness in obtaining many aspects of the patient’s history other than the present illness. In the hands of trained personnel, these quantitative approaches provide acceptably accurate and reliable judgments (r = 0.78–0.86) regarding performance.

Quantitative measures provide educators and researchers with other important advantages, especially that of being able to conduct comparisons of performance (e.g., a comparison of the effectiveness of one form of instruction over another). In addition, quantitative measures provide a mechanism for setting explicit standards and in determining, in a reliable and accurate manner, a trainee’s ability to meet those standards (20).

Previous studies have shown that trainees throughout the United States exhibit wide variations in the balance of medical and psychosocial data collection, limited use of open-ended questions, virtual absence of empathic responses and attentive silence, and highly variable data collection patterns for a given patient with a given clinical problem (16). If these medical interviewing behaviors are important tools that trainees should acquire, we need methods to monitor the acquisition of these skills by trainees.

Although interaction analysis is an excellent research tool, can it be used for operational assessment of trainees? The major disadvantage is its cost, especially the cost of training a coder. In our experience, training a coder requires about 20–40 days of part-time, but carefully supervised, practice. If the expense of training and maintaining an accurate coder is shared among a group of medical centers, overall costs might not be prohibitive. Further savings could be achieved by using interaction analysis to monitor the overall success of an instructional program by applying this technique to a sample of trainees and not attempting to employ it as a means of making pass-fail decisions for individual trainees.

The problem of poor predictive validity regarding diagnosis-specific data collection based on the observation of a trainee with only one or two patients could be solved by observing the trainee with a large number of standardized patients. Such an approach would be expensive. Continued exploration of the role of computerized simulations to assess this data-gathering aspect of physician-patient encounters may result in a much more cost-effective technique for medical schools, licensing authorities, and specialty boards.

This work was supported in part by NIMH Grant T31 MH 152 1206 to the American Psychiatric Association and by additional support from both the APA and the NBME. The authors thank Carolyn Robinowitz, M.D., an organizer of the workshop; Donald G. Langley, M.D., co-leader of the interview evaluation session; and R. Alec Ramsay, M.D., Daniel Frank, M.D., Muriel Bellemore, Suzanne Trudeau who made the Montreal replication possible.

Meeting presentation: An earlier version of this work was presented at the APA Annual Meeting in May, 1982.
INTER RATER RELIABILITY

Location of work: National Board of Medical Examiners; Department of Psychiatry and Human Behavior and Center for Study of Medical Education and Health Care, Jefferson Medical College, Philadelphia, Pennsylvania; and Delaware State Hospital, New Castle, Delaware.

References

11. Hinz CF: Direct observation as a means of teaching and evaluating clinical skills. Journal of Medical Education 1966; 41:150–161
18. Templeton B, Samph T, Best A: Development of techniques to assess physician interpersonal skills, in Evaluating the Skills of Medical Specialists, edited by Lloyd JS. Chicago, IL, American Board of Medical Specialties, 1983
19. Templeton B, MacDonald M: Use of interaction analysis in assessing physician trainee interpersonal skills, in Evaluation of Noncognitive Skills and Clinical Performance, edited by Lloyd JS. Chicago, IL, American Board of Medical Specialties, 1982
AIDS as a Paradigm of Human Behavior in Disease

Impact and Implications of a Course

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Marilyn Iris Auerbach, Dr. P.H.
Milton Viederman, M.D.

A new required psychiatry course for first-year medical students linked the urgent need for acquired immune deficiency syndrome (AIDS) education with the traditional goal of teaching the biopsychosocial model of illness. The course, "Human Behavior in Disease: AIDS as Paradigm," used HIV/AIDS to demonstrate principles of all life-threatening diseases. Formal evaluations of the course's impact indicated that it significantly reduced students' prejudices and increased positive attitudes regarding AIDS patients. The students' ratings of the course indicated that the AIDS paradigm was understood and valued. Our experience suggests that preclinical psychiatry courses can play an important role in the medical educational response to AIDS, while, at the same time, achieving their traditional curricular goals.

The acquired immune deficiency syndrome (AIDS) epidemic presents unprecedented challenges and opportunities for medical education (1,2). Its challenges include its medical complexity and its burden of psychosocial consequences and stigmata that tax physicians' knowledge and skills more than most diseases. AIDS education is further complicated by the fact that physicians (1-4) and medical students (5,6) have prevalent avoidant and fearful attitudes toward patients with AIDS and prejudices, such as homophobia (7), against the groups that have the highest prevalence of the illness. Thus medical educators must respond to the AIDS crisis by providing educational programs to supply the necessary knowledge and skills and to reinforce desirable professional values and address prejudices.

AIDS also represents an unusual opportunity for psychiatric education. AIDS is a rich case study of the emotional and behavioral concomitants of all serious illnesses, including emotional reactions, dynamic meanings, coping and adaptation, the doctor-patient relationship, the role of social support, grief and loss, and the complex interaction of organic and psychological factors in physical illness. There is only one report (8) of a course designed to teach psychosocial aspects of AIDS to medical stu-

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dents. However, because of its elective format, only a self-selected group of less than 10% of the class took the course. Of the students who did not, some reported that they avoided the course because they feared being in the room with a person with AIDS or being seen as homosexual. Thus the lessons of this course were lost to just those students who might have derived the greatest benefit from it.

In response to these challenges and opportunities, members of the Department of Psychiatry developed and implemented a new, required course at Cornell University Medical College titled “Human Behavior in Disease: AIDS as Paradigm.” The course had two goals:

1. the traditional goal of our department’s first-year curriculum—teaching the principles of human disease from biological, psychological, and social perspectives
2. the new goal—addressing medical students’ educational needs regarding the AIDS epidemic

We formally evaluated the course by surveying its impact on medical students’ positive and negative AIDS-related attitudes and asking the students for their ratings of the course’s educational value. In this article we describe the course, report the results of the evaluation, and discuss the role of such a course in a psychiatric curriculum.

METHODS

Course Structure

This new course was given to the entire first-year class of 100 students. It occupied three hours one afternoon each week for eight weeks in the fourth quarter. It replaced a course of the same length given to the four previous first-year student classes that used depression as a paradigm of illness. The old and new courses had the same format: each afternoon included a one-hour lecture followed by two hours for small-group meetings. The overall goal of the new course was to use AIDS as a paradigm for studying the emotional and biosocial dimensions of all serious illnesses. We emphasized this to the students by announcing it in the syllabus and in the first lecture. The lectures, small-group meetings, and readings were all structured to advance this objective.

The eight-lecture series consisted of an introductory lecture followed by lectures on the meaning of illness and the principles of doctor-patient communication; stress and coping; drug abuse; sexual behavior, identity, and homosexuality; risk behavior change; neuropsychiatric complications; and loss and grief. All lectures followed the basic outline of presenting the general principles of the topic, describing the topic in relation to serious or life-threatening illness, and then specifically relating the topic to HIV/AIDS.

About two-thirds of each lecture was devoted to the general principles. We illustrated the principles in every lecture using videotapes of interviews of patients with HIV/AIDS. Importantly, though, other illnesses, such as cardiovascular disease and cancer, were at times compared and contrasted with HIV/AIDS. We felt that the single disease paradigm was best presented in the company of other exemplars, enabling the students to identify the common features. In the small groups we also compared and contrasted AIDS with other illnesses by having the students interview patients with HIV and patients with non-HIV illnesses. Finally, the readings for each lecture topic consisted of one covering the general principles and one on their application to HIV/AIDS.

In each small group, ten students met with two preceptors: a psychiatry faculty member and a senior psychiatric resident or fellow. Each student had the opportunity to conduct an interview with a patient on the medical service of the hospital, and as a
group the students also viewed videotaped interviews and discussed the lecture material and the readings. The students were graded on the basis of their class participation and an objective final examination. (The course syllabus, containing detailed lecture outlines, specific objectives, and course mechanics, is available on request from the authors.)

Course Evaluation

*Measurement of the course's impact on students' AIDS-related attitudes.* Immediately before and after the course, we surveyed the students with a questionnaire for health care personnel that tests HIV-related attitudes. The questionnaire was developed as part of our work under a National Institute of Mental Health contract, "Training for Health Care Providers to Address AIDS" (9). The questionnaire probes fears about the risks of infection, prejudices against members of high-risk groups, and desirable professional attitudes of feeling responsible, prepared, and effective in contacts with AIDS patients. Respondents selected their level of agreement or disagreement with each item on a six-point Likert scale. The verbal anchors included the following: 1 = agree a lot, 2 = agree some, 3 = agree a little, 4 = disagree a little, 5 = disagree some, and 6 = disagree a lot. We field tested this instrument with a number of groups including psychiatrists, psychologists, psychiatric social workers, and hospital volunteers prior to using it for the medical student course.

The questionnaires were distributed to all members of the first-year class. Students were informed of the content of the questionnaire, which had no individual identifiers, and were asked to voluntarily and confidentially complete and return it. Ninety-four of the 100 members (94%) of the class returned the questionnaire just before the first lecture and ninety-three (93%) returned it just after the final exam. Over the eight weeks of the course, April 12 to May 31, 1989, there were no major developments reported in science, politics, or society regarding AIDS that were likely to affect the students' attitudes, and there was no other course dealing with AIDS or HIV. Thus there appear to have been no historical threats to validity. The changes between the before and after surveys probably indicate the influence of the course itself.

We tested two specific hypotheses regarding the impact of the course on attitudes:

1. that it would reduce prejudices against homosexual patients and intravenous drug users (IVDUs) and reduce exaggerated fears about training-acquired HIV infection
2. that it would reinforce the desirable professional attitudes of feeling obligated to treat, feeling prepared to counsel, and anticipating personal effectiveness in working with AIDS patients

Fisher's exact test was used to compare the proportions of students in the pre- and post-course samples who agreed (gave a response of 1, 2, or 3) with the corresponding items on the questionnaire. Fisher's exact was the preferred test because of small cell sizes within 2 x 2 tables.

*Student ratings of the course's value.* Immediately after the course, we distributed a standard course evaluation form used by our department for all of its preclinical courses. Students were asked to rate on a four-point scale (4 = highest, 1 = lowest) their overall satisfaction with the course and the educational value of each component, including the lectures, precept groups, and readings. Two-tailed t tests were used to compare the means of these ratings with those done by the previous first-year class for that year's similarly formatted course featuring depression as the paradigm of illness.
TABLE 1. Comparison of pre- and post-course responses to AIDS-related attitude and value items

<table>
<thead>
<tr>
<th>Item</th>
<th>Agree with item, % of sample</th>
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<tr>
<td></td>
<td>Pre (n=94)</td>
<td>Post (n=93)</td>
<td>Change (%post-%pre)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prejudices and fears</td>
<td></td>
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<tr>
<td>IVDUs have little regard for their health</td>
<td>80.9^</td>
<td>61.4</td>
<td>-19.5</td>
</tr>
<tr>
<td>I worry about getting AIDS from my medical work</td>
<td>89.4</td>
<td>80.6</td>
<td>-8.8</td>
</tr>
<tr>
<td>My family worries about my getting AIDS from my medical work</td>
<td>77.6^</td>
<td>67.8^</td>
<td>-9.8</td>
</tr>
<tr>
<td>I won’t like working with homosexual patients</td>
<td>25.5^</td>
<td>14.0^</td>
<td>-11.5</td>
</tr>
<tr>
<td>I could not be a friend to someone who has AIDS</td>
<td>18.1^</td>
<td>8.7</td>
<td>-9.4</td>
</tr>
<tr>
<td>If I reported training-acquired HIV, this would jeopardize my career</td>
<td>91.5</td>
<td>89.3^</td>
<td>-2.2</td>
</tr>
<tr>
<td>Desirable professional values</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel prepared to counsel AIDS patients</td>
<td>23.4</td>
<td>44.1</td>
<td>20.7</td>
</tr>
<tr>
<td>In my work I could positively influence an AIDS patient’s life</td>
<td>88.4^</td>
<td>96.7</td>
<td>8.3</td>
</tr>
<tr>
<td>Physicians have an obligation to treat persons with AIDS</td>
<td>97.9</td>
<td>98.9</td>
<td>1.0</td>
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</tbody>
</table>

*Calculated using one-tailed Fisher’s exact test.
^n=93 (one student in pre-course sample did not respond to this item).
^n=92 (one student in post-course sample did not respond to this item).
^n=91 (three students in pre-course sample did not respond to this item).
NS=not significant

RESULTS

Impact of the Course on Students’ Attitudes

For the first hypothesis, we tested the following six attitudinal items: expecting to not like working with homosexual patients, feeling unable to be a friend to someone with AIDS, believing that IVDUs have little regard for their health, fearing becoming infected with the AIDS virus during training, believing that one’s family is worried that one will become infected, and feeling concerned that one’s career would be jeopardized if one were to report training-acquired HIV infection to the school. For the second hypothesis, we tested the following three items: sense of an obligation to treat, feeling ready to counsel, and the sense that one’s medical work could positively influence the life of an AIDS patient. The results are displayed in Table 1.

Because the pre-course questionnaire results revealed high frequencies of self-protective concerns such as the fear of acquiring HIV infection during training and of jeopardy to one’s career due to reporting such infection, we followed up the career jeopardy item with additional questions in the post-course questionnaire about three hypothetical career consequences. The percentages of students in the post-course sample who agreed with each follow-up item are shown in Table 2.

Student Ratings of the Course

Ninety-nine students (99%) completed and returned this form rating the lectures, small groups, readings, and the course as a whole. The results of these ratings are displayed in Table 3. Ninety students (90%) in the prior first-year class completed and returned the same form rating their course, which used depression as the paradigm of illness. The means of the two samples’ ratings, as displayed in Table 3, reveal significantly more favorable ratings for all aspects of the AIDS paradigm course.
DISCUSSION

The main findings were 1) that the course reinforced the students' positive AIDS-related attitudes, reduced their prejudices and fears, and identified some of their rational self-protective concerns; and 2) that AIDS can be a valuable educational paradigm of disease and effectively taught by psychiatry.

The course helped a significant number of students reduce their prejudices against persons in groups at risk for HIV/AIDS and strengthen their positive attitudes regarding anticipated professional involvement with AIDS patients. In fact, the increase in the sense of being prepared to counsel AIDS patients (+20.7%) and the decrease in the anti-IVDU sentiment (-19.5%) were the largest pre-post changes in the survey. While stereotypic attitudes might be assumed to be relatively inflexible aspects of one's belief and value systems, some students indicated on the course evaluation that overcoming their prejudices was the most important achievement of the course for them.

Equally interesting are the items that were not affected by the course. There was an almost unanimous consensus within the class, even before the course began, that physicians are obligated to treat patients with AIDS. Perhaps this perceived moral imperative catalyzed the reexamination of stereotypes. At the same time, the self-protection-oriented concern that training-acquired HIV infection, if reported to the school, would jeopardize one's career was the most prevalent fear both before (91.5%) and after (89.3%) the course.

The post-course follow-up of the career jeopardy item indicated that two-thirds of the medical students feared that, if they were to become infected and report this to the school, they would not be allowed to finish medical school. Although Cornell is in the process of drafting a policy to protect students who may acquire HIV infection during training from jeopardy to their student status, the lack of a policy in force may permit such fears to develop. We believe that educators at all medical schools must address student concerns that they may lose institutional and professional support if they should become infected with HIV. A recent first-person account of the plight of a house officer with training-acquired HIV infection (published after the course) provides a poignant presentation of these issues (10). Medical educators should acknowledge the risks that medical students face and develop, in consultation with student representatives,

<table>
<thead>
<tr>
<th>TABLE 2. Followup questions for career jeopardy concern (post-course only)</th>
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<tbody>
<tr>
<td><strong>Item</strong></td>
</tr>
<tr>
<td>I'm concerned about jeopardy to my career due to reporting training-acquired HIV because:</td>
</tr>
<tr>
<td>The information would not be treated confidentially</td>
</tr>
<tr>
<td>I would not be allowed to finish medical school</td>
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<tr>
<td>I would not be able to obtain residency position</td>
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<thead>
<tr>
<th>TABLE 3. Comparison of medical students' ratings of illness paradigms for first-year medical student course: depression vs. AIDS</th>
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<tbody>
<tr>
<td><strong>Depression (n)</strong></td>
</tr>
<tr>
<td>Overall satisfaction</td>
</tr>
<tr>
<td>Value of lectures</td>
</tr>
<tr>
<td>Value of small groups</td>
</tr>
<tr>
<td>Value of readings</td>
</tr>
</tbody>
</table>

*Note: Values are means±SD; n=number of students responding. Rated on a four-point scale, where 1 is not valuable and 4 is most valuable.*
clear policies for medical students who may become infected with HIV.

The students' ratings of the course suggest that AIDS is a successful vehicle for teaching the biopsychosocial model and that, given the urgency felt by medical faculty and students to grapple with AIDS, this disease may be preferable as a paradigm over a core psychiatric disorder, such as depression. The AIDS paradigm course was enthusiastically received and elicited several comments like "this course reminds us why we came to medical school."

The course evaluation results also suggest that, regardless of the disease paradigm, small-group teaching is the component of this kind of course most valued by the students. This is not surprising since small groups incorporate exciting and challenging active experiences including interacting with patients, integrating new facts and concepts, and relating to faculty role models. We believe that the lectures provided the necessary factual and conceptual structure for each topic covered and set the stage for an experiential synthesis to take place in the small groups.

These findings may be generalizable to other medical schools, where similar courses could be instituted. However, we caution that the particular conditions of this study may have influenced some of the results. Cornell University Medical College is located in New York City, an area of the country with the largest number of AIDS patients. About 50% of the students are from the New York metropolitan area. Therefore, the setting, self-selection, and students' backgrounds may have contributed to their responsiveness to the course. Future research should compare the effects of similar courses on students in different settings. Follow-up studies to determine the duration of the attitudinal effects and need for related programs in the clinical years are needed.

Our experience indicates that departments of psychiatry can play a central role in addressing medical students' educational needs regarding the AIDS epidemic. In designing this course we linked the urgent need for AIDS education felt by all medical educators with the traditional goal of psychiatric educators to teach an integrated approach to human illness utilizing biological, psychological, and social perspectives. We believe that AIDS provides an excellent vehicle for this traditional aim of psychiatric undergraduate medical education. While virtually no single element of the AIDS epidemic is unique, its many biobehavioral and psychosocial ramifications comprise a problem of unparalleled richness and challenge for medical students to study. AIDS as a disease represents a deep reservoir of lessons in precisely those behavioral, intrapsychic, and humanistic issues that have been on psychiatry's traditional undergraduate educational agenda.

The authors thank the course faculty; Samuel Perry, M.D., for help in drafting the questionnaire; Fatima Badr, M.S., for data processing; Carl Rosenberg, Ph.D., for statistical consultation; Arnold Cooper, M.D., for comments on a draft of this article; and Robert Michels, M.D., for support of the course's development and comments on drafts of this article.

This work was supported in part by National Institute of Mental Health contract 278-88-0013 (ES), "Training for Health Care Providers to Address AIDS," Cornell University Medical College.

References

3. Richardson JL, Lochner T, McGuigan K, et al: Physician attitudes and experience regarding the care of
patients with acquired immunodeficiency syndrome (AIDS) and related disorders (ARC). Med Care 1987; 25:675–685
An Assessment of Psychiatric Residents’ Knowledge and Attitudes Regarding ECT

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William Dubin, M.D.

Graduating psychiatric residents in the Philadelphia area were surveyed about their attitudes, training experiences, and knowledge regarding electroconvulsive therapy (ECT). Twenty-nine residents were interviewed. Although the majority of respondents expressed positive attitudes about the use of ECT, only two (7%) expressed confidence in their own ability to perform the treatment without supervision. The residents’ general attitudes regarding ECT as a therapeutic modality were consistent with those of previous surveys of practicing psychiatrists. The level of knowledge of the residents interviewed was not related to reported didactic or practical experience. Significant gaps in training were noted. The need for more thorough, standardized training in ECT is discussed.

As electroconvulsive therapy (ECT) passes its 50th anniversary of use in the United States, much of the early controversy surrounding the treatment has subsided. An increasing body of knowledge based on careful clinical research has defined its use in general psychiatry, and its acceptance as a treatment for specific psychiatric illness is widespread. Within the clinical armamentarium available to psychiatry, however, it remains the most invasive, or at least aggressive, nonsurgical form of therapy. Therefore, training in this modality should be consistent, available, and well-standardized to allow psychiatry residents the opportunity to develop the cognitive and practical skills necessary for its safe administration.

Unfortunately, it is doubtful that these training goals are met regularly. Training in the theory and practice of ECT was noted to be “anything but standardized” by the 1978 APA Task Force report on ECT (1). In devoting a chapter of the report to training and education, the Task Force recommended that the apprenticeship model often utilized for ECT training be replaced by more thorough training programs. One of the stated mandates of the Association for Convulsive Therapy has been to support increased teaching of ECT in medical school curricula and residency training programs (2). In 1986, Fink noted continued deficiencies in ECT education, based on surveys in the United States, Great Britain, and Scandinavia, and
called for increased attention to ECT training for psychiatrists and anesthesiologists (3). Benbow has recently called attention to similar problems in medical student education about, and experience with, ECT (4). In 1990 a new Task Force on ECT provided guidelines on ECT training at the request of the American Psychiatric Association (5).

The purpose of this survey was to evaluate the current attitudes and training of residents graduating from their psychiatric residency programs. Our primary goal was to directly assess their sense of preparedness in ECT based on their training experiences. The residents surveyed were all completing their training within a single metropolitan area with several institutions providing medical education.

An additional goal of the survey was to assess the relationships, if any, among degree of knowledge about, level of experience with, and attitudes regarding ECT. Previous studies with diverse groups of health professionals have documented a positive correlation between seeing ECT used as a treatment and becoming comfortable with its prescription (6). Similar correlations would be significant in predicting the future utilization of ECT (i.e., through referrals) by non-ECT practitioners.

**METHODOLOGY**

All PGY-4 residents in the Philadelphia metropolitan area graduating in June 1989 were asked to complete a questionnaire investigating their attitudes and knowledge regarding ECT. The questionnaire elicited information regarding demographics, didactic and practical experience, attitudes about ECT use, self-assessment of ECT skills, and types of illnesses considered appropriate for ECT use. For each topic three or four statements were offered from which the resident could choose. This allowed choices from among a range of feelings or attitudes about ECT training. In addition, a 10-question quiz on basic knowledge of ECT tested residents' knowledge about this treatment modality. The questions about selection of patients, and the quiz, were based on the 1978 Task Force recommendations for residency training. Only three quiz questions specifically addressed ECT technique. The majority of the questions focused on the prescription of ECT, selection of modality (i.e., bilateral or unilateral), pre-ECT workup, and management of a patient through an ECT course. Because no standardized criteria existed for the assessment of resident training in ECT, the 1978 Task Force Report was identified as a model to which the programs could be compared. Our goal in utilizing the Task Force Report was to formulate rudimentary questions about patient selection and management that graduating residents could be expected to know about ECT regardless of differences in standards of training that might exist among the area programs. A copy of the questionnaire is available upon request; the 10-question quiz is supplied in the Appendix.

Questionnaires were completed during resident meetings at the training institutions. This followed a telephone contact requesting that all graduating residents be present on a selected date. A total of 29 residents (16 male and 13 female) responded to the questionnaire. This represented 65% of the 44 residents graduating from 8 programs in the Philadelphia area. The residents' mean age was 34. Seven residents (24% of responses) were not present at their meetings but provided responses by mail. One state hospital, graduating four residents, was excluded because ECT was not part of their curriculum (no state hospital in the Philadelphia area currently provides ECT).

The relationships among reported didactic experience, practical experience, and quiz performance were examined for the responding resident group. The group median was used to define high and low subgroups for each of these three variables, and chi-square tests were used to assess the relationship between high and low quiz scores and
high and low levels of didactic and practical experience.

RESULTS

As shown in Table 1, most responding residents reported receiving both didactic and practical training. Didactic training was estimated at a mean of 3.2 hours of formal lectures (range 0–12, with the exception of one resident reporting 120 hours who, as such an "outlier," was not averaged with the group) and an additional 2.4 hours of individual reading (range 0–10 hours). A variety of texts were cited, including both specialty texts and comprehensive psychiatric textbooks.

In terms of practical experience, a mean of 19 treatments (range 0–100) were performed by the residents, using bilateral treatments in 37% and unilateral treatments in 63% of the cases. An average of five patients were personally followed by the residents through the course of ECT, with a range of 0–20 (with the outlying resident previously described following 60 patients). Twenty-one (72%) of the residents indicated a teaching attending psychiatrist at their primary institution provided their practical training, with another three (10%) reporting that teaching attendings at the primary and an affiliate hospital provided training. Three residents (10%) did not respond to the question regarding who had primary responsibility for their practical training in ECT.

Attitudes and Confidence in Performing ECT

The PGY-4 residents generally indicated favorable impressions toward the use of ECT. Fifteen residents (52%) responded affirmatively to the statement "I am strongly in favor of the use of ECT for appropriate patients and consider it an effective psychiatric treatment." Another six (21%) responded affirmatively to the statement "I am comfortable with the use of ECT and would refer appropriate patients, but would..."
feel uncomfortable if called upon to deliver this treatment myself." The remaining eight (27%) endorsed both of these statements; no residents endorsed the choices reflecting opposition to ECT (either "I am unsure of the role of ECT in modern psychiatry"; or "I am opposed to the use of ECT and feel that its side effects outweigh any potential benefits to patients").

Thirteen residents (45%) responded affirmatively to the statement "I believe that formal training in ECT (didactic and practical) should be provided to all psychiatric residents." Fifteen residents (52%) responded affirmatively to the statement "I received moderate training and feel comfortable with patient selection, but would require supervision for the actual delivery of ECT to a patient."

Only two residents (7%) indicated comfort in performing ECT themselves without supervision after graduation from their residency program. One of the two residents reported having the most extensive experience of the entire group, with 120 lecture hours, 60 patients followed, and 100 treatments given; the other, however, fell well within the norms, with 2 lecture hours, 5 patients followed, and 20 treatments given. Twelve residents (41%) either did not feel prepared to perform unsupervised ECT (5 residents) or felt their didactic and clinical training was inadequate (7 residents). The remaining 15 residents (52%) felt they would need further supervision before personally administering ECT to a patient.

Patient Selection

All but one resident (97%) identified severe depression as an indication for ECT—the exception was one person selecting medication-refractory mania as the sole indication. Seven residents (21%) coupled refractory mania with depression as indications for ECT, and nine (31%) felt that these, plus medication-resistant schizophrenia, represented valid indications. No residents elected "none" or "other" as responses.

Level of Knowledge

The mean average score on the 10-question quiz was 57% correct. The mean quiz scores for the seven quizzes mailed back was 54%, compared with a mean score of 58% for the rest. The similarity in scores suggested that the results could be combined. The results by specific topics are provided in Table 2. The lowest score reflected over-inclusiveness in the ECT workup, with 19 residents (63%) incorrectly identifying a CAT scan as essential (1).

The only two residents who felt prepared to perform ECT independently both scored 70% on the didactic quiz, somewhat higher than the mean quiz score, but otherwise they showed no differences from the other respondents in terms of their knowledge bases. Furthermore, for the total sample there was no significant relationship between quiz scores and either hours of study or number of ECT treatments performed.

DISCUSSION

Although the overwhelming majority of residents polled indicated a generally favorable opinion regarding the use of ECT and seemed to have had positive exposure to this treatment modality during their training periods, some results were disconcerting. Most responding residents did not feel qualified to perform this treatment in an unsupervised fashion; presumably the same would not hold true for the practice of psychotherapy or pharmacotherapy or other treatment modalities provided for in a general residency curriculum. Further apprenticeship training will still be required by the majority of residents who obtain employment that includes ECT delivery.

Whether such training is expected to occur in residency training is a critical issue. No formal fellowships in ECT are offered in
The results thus corroborate the impressions in 1978 of the APA Task Force which found that ECT training was unstandardized. In the Philadelphia metropolitan area, it remains so 10 years later. In addition, the number of graduating residents ready to perform ECT could prove inadequate to maintain the programs currently offering this treatment. If this potential deficiency of ECT training exists throughout other metropolitan areas and throughout the United States, then ECT delivery will remain unstandardized (and potentially substandard) or will decrease in actual use despite patient needs.

Improvement in ECT training will require several approaches. Activity by ECT practitioners in resident curriculum committees can focus attention on possible training deficits and their remediation in individual programs. An increased research presence in local and national professional meetings can increase the awareness of physicians of the complexity of modern ECT and of the need for enhanced training. More stringent privileging and credentialling requirements can ultimately result in more thoroughly trained residents and ECT practitioners. The 1990 APA Task Force guidelines include specific recommendations in this regard (see Ref. 5, pp.1–3).

Our data suggest that the current training in ECT offered by psychiatric residencies fails to meet clear educational objectives. New recommendations for a training format with specific educational objectives are now available in the 1990 Task Force report (see Ref. 5, pp. 115–120). The 1990 Task Force recommends that all residents receive didactic instruction including mechanism of action, patient selection, side-effects, pre-ECT workup, informed consent, methods of administration, evaluation of outcome, and management of patients after a course of ECT. The recommendations are for a minimum of 4 hours for presentation of didactic information. Specific recommendations for developing adequate practical skills include

the Philadelphia area (or elsewhere in the United States, to our knowledge). No suggestions that these skills be developed after residency training (as is the case, for example, with psychoanalytic training) have been introduced. The 1990 APA Task Force Report states that “elective opportunities for advanced training in ECT for residents and fellows should be available” (section 15.3.4) but does not propose a formal fellowship program in clinical ECT practice. Thus, if basic competence in ECT is to be achieved, it should occur during residency training.

The disproportionately small number of residents (two) who felt prepared to perform ECT reported hands-on experience and didactic education that equaled or exceeded the average resident respondent; it was not clear why other residents with equal or more training did not perceive themselves qualified in the actual practice of ECT. A relevant factor might include the quality of the training, real or perceived, rather than the quantity of hours spent or patients seen and treated. It is also conceivable that competence in ECT delivery had not been as explicit a goal as cognitive understanding of the treatment. The fact that resident responses regarding patient selection did reflect a level of confidence consistent with most psychiatric practitioners supports this possibility (1).

The lack of a relationship between reported hours of training and actual knowledge base supports the conclusion that little standardization currently exists in the ECT curricula of the programs studied. We are further concerned by the fact that at the state hospital residency program we contacted, ECT could not be performed on site (a situation noted by Fink to be typical of many state and Veterans Administration hospitals (3) and a curriculum of ECT was not offered at all, despite the availability of numerous local ECT practitioners who could, presumably, offer didactic lectures, and the availability of valuable, easily obtained training videotapes (7).
the administration of at least 10 treatments, with at least three separate patients treated. The Task Force further recommends that at least two additional patients be managed through their course of ECT, including the pre-ECT evaluation and decisions about the ECT administration itself. Our recommendations do not differ. For optimal experience, we feel that specific objectives should be individualized for each resident; those residents who anticipate becoming ECT practitioners clearly require a more rigorous assessment of skills than those residents who indicate an interest in prescribing but not performing ECT. Didactic teaching can generally be provided during the first and second program years, when residents are likely to refer patients for ECT, with the practical skills being developed through the course of the residency. Particular focus on

<table>
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<tr>
<th>APPENDIX</th>
<th>A series of brief questions to assess basic familiarity with ECT concepts and history:</th>
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<tbody>
<tr>
<td>1. ECT was first utilized as a therapy by:</td>
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<td>(a) Meduna</td>
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<td>(b) Cerletti and Bini</td>
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<td>(c) Otoson and Kalinowsky</td>
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<td>(d) Kalbach</td>
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<td>2. The D'Elia technique refers to:</td>
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<td>(a) The use of barbiturate, anesthesia and muscle relaxants to reduce ECT side-effects.</td>
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<td>(b) The use of multiple “regressive” ECT treatments for schizophrenia.</td>
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<td>(c) A specific electrode placement for the delivery of unilateral treatments.</td>
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<td>(d) The use of “monitored” ECT involving EKG and EEG monitoring.</td>
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<td>3. In comparing unilateral nondominant treatments to bilateral treatments:</td>
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<td>(a) Unilateral ECT is found to clearly decrease the memory difficulties associated with treatment.</td>
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<td>(b) Bilateral treatments are clearly recognized as more effective for severely depressed patients.</td>
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<td>(c) Unilateral treatments are clearly felt to be superior for the treatment of nondepressed patients, i.e., those with schizophrenia or mania.</td>
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<td>(d) Unilateral treatments are technically more difficult to perform.</td>
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<td>4. In monitoring seizure duration in ECT:</td>
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<td>(a) Seizures of greater than 30-seconds duration should be stopped with the use of additional barbiturate to prevent a prolonged seizure.</td>
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<td>(b) The adequacy of the ECT treatment can be ascertained by noting the grimace when the patient is stimulated.</td>
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<td>(c) Care should be taken not to hyperventilate the patient prior to ECT as this will shorten the seizure duration.</td>
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<td>(d) The “cuff” method, inflating a blood pressure cuff prior to the injection of muscle relaxant to allow the observation of tonic-clonic movements, is a simple and reliable monitoring method.</td>
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<td>5. The role of atropine in ECT is primarily:</td>
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<td>(a) To prevent ECT-induced bradycardia.</td>
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<td>(b) To primarily reduce oral secretions during ventilation.</td>
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<tr>
<td>(c) To reduce muscle fasciculations secondary to succinylcholine.</td>
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<tr>
<td>(d) To lower the seizure threshold.</td>
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<td>6. The absolute contraindications to ECT include:</td>
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<td>(a) Space occupying intracranial mass</td>
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<td>(b) History of CVA</td>
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<td>(c) Both</td>
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<td>(d) Neither</td>
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<td>7. Medications that should not be used concurrently with ECT include:</td>
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<td>(a) Lithium</td>
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<td>(b) MAO inhibitors</td>
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<td>(c) Theophylline derivatives</td>
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<td>(d) All of the above</td>
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<td>8. Pre-ECT workup must include:</td>
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<td>(a) EKG</td>
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<td>(b) CAT scan of the head</td>
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<td>(c) Complete liver profile and urinalysis</td>
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<tr>
<td>(d) All of the above</td>
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<td>9. Multiple monitored ECT:</td>
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<td>(a) Refers to the use of multiple ECTs in a given session to accelerate recovery.</td>
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<td>(b) Refers to the delivery of three or more treatments in a given week.</td>
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<td>(c) Refers to the use of EKG and EEG monitoring of the patient during ECT.</td>
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<tr>
<td>(d) Refers to the use of multiple methods of determining seizure duration, i.e., EEG, cuff method, pulse rate.</td>
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<td>10. Memory loss with ECT:</td>
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<td>(a) Is of therapeutic benefit when painful, unpleasurable memories are erased.</td>
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<td>(b) Usually includes impairment of new learning for 2–3 months.</td>
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<td>(c) Is decreased with unilateral treatments.</td>
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<tr>
<td>(d) Is independent of patient age.</td>
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assessment of residents' ECT skills should be undertaken in the senior year and state-of-the-art information should be provided to ensure that interested residents are, and perceive themselves to be, competent in ECT administration.

The 1990 APA Task Force notes that some residency programs have limited resources for practical ECT training. They cite the need for assigned readings, video tapes, and outside speakers in these situations and note that residents may require supplementation of their practical training before performing ECT on an unsupervised basis. It is our impression that residents are likely to heed this admonition and, in fact, may be more inclined to identify their limitations than their program directors. We would recommend that those programs lacking adequate resources in ECT delivery develop cooperative relationships with other health care facilities in their areas to allow residents sufficient clinical exposure to and training in ECT. A consortium of training programs can provide sufficient clinical experience for interested residents to meet the Task Force recommendations in most geographical areas. This can help ensure that motivated residents will provide state-of-the-art treatment as they enter clinical practice.

References


This study was supported in part by National Institute of Mental Health Grant MH-12507. The authors thank Ms. Delores Cherry for preparation of the manuscript.
From the Benches to the Trenches

Training Residents to Provide Emergency Outreach Services—A Public/Academic Project

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The Charleston Area Mental Health Center and the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina have collaborated to form a comprehensive emergency service with mobile capacity. The service is staffed by an interdisciplinary team of professionals from public and academic psychiatry. Psychiatric residents are fully integrated into the service. A description of the program demonstrates how such liaisons can promote improved access to high-quality services, while enriching the training of psychiatrists through outreach experiences.

In recent years there has been a resurgence of interest in public/community psychiatry with a focus on improving access to treatment for the homeless mentally ill, for the "dually diagnosed," and for those suffering from schizophrenia and severe forms of mood disorders (1–3). In general, however, indicated treatments continue to lie beyond the reach of those in need. Traditional mental health services are often relatively inaccessible to patients with the most severe forms of psychiatric disorders. Thought disorganization, severe depression, homelessness, or paranoid delusions may prohibit patients from attending traditional clinics or keeping set appointments with therapists. Thus, patients frequently remain ill, experiencing crises and exacerbations of their illnesses on a regular basis.

In an effort to better serve these patient populations, residency training programs have begun to expose residents to more flexible service delivery models (4). In South Carolina, the Department of Mental Health made funding available to the Charleston Area Mental Health Center (CAMHC) for the development of an Emergency Psychiatry/Mobile Crisis Program to operate in collaboration with the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina (MUSC). The overall mission of the program includes the following: 1) to remove barriers to emergency care in the community by using a dedicated emergency team through a mobile crisis model, 2) to provide care for patients in their local community such that

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hospitalization in centralized state hospital facilities (100 miles from Charleston) is used only as an option of last resort, 3) to prevent inappropriate admissions to public sector inpatient facilities, and 4) to expose psychiatric residents to public psychiatry in the context of community outreach.

The program links the clinical and fiscal resources of the public sector with the academic resources of the university medical center. The service has now been fully integrated within the residency curriculum at MUSC. It has yielded unique advantages to trainees, patients, and Charleston’s mental health care system.

DESCRIPTION OF SERVICE

The Emergency Psychiatry/Mobile Crisis Program is staffed by an interdisciplinary team of faculty psychiatrists and psychiatric residents from MUSC and by nurses and Master's-level clinicians (i.e., social work, psychology, counseling) employed by the CAMHC. The team is available 365 days a year, 24 hours a day. The catchment area has a population of approximately 400,000 people. Approximately one-third of the patients seen have chronic psychotic disorders, many of whom are “dually diagnosed.” The team responds to psychiatric emergencies presenting to area hospital emergency rooms, or in the community directly, through mobile crisis intervention.

Emergency calls requesting outreach services come from numerous sources within the community, including area emergency rooms and clinics, police, the Emergency Medical Service (EMS), the Department of Social Services, probation and parole boards, probate court, family members, landlords, health professionals, and private individuals. It is not uncommon for the team to be called to private homes, group homes, shelters for the homeless, hotels, street corners, malls, public buildings, back yards, or back seats of police cars. The entire county of Charleston serves as the team’s “office.” Each situation provides an opportunity for creative treatment planning.

All calls are carefully screened by clinicians who are expected to employ a highly facilitative “how can I help you” approach from the first moment of telephone contact with a caller. While there is no cumbersome intake or appointment procedure, the clinicians ask a series of structured questions before agreeing to respond to a request for mobile emergency services. Clinicians thus attempt to estimate the level of potential danger and the nature of the danger. For example, they will determine if the patient is suffering from a medical or neurologic emergency, or whether the identified patient is willing to be seen by the team (since unwilling patients may pose greater safety risks to staff). Such determinations will indicate different actions.

Police requests for assistance in “life or death” situations are responded to immediately. If a situation is potentially dangerous, for example, a suicidal or homicidal person with a loaded gun, the team members would attempt to calm and support the person over the phone or would go to the site with police officers. If there is no security risk the team will respond alone when the patient is unable or unwilling to go to a clinic or hospital. Team members work closely with the area’s numerous police and sheriffs departments and have set up communication protocols with dispatchers. The team always alerts police dispatchers of their destination via cellular telephone so that officers can reach them rapidly if needed. In the majority of cases, the police are not called to the scene. If there appears to be a medical emergency, EMS is dispatched to the scene (if unclear, the team responds along with EMS). If there is a mental health professional known to be involved with the case, that individual’s assistance is sought. If the situation is not an emergency and can be referred to a clinic-based mental health service, a team member will make the appointment and follow up on the contact.
The field team always consists of at least two individuals, one of whom is a PGY-1 psychiatry resident. The resident's specific contribution involves clarification of physical/mental diagnostic issues and psychopharmacologic treatment options. The team physicians and nurses are capable of administering medications in the field, and they carry an array of psychopharmacologic agents to each emergency. All clinicians are trained in DSM-III-R diagnosis, crisis intervention, and accessing community resources. Residents can also serve as certifying physicians for patients requiring emergency commitment and subsequent transportation to hospitals by sheriff's officers. For supervision, the team contacts a chief resident and/or attending via cellular phone to review the case and develop treatment and dispositional plans. The attendings and chief residents discuss all cases further with the team at daily meetings and are responsible for the continuous training of all clinicians.

Because the team functions as the emergency service of the CAMHC, it can make initial contact with new patients and then quickly link them to continuing outpatient care and long-term treatment programs that help prevent hospitalizations. When necessary, the team will visit patients several times until a crisis is resolved. If patients require hospitalization and no local beds are available, the team may provide more intensive services to manage patients in the community until a local bed becomes available. To support continuity of care, patients' therapists are always contacted by the emergency team in an attempt to ensure the link to long-term mental health care providers. If appointments arranged for patients by the team are not kept, the team often follows up with a mobile response.

The following case examples illustrate the work of the team:

**Case 1.** Adult Protective Services requested that the team visit a woman who was “manic,” (hypersexual, labile, throwing knives at people, and trying to eat glass). After contacting the patient by phone, she agreed to allow the team to visit her. On examination, she appeared disheveled, emaciated, and completely disoriented. The psychiatric resident diagnosed a delirium and arranged EMS transport to the hospital. She was examined by neurosurgery and admitted for an emergency shunt procedure to treat acute hydrocephalus.

**Case 2.** The team was called to the home of a woman who was crying and agitated. While assessing the patient, the attending psychiatrist noted two loaded shotguns at the foot of the bed. The family was immediately asked to remove the weapons in the presence of the team. The attending psychiatrist ascertained that the patient had no suicidal intent but was in need of acute sedation and antidepressant medication. As there were no local psychiatric inpatient beds available at that time, the family of the patient devised an around-the-clock support plan to help the patient through the crisis period and avoid state hospitalization. She was medicated and seen daily by the resident until her acute symptoms resolved. She was subsequently reconnected with her former therapist for ongoing treatment.

**Case 3.** Police officers requested a home visit to evaluate a woman who was alert but who had taken an overdose of tricyclic antidepressants. The psychiatry resident informed the officers that the patient would need to be transported to the hospital emergency room. The officers, puzzled as to why staff could not see the patient in her home, were told that such an overdose could be life-threatening and thus emergency hospital management was more appropriate. At this, the officers agreed to immediately transport the patient to the hospital via EMS.

**Case 4.** A patient’s brother requested a home visit to evaluate his sister. She believed
he was Satan and she would not go to the CAMHC because of her belief that "foreigners" were plotting her death there. She refused to allow the team in when they arrived at her home, saying she had "closed her account" with them. A program brochure was left at her door and she was asked to call if she changed her mind. The next day she did call and gave the team permission to visit her. During the visit, the resident was able to form a treatment alliance with the patient and obtain her consent to begin antipsychotics. After several home visits she showed much improvement and was, in fact, calling the resident to remind him to bring her medications on the next visit. Rather than being committed, as her brother had feared, she improved and was referred to one of the CAMHC's continuous treatment teams (5,6).

Case 5. A man with schizophrenia, homeless for three years, was seen at the local shelter and found to be extremely disorganized and psychotic. The resident attempted to stabilize the patient with oral medication until an admission was arranged in the local psychiatry unit. He was started on a depot antipsychotic at the hospital and, once stable, returned to the local shelter. He was followed on-site at the shelter and became eligible for Medicaid, housing, and vocational rehabilitation. Eight months later, his illness had stabilized; he was employed, had married, and was living independently.

Case 6. A former naval officer stayed in his house during Hurricane Hugo. The storm surge broke through his window, washed him off his bed and slammed him into the toilet in the next room. Over the next three weeks he developed symptoms of post-traumatic stress disorder and began drinking heavily. He called the mobile team in a suicidal state, with a loaded gun pointed to his head. The resident and other clinicians talked him into relinquishing the weapon to the police, provided crisis therapy at his home, and arranged for emergency hospitalization in Charleston.

TRAINING AND SUPERVISION

During the week from 8 a.m. to 5 p.m., an attending psychiatrist, chief resident (PGY-4), and first-year resident (PGY-1) constitute the medical staff on the team. After hours and on weekends, two residents and an attending are on call for this and other departmental services. All twelve first-year residents are assigned to the team for one month during PGY-1. Night call frequency for PGY-1s is four to five times per month, and for PGY-2-4s is one to two times per month. Two fourth-year residents are appointed as clinical chiefs for a six-month block each as one of several selects for the PGY-4s in our program.

The PGY-1 resident’s role is that of physician for the field team. Because at any given time the number of active cases vary, the residents learn to be efficient within a fluid system. The resident is required to seek supervision about clinical decisions from the chief resident or attending psychiatrist. Also directly available to supervise is the team’s program manager, a Master’s-level clinical social worker. When residents go into the field, they are always accompanied by experienced team members. “On the spot” supervision is supplied by either an attending or the chief resident (each covering half a day). At the beginning of each rotation, the attending or chief resident will accompany the new PGY-1 on several mobile calls. After this introduction and orientation, on-site supervision is structured through a cellular phone with discussion of each case in detail. The attending or chief resident is available to go to the scene if necessary. At times the residents are asked to be only observers, thus allowing them to learn through modeling of more senior clinicians.

Supervision of the clinical staff is jointly provided by the program director, an academic psychiatrist (J.J.Z.), and by the pro-
gram manager (J.P.), a clinical social worker employed by the mental health center. Each day begins with "supervision rounds," where cases seen during the previous 24 hours are reviewed and treatment planning for all active cases is formulated. All staff benefit from biweekly staff conferences and in-service training to keep abreast of new information and help foster teamwork. During "down time," the team is gathered for case-specific discussion.

All PGY-1 residents meet weekly for a one-hour professional development group followed by a one-hour lecture on topics in general psychiatry throughout the year. They are granted time off all other internship rotations (medicine, neurology, psychiatry, family medicine) for this weekly activity. The director of the emergency service coordinates the lecture series. In addition, weekly individual tutorials are provided for examination of emergency psychiatry topics, such as evaluation and treatment of the violent patient, differential diagnosis, handling emergency telephone calls from patients, psychopharmacology, family dynamics, perspectives on mental health services, and legal psychiatry.

During the rotation, faculty psychiatrists provide the residents with detailed information on the clinical and administrative programs within the local and state mental health system. Residents are introduced to the philosophical approach of community-oriented treatment for the severely mentally ill. Case vignettes are used to highlight how community-based treatment enhances continuity of care. Longitudinal case reviews illustrate how "revolving door" patients are kept from "falling through the cracks" through assertive outreach. These case histories are also used to introduce the concept of cost effectiveness and the financing of mental health services. With this systems-level understanding, residents can learn to identify strategies to help their patients navigate through administrative obstacles.

Faculty take an assertive approach in dealing with systems conflicts directly on an administrative level. PGY-1 resident involvement in political or direct administrative conflicts is thereby avoided by taking such matters out of their hands. In addition, it is never assumed that a PGY-1 resident is naturally able to work within a multidisciplinary team; thus, they are closely supervised on their "team work" by the chief resident or attending.

The program's attending staff attempt to nurture the residents' social conscience and increase their ability to empathically relate to difficult patients. The faculty is quite active in fostering and maintaining positive working relations with the CAMHC. In this way, the program emphasizes the opportunity for improved patient care that results from a public-academic collaboration.

**Evaluation**

Since this project was integrated into the general training program, there has been a significant positive trend in the number of residents who have shown interest in community-based public psychiatry as a potential career. Our residents' PRITE scores in emergency psychiatry have also increased substantially since the introduction of this rotation. On the 1989 PRITE exam, class percentile rank in emergency psychiatry was above all other subsections for both classes having rotated through the service. Resident comments about the training experience were obtained from all residents who rotated on the service during its first two years of operation (N=24). Our rotation evaluation instrument encourages spontaneous comments on strengths and weaknesses and is not set up for quantification. For both years surveyed, this rotation received the most enthusiastic comments and the fewest negative comments compared with the other two PGY-1 psychiatric rotations (adult inpatient, substance abuse). Residents found learning about psychiatric emergencies outside the hospital challenging and stimulating. Fre-
quently reported benefits to field work were a better understanding about the gradual development of a crisis and the opportunity to learn about patients' natural environments (particularly those with severe/chronic disorders living in the community). Residents also responded favorably to working within a multidisciplinary team in the field. Negative points most often cited were frustration about dispositional dilemmas due to lack of adequate residential alternatives and lack of cooperation among different human service agencies (mental retardation, mental health, social services, vocational rehabilitation, alcohol and substance abuse). These frustrations have greatly diminished as our program has effectively networked with community agencies.

DISCUSSION

Mobile crisis services are important resources for emergency treatment and prevention of hospitalization (7-12). Patients in crisis are often confused or afraid. Transporting the mental health system to the patient circumvents the inaccessibility of traditional services. The often inevitable route of involuntary hospitalization can be avoided if psychosocial and biological interventions are available at the scene of the crisis. Mobile response capabilities allow the team to assess the strengths of the patient's support system and explore all alternative dispositions.

The team has worked effectively with numerous community agencies and, through such collaboration, has broadened the resources available for crisis intervention. The community has welcomed the program as a new resource. There has been extensive media coverage of the team's work with local police departments in several life-or-death situations involving mentally ill individuals. In addition, the program was invaluable during the period after Hurricane Hugo, when many mentally ill patients were immobilized.

Through its collaborative nature, the program has been able to deliver previously unavailable services while helping to bridge the gap between academic and public sector psychiatry. CAMHC clinicians bring their practical experience to the program and teach their skills to their colleagues in academia. Thus residents and supervising faculty learn about community resources and principles of case management. University staff share new research data with their CAMHC colleagues, who are then able to offer better clinical services to their patients.

An orientation toward alternative service delivery models is timely. Psychiatrists must become comfortable dealing with patients outside the office and hospital if they are to play a leadership role in the care of patients with severe and persistent mental disorders. Residency training programs should prepare future practitioners for this challenge and broaden their awareness of alternatives to the office and hospital models.

As mental health service researchers establish the efficacy of community support programs, educators and curriculum planners will need to develop training assignments involving these systems. Such programs offer residents an opportunity to learn about the fluid nature of psychiatric symptoms and the effects of acute "field" interventions on the course of an illness. Exposure to such programs can afford residents a valuable lesson in medical economics and also acquaint them with the political obstacles to development of comprehensive community-based treatments. A structured, well-supervised training experience that demonstrates the positive clinical outcomes of such services will, hopefully, encourage more university-trained psychiatric residents to enter the field of public and community psychiatry.
References

New Ideas

Teaching Short-Term Psychotherapy With Blind Role Playing

James E. Groves, M.D.

This report describes the use of blind role playing to introduce the theory and techniques of the short-term psychotherapies in a combined "laboratory" and lecture course. "Therapist" and "patient" (but not instructor) are blind to each other's governing assumptions about therapy, yet must respond creatively to each other based on the algorithms of the "script" and on real-life experience as both doctor and patient.

Role playing is an old strategy in medical education. Kurt Lewin (1), among others, used role plays to focus on the subjective psychological experience of the subject (Versuchsperson) during various enacted roles and prescribed the steps for instructor or experimenter to follow when briefing the player and directing the learning situation.

Role plays have recently been rediscovered as an important teaching tool in the Harvard Medical School "New Pathways" Patient-Doctor course. Role plays are used to initiate medical students into the mastery of empathic, effective patient interventions (personal communications, Drs. W. Branch and P. McArdle). A gambit that may be original to the Harvard course is the blindness aspect, by virtue of which the "patient's" script directs him or her to reveal important data (e.g., the existence of unsafe sexual practices, substance abuse, covert worries, etc.) only if the "doctor" combines good scientific data-gathering with skilled interpersonal handling of the relationship (e.g., open-ended questions, empathic listening, and respectful pressure on the "patient").

Short-term psychotherapy training is particularly in need of teaching tools that pave the way for students (2). Although Flegenheimer (3) states that brief therapy may be easier to teach than long-term therapy because students have fewer bad habits to unlearn, the consensus (4-7) is that brief therapy is harder to learn and harder to do because of the less forgiving framework of time constraints.

Didactic role plays appear to provide two powerful educative elements for the classroom learning of short-term therapies.

1. Organized theory can be embedded in the subtext of the short-term therapy or "script" narrative (8).
2. The experience of doing therapy can serve as a mnemonic binder for theory.

To these may be added two unique elements of "blindness" of the players.

3. The element of surprise (as the "patient" produces unexpected history or unpredictable mental status findings) stimulates creativity both in the "doctor" and in the classroom observers.
4. The unspecified elements in the doctor's and patient's narrative scripts

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inevitably demand that students supply to their roles their own personal experiences as a doctor or patient; this lends an element of verisimilitude that can be lacking in exercises that use paid actors.

These four elements of theory, practice, creativity, and life experience make blind role plays effective and, not unimportant, maintain patient confidentiality and supervisory privacy (9).

MATERIALS AND METHODS

For a class of a dozen trainees meeting for a dozen sessions, eight “patient” and eight “doctor” scripts are used in conjunction with pertinent readings (7,10). Tables 1 and 2 summarize 16 roles that may be used year after year. Worth noting is that each role name and problem is gender-inclusive and that all roles may be played by a trainee of either sex under the name given. As a teaching aid for the seminar leader, each doctor name and each patient name also functions as a pun or mnemonic device linked to the main idea of the role. For instance, “Lynn Lightner” was an antidepressant or mood lightener to his or her mother upon the death of a sibling, “Dr. Tuhok” is Kohut backwards, and so on.

The classroom procedure is fairly simple. For 12 trainees learning six basic schools of short-term dynamic therapy (7,10), each trainee receives one doctor script and one patient script and is told to prepare each role for presentation by a specific class date. Each trainee receives an article providing an overview of the brief therapies, a doctor script, and a patient script (“Note: Until the exercise is over, please do not share this script with your colleagues.”). Trainees are expected to prepare for the two performances by intensively reading only the literature pertinent to each of the two roles. The task of preparation for the doctor role includes some review of short-term methodologies; for the patient role, review of selection criteria is helpful. For some of the problems and plots, the doctor’s or patient’s role is matched with congruent aims and goals, while others are linked discordantly (Table 3). Only the instructor is not blind to concordance and discordance of “patient” diagnosis and “doctor” ideology.

For example, “Jamie Jumpers” is in a nascent psychotic break and will respond adversely to affect-laden confrontations à la

<table>
<thead>
<tr>
<th>TABLE 1. Patient roles</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient</strong></td>
<td><strong>Description</strong></td>
</tr>
<tr>
<td>Franny Fragmento</td>
<td>Middle-aged phlebotomist with borderline personality disorder but some real strengths and motivation to change.</td>
</tr>
<tr>
<td>Jamie Jumpers</td>
<td>College student with incipient psychotic episode.</td>
</tr>
<tr>
<td>Kris Kronack</td>
<td>Normal young adult in developmental crisis set against the backdrop of a chronic illness.</td>
</tr>
<tr>
<td>Lou Leffback</td>
<td>Marginal alcoholic with successful business and “empty-nest syndrome.”</td>
</tr>
<tr>
<td>Lynn Lightner</td>
<td>Law student with failure to succeed and impending marriage.</td>
</tr>
<tr>
<td>Dale McDermott</td>
<td>Young dermatologist with pathologic grief reaction.</td>
</tr>
<tr>
<td>Marin MacManager</td>
<td>Software sales manager, incest victim, and secret bulimic.</td>
</tr>
<tr>
<td>Sammy Sellsars</td>
<td>Sales executive with midlife crisis and guilty sexual secret.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TABLE 2. Therapist roles</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name</strong></td>
<td><strong>Orientation</strong></td>
</tr>
<tr>
<td>Dr. L. Brain</td>
<td>Biological and cognitive</td>
</tr>
<tr>
<td>Dr. D. van Daloo</td>
<td>Á la H. Davanloo</td>
</tr>
<tr>
<td>Dr. S. F. Davenport</td>
<td>Very orthodox Freudian</td>
</tr>
<tr>
<td>Dr. M. Goodenough</td>
<td>British object relations school</td>
</tr>
<tr>
<td>Dr. M. James</td>
<td>Mann’s strict time limitation</td>
</tr>
<tr>
<td>Dr. G.M. Klerowitz</td>
<td>Klerman, et al., Interpersonal, or Horowitz, et al., eclectic</td>
</tr>
<tr>
<td>Dr. V. Lowe</td>
<td>Eclectic</td>
</tr>
<tr>
<td>Dr. H. Tuhok</td>
<td>Eclectic: Malan plus Budman &amp; Gurman</td>
</tr>
</tbody>
</table>
Davanloo (10) ("Dr. van Daloo") but will reconstitute under the structured care of Horowitz et al. (10) or Klerman et al. (10) ("Dr. Klerowitz"). Davanloo would find his method appropriate for a patient as healthy as patient "Kronack" but excludes from his method bulimics like "MacManager" (10). At each class meeting the instructor chooses the play combinations as required by the progress of the course as a whole.

**EXAMPLES OF “PATIENT” AND “DOCTOR” ROLES AND THEIR LIKELY THERAPEUTIC INTERACTIONS**

"Patient" Lynn Lightner is a healthy law student who is under an unconscious compulsion to act as an "antidepressant" to a mother with a pathologic grief reaction because of the death of a child. As a result, he or she tends to return home to support mother when maturation (graduation, marriage) "threatens" even more distance from mother.

**TABLE 3. Role matches and mismatches**

<table>
<thead>
<tr>
<th>Therapeutic Role Match</th>
<th>Therapists</th>
<th>Heuristic Point</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Therapeutic Role Match</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fragmento or Jumpers</td>
<td>brain; Klerowitz</td>
<td>Decompensating patients need structure.</td>
</tr>
<tr>
<td>Kronack</td>
<td>Goodenough; van Daloo</td>
<td>Aggression is mobilized in separation/individuation.</td>
</tr>
<tr>
<td>Leffback or Lightner</td>
<td>James</td>
<td>Developmental arrests recapitulate previous conflicts.</td>
</tr>
<tr>
<td>McDermott</td>
<td>Davenport; Lowe</td>
<td>Guilt blocks normal grieving.</td>
</tr>
<tr>
<td>MacManager</td>
<td>van Daloo</td>
<td>Incest breeds shame and oral rage.</td>
</tr>
<tr>
<td>Sells</td>
<td>Goodenough; Tuhok</td>
<td>Selfhood and sexuality are inextricable.</td>
</tr>
<tr>
<td><strong>Antitherapeutic Match</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fragmento or Jumpers</td>
<td>van Daloo</td>
<td>Overstimulating.</td>
</tr>
<tr>
<td>Kronack</td>
<td>Davenport</td>
<td>Inappropriate focus.</td>
</tr>
<tr>
<td>Leffback or Lightner</td>
<td>Klerowitz</td>
<td>Developmental arrest wasted as opportunity for further growth.</td>
</tr>
<tr>
<td>Sells</td>
<td>Brain</td>
<td>Inappropriate focus.</td>
</tr>
<tr>
<td><strong>Questionable Match</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kronack</td>
<td>Lowe</td>
<td>What are the countertransference pitfalls?</td>
</tr>
<tr>
<td>Leffback or Lightner</td>
<td>Tuhok</td>
<td>Is self psychology appropriate in acute developmental crises?</td>
</tr>
<tr>
<td>Sells</td>
<td>Davenport</td>
<td>Does this &quot;neurosis&quot; really require a pure psychoanalytic approach?</td>
</tr>
<tr>
<td>MacManager</td>
<td>James</td>
<td>Is 12 sessions enough?</td>
</tr>
</tbody>
</table>

Although you make good grades, you are about to drop out of law school in your second year to return to the Midwest to work in your father's store. This complicates your upcoming marriage (to a classmate), but you sometimes don't think you can stand another day here.

Now in your thirties, you are the eldest surviving child of your parents and your mother's favorite. In some ways, your mother is your best friend as well. But she wants you to finish law school before coming back to Ohio. In this evaluation you need to ventilate about law school and are impatient about the irrelevance of family and developmental history the doctor is trying to elicit, and are even somewhat belligerent if you start to feel sad. For years, you have wondered about—but pushed back in your mind, especially in the interview—the meaning of the death of your parents' first-born, a baby they never mention. This child would be exactly two years older than you (since coincidentally you share a birthday) and was also named Lynn.
If the trainee preparing this role follows the script, the "doctor" and the observing class will begin to realize the link between the dead sibling and the patient's guilt over advancing development.

"Doctor" roles that are less likely to elicit this link between past and present are Drs. Brain and Klerowitz; but more interesting to the class observers will be the role played pairing the patient Lynn Lightner with Drs. Davenport or van Daloo.

**Dr. S.F. Davenport**

Your earliest memory is discussing dreams with your parents at the breakfast table. (Their theory was that the content referred to the dreamer's last thought before falling asleep.)

In college, Freud's *Interpretation of Dreams* changed your life. A strict constructionist, you believe even nightmares and trivial slips contain wishes. After years of moonlighting, you finally saved enough for psychoanalysis with a training analyst from the Boston Psychoanalytic Society and Institute, Inc.

You don't believe in short-term therapy, but if you did it would be the anxiety-provoking therapy of Peter Sifneos, but with even more stringent exclusion criteria.

**Dr. van Daloo**

Of immigrant background, your prime personal goal is to belong. Now secure and totally acculturated, you have found that your main stumbling block was fear of aggression; to fit in, you and your parents always held everything in. One day, however, you found you could be aggressive, gruff—even disagreeable publicly—and students and others in your hospital and university still respected and deferred to you.

On a private level, you get depressed when you hold feelings back. And conversely, you find yourself even closer and more intimate with others (your spouse, for instance) after a fight.

As a therapist, you unreservedly embrace the tenets of Davanloo's short-term therapy.

In the role play with Lynn Lightner, Davenport's techniques bring out the second-generational impact of pathologic grief and van Daloo's techniques would display the toxic effect of unconscious anger binding the grown child to the parent.

**Kris Kronack**

Your family physician, Dr. Krebs, told you last checkup that physically you are perfect. The phenylketonuria that prevented your eating so many delicious things until age 13 (and caused classmates at your private school to tease and torment you) has left no sequelae whatsoever. Your wealthy parents, however, (also his patients) asked him to refer you for long-term psychotherapy. They feel you must be depressed, because you are near the bottom rung in your company, a process chemical laboratory where you work as a chromatographer, and are engaged to someone who has only an associate's degree from a two-year college.

You feel better than you ever have. Your job prospects are good, you love this person, and your only major problem is moving from your current apartment, which you hate. But you love your parents to death and suppose that they must be right. Besides, everybody can use somebody to talk to. You just hope you'll be able to keep from biting your nails during the interviews, a secret habit you still use to soothe yourself when anxious—or angry.

Kris Kronack is a healthy young person at a developmental crisis, but there is little evidence that he or she actually needs treatment to pass it. There is conflict and aggression ("you love your parents to death") but the best strategy here might well be no treatment for now (11) to validate the autonomy that has thus far worked so well. Trainees may well not see this initially, but the argument and denouement provide a dramatic teaching device. One can imagine role plays between the Kronack and Davenport characters or between Kronack and van Daloo with their focus on psychopathology, followed by the course instructor arguing against any
treatment at all for now and modeling how to make this no-treatment recommendation to the patient empathically and therapeutically.

**CURRICULUM RATIONALE**

While it could be argued that short-term therapy needs a year of weekly didactics to be learned properly, the guiding notion behind this course (7) is that short-term therapies differ from the long-term therapies and among themselves mainly with regard to the four parameters of **brevity, focus, therapist activity, and patient selection**. Thus, much short-term technique is left to other seminars in the curriculum on psychodynamics, evaluation, termination, etc., and this course focuses primarily on proper patient selection and therapeutic match to the ideology of the therapist. The role playing conveys evaluation, selection, framing, and contract. Postplay discussion covers the therapist’s technique, especially regarding holding the focus and the brevity contract.

**EVALUATION**

As a pilot exercise, eleven PGY-3 residents received a 10-session course in early 1990. Materials consisted of readings (7,10) and one doctor and one patient role for each resident. At the first meeting, scripts were issued at random and recorded for the instructor’s use. For subsequent meetings residents were paired and assigned their two roles and pertinent readings. Aside from writing the scripts and accumulating materials, preparation for each class required approximately one hour per week of the instructor’s time.

Because it was this group of residents’ only experience with short-term didactic exercises, a “control group” was not feasible. At the final meeting, anonymous questionnaires were prepared by seven residents attending (64% response rate). Results were uniformly in agreement that role playing had at least equaled other teaching tools. Only a continuous case format, live patient interviews, and videotapes were seen as more valuable; and residents’ evaluation of role playing was higher than their evaluation of audiotapes, programmed texts, actor-simulations, and most didactic presentations.

Generally, residents felt role plays compared favorably with their favorite teaching methods, although they gave some edge to methods that allowed them more “passive learning” and required less active preparation.

The residents felt role plays were equally helpful to play or watch, that playing doctor and patient roles were equally useful for learning, and that the number of plays per session and overall was about right. They consistently criticized the role plays as less helpful than didactics for differentiating among various types of short-term therapy but praised them for verisimilitude and helpful preparation for real-life patients and actual therapeutic situations.

**DISCUSSION**

As the theater section of the newspaper so well demonstrates, reading is different from seeing a dramatic production. This report necessarily lacks what the reader must to some extent take on faith: blind role play teaches introduction to short-term psychotherapy powerfully without excessive preparation by either teacher or students and without violating patient confidentiality or supervisory privacy or necessitating professional actors. Trainees are social animals, and responsibility for preparing for two roles provides an inarguable incentive to read material pertinent to specific roles prior to each participant’s public performance. When the occasional play does not go well, it can be used for teaching if the instructor proceeds from the assumption that the “patient” and the “doctor” roles are probably an antitherapeutic match.
This paper benefited greatly from helpful discussions with Anne Alonso, Ph.D., Paul Hamburg, M.D., Jonathan F. Borus, M.D., and Barbara Siegert, R.N. Ms. Rita Hynes prepared the manuscript.

Copies of the eight doctor and eight patient scripts may be obtained by sending a $20 check payable to the General Psychiatry Practice, Massachusetts General Hospital, Boston, MA 02114.

References

11. Frances A, Clarkin JF: No treatment as the prescription of choice. Arch Gen Psychiatry 1981; 31:542-545
The Inpatient Database as a Technique to Prevent Junior Faculty Burnout

George R. Brown, M.D.

Junior faculty members beginning their careers in academic psychiatry are frequently assigned major clinical duties as directors of busy inpatient psychiatry units, leaving them little time or energy for research. The turnover in these positions is high and job dissatisfaction higher. This paper describes an inpatient database developed and used by the author as a clinical research tool to explore interesting questions about inpatient psychiatry and better integrate the academic and clinical service aspects of his junior faculty role.

Junior faculty members of academic departments of psychiatry are generally the least experienced but most energetic members of the teaching staff. Often they are recent graduates from residency training who have limited choices about their position on the faculty. There is little disagreement that acute inpatient ward responsibilities are among the most demanding and intensive duties available, resulting in frequent openings as inpatient unit directors depart and few or no senior faculty volunteer to fill these positions (1). Therefore, new junior faculty members are often assigned to these positions.

The time-intensive nature of inpatient work and the additional teaching time required by inexperienced residents and third-year medical students who work on these units leaves little time for junior faculty members to pursue their own research interests. Burke et al. (2) hypothesize that the relative lack of active psychiatric researchers, even in established academic departments of psychiatry, is largely traceable to this phenomenon. Boredom with inpatient work is common after several hundred admissions, and job dissatisfaction often ensues. The many other ingredients of job dissatisfaction on the inpatient service include limited contact with senior faculty, few opportunities for teaching senior residents, little time for academic development, limited opportunity to work with "high functioning" patients in psychotherapy, greater medicolegal exposure, and the unending, 24-hour-a-day responsibility of caring for inpatients. A "burnout syndrome" has been described distinct from simple job dissatisfaction in staff who are highly committed to their positions (3-11). Symptomatic expressions of such professional burnout can include somatic symptoms (fatigue, headaches, insomnia), psychological manifestations (depressed mood, apathy, cynicism, anxiety), and interpersonal difficulties (distancing maneuvers, avoidance, foreshortening interviews) (5).

It comes as no surprise, therefore, that the attrition rate of disenchanted junior faculty is high, leaving inpatient unit director positions unfilled and resulting in the loss of valuable, creative psychiatrists from the dwindling ranks of academic psychiatry.
Unfortunately, this cycle often repeats itself. Of the job openings recently advertised in a leading source for psychiatry positions (12), 89% involved inpatient positions (49% were exclusive assignments to an inpatient unit). Seventy-five percent of the university-based academic positions advertised were for inpatient positions at the assistant or associate professor level. The lack of experienced clinician-researchers interested in topics of import to the inpatient setting has also been described, with the resulting dearth in research literature on these topics (1,2). This is no more apparent than in the submission materials for the 1991 Annual Meeting of the American Psychiatric Association, in which, of forty-eight topic areas covering the range of submissions, neither inpatient psychiatry nor hospital psychiatry are mentioned as possible choices (13).

Three factors impede a newly appointed inpatient unit director in his or her attempt to cultivate a rewarding academic career: the structure of academic departments, the transition issues inherent in assuming a faculty role, and the overwhelming job requirements of an inpatient director, all of which frequently culminate in professional burnout and early attrition (1). In the report that follows, I will describe the inpatient database I created to overcome the above impediments and the ways it has contributed to my professional development and the department's research efforts by residents, students, and staff.

CREATION OF THE INPATIENT DATABASE

Wilford Hall Medical Center is the United States Air Force's largest teaching facility, with 850 beds (86 psychiatric) and 45 accredited residency training programs and fellowships in all major specialties and most subspecialties. The Department of Psychiatry has eleven full-time psychiatrists and an average of twenty-four residents in all four years of postgraduate training. On completing my residency I was assigned to the faculty position of staff psychiatrist in charge of an acute, thirty-bed inpatient unit staffed by junior psychiatry residents. Although not my stated choice, I received this assignment because none of the senior faculty members wanted this position.

In thinking about ways to make the best of my new faculty role, I began exploring the research opportunities in inpatient work. I quickly discovered that very few researchers directly involved in the clinical care of inpatients have prospectively maintained consecutive admissions in a database format for an extended period of time. For example, the largest published study of childhood abuse histories in adult inpatients that used a contemporaneous interview design has an N of only 100 (14). I then formulated several interesting research questions that could be explored with such an inpatient database: 1) What is the incidence of brief reactive psychosis on admission versus at discharge? 2) Are inpatients with childhood histories of sexual and physical abuse different in important ways from inpatients without such histories? Is there a characteristic "profile" of previously abused adult inpatients? Is Borderline Personality Disorder significantly correlated with past histories of physical, sexual, or combined abuse? 3) Is the length of hospitalization for depressed elderly patients in our hospital longer than for depressed patients under the age of fifty?

I decided to design a database and selected data fields (see Table 1) that could both address the above research questions in a prospective fashion and allow for retrospective review of factors of other critical inpatient issues that have received limited attention in the research literature, e.g., characteristics of patients who require restraints as part of their management and the influence of comorbid psychiatric conditions on medication requirements and length of stay (1). I anticipated that many of the latter questions could be addressed as feasible research projects by psychiatric residents within a
time frame that did not exceed the duration of their training.

Data entry forms were mass-produced and completed by me during each patient’s stay, with the final data fields relating to disposition and discharge medications completed at or near the day of discharge. This became routine after several admissions and required little additional time. Approximately five minutes was required to enter each form into the computer. Because the form was completed as an ongoing aspect of the patients’ care, it also served as a quality assurance checklist and teaching tool, enabling residents and medical students to learn how to deliver comprehensive care. I could quickly detect omissions in history-taking or laboratory evaluation while entering the data from the forms and could address these readily with the trainee while the patient was still “in house.”

During the 26-month period from August 1987 to October 1989, data from 1,040 inpatient admissions were entered into the database prospectively. The database file format was adapted to the Medical Center’s mainframe computer, and all data have been transferred there to enable sophisticated statistical analyses and access by other researchers. It is now the largest database of its type ever constructed at the Medical Center.

USES OF THE INPATIENT DATABASE

The inpatient database has proven useful for a variety of purposes. It has become a data source for both prospective and retrospective research projects; it has helped to integrate my service commitment and research interests as a junior faculty member; it has helped to prevent boredom and professional burnout by providing additional “meaning” to each patient contact; it has provided immediate access to patient information crucial to continuity of care; and it has served as an automated patient care log for psychiatric residents on the unit.

Most research involving large numbers of inpatients involves retrospective chart reviews as a primary source of data. The methodological problems with this approach are many (15). These methodological problems can be partially avoided by prospective maintenance of a standard inpatient database by the psychiatric staff and residents directly involved in the evaluation and treatment of the included inpatients. Several of the projects described above were defined in conjunction with the creation of the database and were truly prospective in nature. Additional research questions have also been addressed using the database in a retrospective fashion with some of the attendant problems inherent in such designs; however, the disciplined standardization of the data collection process for such a database is likely to enhance the quality and completeness of the data set available for

<table>
<thead>
<tr>
<th>TABLE 1. Inpatient database entry fields</th>
</tr>
</thead>
<tbody>
<tr>
<td>First name</td>
</tr>
<tr>
<td>Last name</td>
</tr>
<tr>
<td>Social Security no.</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Hx sexual abuse?</td>
</tr>
<tr>
<td>Identities of abusers</td>
</tr>
<tr>
<td>Hx physical abuse?</td>
</tr>
<tr>
<td>Identities of abusers</td>
</tr>
<tr>
<td>Military status</td>
</tr>
<tr>
<td>Rank</td>
</tr>
<tr>
<td>Branch of service</td>
</tr>
<tr>
<td>Marital status</td>
</tr>
<tr>
<td>Race</td>
</tr>
<tr>
<td>Years military service</td>
</tr>
<tr>
<td>Basic trainee data</td>
</tr>
<tr>
<td>Date admitted</td>
</tr>
<tr>
<td>Date discharged</td>
</tr>
<tr>
<td>Length of stay</td>
</tr>
<tr>
<td>Psych resident on case</td>
</tr>
<tr>
<td>Referral source</td>
</tr>
<tr>
<td>Duration of symptoms</td>
</tr>
<tr>
<td>First time admitted?</td>
</tr>
<tr>
<td>Inpatient admission no.</td>
</tr>
<tr>
<td>Previous outpatient Tx</td>
</tr>
<tr>
<td>Voluntary admission?</td>
</tr>
<tr>
<td>Family psych Hx</td>
</tr>
<tr>
<td>Consultations requested</td>
</tr>
<tr>
<td>Psychological testing info</td>
</tr>
<tr>
<td>Illicit drug use Hx</td>
</tr>
</tbody>
</table>
such retrospective studies.

Once established, the database can serve as a ready source for circumscribed projects that can be completed by residents during a one- or two-month research elective. It is clear that a lengthy data collection phase is the rate-limiting factor in resident involvement in clinical research at most institutions. This problem has been virtually eliminated for residents interested in specific inpatient research questions, which can be addressed in either the ongoing prospective studies or in carefully designed retrospective studies of limited focus. Often this introduction to clinical research sparks enough interest in junior residents to help them overcome “research phobia”; at the very least, it assists them in becoming more informed users of data from other investigators’ research efforts. Senior medical students interested in psychiatry have also been introduced to research principles and skills with this database. To date I have co-authored several manuscripts for publication (16) and helped to develop presentations using information in our database, and I anticipate that the database will be used in the development of many more papers and presentations.

The database has turned the tremendous service commitment of inpatient work into a data-gathering enterprise of the same magnitude. Although not originally interested in inpatient research, I found that with the database I could explore interesting clinical questions as part of the routine delivery of care on the inpatient unit. An additional benefit of such research at my institution is that it avoids the need for consent forms and lengthy Institutional Review Board (IRB) hearings because the data are collected as part of the routine delivery of clinical inpatient care. Although investigators elsewhere should consult their local IRB guidelines, in our Medical Center data collected in this way are exempt from institutional review (17).

Inpatient psychiatrists frequently feel overwhelmed by the service demands of caring for severely ill psychiatric inpatients. The database helped me reframe each new admission to the ward into another opportunity to expand the database and further psychiatric knowledge. This approach added another dimension in meaning, in the existential sense (18), to what would otherwise be experienced as stressful, unrewarding work after several hundred admissions. This additional meaning can help stave off feelings of boredom, professional stagnation, and burnout.

The computerized database has also proven clinically useful for patients readmitted to the inpatient service. With the integrated medical chart not always available at our institution, the database serves as a “corporate memory” for vital patient data, e.g., medications previously used and their dosages. All too often, residents have been unable to address important patient care issues because inpatients were unable to provide reliable histories of their prior treatment or because past medical records were inaccessible. Although I am not advocating that an unwieldy “alternative chart” be created specifically to address medical records access problems, this adjunctive function of the inpatient database has been an unanticipated dividend. Additionally, the speed with which data can be accessed with the database far exceeds what is possible by a manual chart review.

Lastly, the database has been very useful in maintaining the Psychiatry Residency Review Committee-required log of patient demographic characteristics that all psychiatric residents must maintain. Both residents and the Director of Residency Training can quickly assess a resident’s “patient mix” with database information and tailor the inpatient experience to provide a broad variety of patient care experiences.

DISCUSSION

It seems to be a fact of academic life that junior faculty members new to departments
of psychiatry will be relied upon to fill critical positions on busy inpatient services. These positions are often the first and last held by newcomers to academia, with the resultant attrition of junior faculty posing significant problems for many programs. Burke et al. (2) suggest that the lack of skilled, motivated clinician researchers may be the limiting factor in the progress of psychiatric research in this country, irrespective of funding concerns. Unless creative ways are implemented to enable young psychiatrists to develop academically, it is unlikely this cycle will be broken. Others have suggested that “an emphasis on research” is one strategy to prevent professional burnout in hospital-based psychiatrists (5) and that the computerization of inpatient data can provide “a significant advantage in conducting systematic studies” (1).

We have found that development of a contemporaneous, prospectively maintained inpatient database can play an important role in preventing junior faculty boredom and professional burnout by providing a number of clinical research opportunities, both prospective and retrospective, without having to “find” or recruit patients, develop consent forms, or, in many instances, engage in protracted battles with Institutional Review Boards. An obvious caveat is that such a database could be misused as a “paper-writing machine” to produce a large quantity of low-quality manuscripts. Access to and utilization of this research resource should therefore be monitored by the department’s Director of Research and limited to carefully thought out projects. Development and maintenance of the inpatient database requires dedication and perseverance, and it is clearly not a panacea for all the woes of beleaguered junior faculty. However, it can be an important tool in addressing the ubiquitous “academic dilemma” of inpatient unit directors. Our positive experience confirms the recent recommendation (1) that departments of psychiatry consider providing needed computer equipment to inpatient units as an investment in the research capability and academic development of their junior faculty.

The author thanks Tom Wise, M.D. for the inspiration to write this report and for critical comments on the manuscript and Sandra Dinwoodie for assistance in data entry for the inpatient database described.

The opinions expressed here are those of the author and do not necessarily represent those of the United States Air Force, the Department of Defense, or the Department of Psychiatry at Wilford Hall Medical Center.

References

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CORRECTION: In an article published in the Summer issue of Academic Psychiatry (El-Mallakh R5, Riba M: Post-psychiatry residency career choice: current trends, vol. 14, no. 2, 1990, p. 86-91), Table 1 was incorrectly printed. A corrected version of Table 1 is reprinted below.

<table>
<thead>
<tr>
<th>Graduating Year/Program Type</th>
<th>Total Number of Residents</th>
<th>Private Practice</th>
<th>Academic Positions</th>
<th>Hospital Staff</th>
<th>HMO Staff</th>
<th>Community Psychiatry</th>
<th>Fellowshipa</th>
<th>Otherb</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986/Unknown Nonuniversity</td>
<td>23 (26.0)</td>
<td>4 (2.4)</td>
<td>51.5 (30.8)</td>
<td>1 (0.6)</td>
<td>25 (15)</td>
<td>29 (17.4)</td>
<td>8 (4.8)</td>
<td></td>
</tr>
<tr>
<td>University</td>
<td>277 (34.8)</td>
<td>46 (16.6)</td>
<td>45 (16.3)</td>
<td>1 (0.4)</td>
<td>25 (10.7)</td>
<td>43 (15.5)</td>
<td>15 (5.4)</td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td>467</td>
<td>146 (31.3)</td>
<td>52 (11.1)</td>
<td>99.5 (21.3)</td>
<td>4 (0.9)</td>
<td>55.5 (11.9)</td>
<td>77 (16.5)</td>
<td>28 (6)</td>
</tr>
<tr>
<td>1987/Unknown Nonuniversity</td>
<td>19 (22.7)</td>
<td>7.5 (3.7)</td>
<td>70 (34.5)</td>
<td>2 (1)</td>
<td>25 (12.3)</td>
<td>35.5 (17.5)</td>
<td>16 (7.9)</td>
<td></td>
</tr>
<tr>
<td>University</td>
<td>280</td>
<td>83 (29.6)</td>
<td>44.5 (15.9)</td>
<td>3 (1.1)</td>
<td>25 (10.5)</td>
<td>45 (16.1)</td>
<td>11 (3.9)</td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td>529</td>
<td>132 (25)</td>
<td>53 (10)</td>
<td>134 (25.3)</td>
<td>5 (1)</td>
<td>55.5 (10.5)</td>
<td>83.5 (15.8)</td>
<td>31 (5.9)</td>
</tr>
<tr>
<td>1988/(anticipated) Unknown Nonuniversity</td>
<td>23</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>University</td>
<td>254</td>
<td>83 (32.7)</td>
<td>27 (10.6)</td>
<td>42 (16.5)</td>
<td>4 (1.6)</td>
<td>20 (7.9)</td>
<td>48 (18.9)</td>
<td>32 (12.6)</td>
</tr>
<tr>
<td>Subtotal</td>
<td>407</td>
<td>125 (30.7)</td>
<td>31.5 (7.7)</td>
<td>86.5 (21.3)</td>
<td>4 (1)</td>
<td>32 (7.9)</td>
<td>70 (17.2)</td>
<td>61 (15)</td>
</tr>
<tr>
<td>Total</td>
<td>1,403</td>
<td>403 (28.7)</td>
<td>136.5 (9.7)</td>
<td>320 (22.8)</td>
<td>13 (1)</td>
<td>143 (10.2)</td>
<td>230.5 (16.4)</td>
<td>120 (8.6)</td>
</tr>
</tbody>
</table>

Note: Values in parentheses are percentages. Sum of resident full-time equivalents may exceed or be less than total number of residents, but reflect numbers reported by program directors.
aSee Table 4.
bSee Table 5.
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