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Special Article

General Systems Approaches in Mental Health Administration

Developing State-University Collaboration Programs

Glenn R. Yank, M.D.
Wil W. Spradlin, M.D.
Patricia B. Porterfield

Developing state-university collaboration is the process of creating mechanisms to couple two systems for mutual benefit. Collaboration requires setting new organizational boundaries for both the state agency and the university and developing new patterns of information flow within and between the organizations. Each organization’s homeostatic properties resist change; this resistance must be balanced by leaders’ attention to the organization’s developmental needs. The impact of collaboration increases tremendously after key thresholds of involvement are attained and a “critical mass” of faculty exerts a synergistic effect that shifts both the state agency and the university department to new functional states.

Although the literature on mental health administration describes useful conceptual frameworks for addressing specific clinical-administrative tasks, it lacks a generally accepted unifying theory of organizational dynamics to apply to these tasks (1,2). General systems theory, which identifies and integrates many generalizable principles underlying more specific administrative approaches, has been used extensively to explain organizational behavior and guide organizational development (3–10). The Task Force on Teaching of Administration in Psychiatry, established by the American Association of Directors of Psychiatric Residency Training, considered systems theories to be part of a core curriculum for the teaching of administrative aspects of psychiatric practice (11).

Drawing examples from the collaboration program of the University of Virginia (UVA) and Virginia’s Western State Hospital (WSH) (12), we will discuss the value and application of systems concepts in mental health administration, examining their use in developing programs of collaboration between states and universities. We will consider specific conceptual principles including open systems, hierarchical organization and subsystems, self-regulation, “evolutionary feedback” (13) in nonequilibrium steady states, boundaries, information processing and communication, and coupled systems.

It is timely to use the development of state-university collaboration programs to illustrate the relevance of systems theories to

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 administrative psychiatry. Such programs are of increasing interest to academic psychiatry, state mental health programs, and national organizations (14–16), and their development and maintenance can present perplexing challenges (17–22). Although Talbott and Greenblatt (19) identified key “lessons learned” from attempts at state-university collaboration, these “lessons” have not been brought together within a unifying conceptual model. Systems theory directly addresses several of these issues of collaboration as they pertain to the structural characteristics of the linkage or intersection of two organizations (13). Further, systems theory’s principles of evolutionary processes and communication address the dynamics of bridging two systems through the creation of coupling mechanisms (23–26).

BASIC DEFINITIONS AND CONCEPTS OF SYSTEMS THEORY

For the purposes of this discussion, a “system” can be most broadly defined as “a set of objects together with relationships between the objects and between their attributes” (27). The objects that are components of the system can be physical or abstract. This definition is quite different from a formal mathematical definition of a “dynamical system” (28). Similarly, the term “model” will be used broadly to include verbal and conceptual representations of the structure and functioning of specific phenomena (29). This broad definition differs from the formal definition used in mathematics (28,30); however, the process of developing modeling relations between naturally occurring systems and formal mathematical systems has been described in detail (31).

Discussing the applicability of systems theory to organizations, Katz and Kahn (3) comment:

In some respects open-system theory is not a theory at all; it does not pretend to the specific consequences of cause and effect, the specific hypotheses and tests of hypotheses which are the basic elements of theory. Open-system theory is rather a framework, a meta-theory, a model in the broadest sense of that overused term. Open-system theory is an approach and a conceptual language for understanding and describing many kinds and levels of phenomena. (p. 452)

Open systems interact with their environment, exchanging and transforming energy, material, and information so as to develop and maintain their organization (27,32–36). Because increasing organizational complexity requires that open systems dissipate to the environment the products of entropy, the inherent tendency toward increasing disorder, such systems have also been termed “dissipative” systems (37,38).

“Wholeness” refers to the interaction of a system’s components in such a way that events and forces affecting one part of the system affect the system as a whole. A corollary to wholeness is the concept of emergent phenomena—phenomena that cannot be predicted by analyzing the components of the system individually, but that emerge from their interaction. Similar concepts of system components interacting to create new properties have been termed “synergy” and “synergetic” properties (39–41).

Open systems show hierarchical organization: they are organized with multiple levels of complexity, but similar properties of organization can be identified at all levels. For example, hospitals are often composed of units or programs, which are composed of wards, which, in turn, are composed of treatment teams, demonstrating four distinct levels of hierarchical organization. The components of an open system, termed its subsystems, are themselves systems at the next lower level of the organizational hierarchy. Further, a particular system is also a subsystem of the next higher level system. The mechanisms that control a system’s development and that provide feedback about how the system’s functioning compares
with target values are examples of subsystems. Greater differentiation of subsystems allows for increased specialization of function as systems become more complex. However, the integrative functioning of a system requires that it set limits on the range and variance of the actions and behaviors of its subsystems (3).

ORGANIZATIONS AS OPEN SYSTEMS

Miller (33) showed that organizations are open systems. Both state mental health agencies and university departments of psychiatry are thus open systems that interact with environments that provide various components, including patients to treat, resources (money, material, staff), and information (policies, directives, supervision). Some of the environments that provide these components are specific to the organizations; others, such as the public, are external.

State mental health agencies and university departments of psychiatry are subsystems of higher-level systems in their organizational hierarchies. Often, collaboration efforts involve particular hospitals or mental health centers that are subsystems of a state mental health agency, which may be a subsystem of a state cabinet-level department, which reports to the governor. A university department of psychiatry functions within a medical school and/or teaching hospital, and its chairman may report to a dean of the medical school and/or a hospital chief of staff, who report to higher levels of university and hospital governance. These higher-level systems will inevitably impose certain constraints on the collaboration activities of the state mental health agency and department of psychiatry, through control mechanisms such as goal setting, budgeting, and policies (3).

When key leaders in collaboration efforts fulfill roles at higher levels within their agencies in addition to their primary roles, they can provide feedback about the effects of higher-level regulation on the collaboration, as well as about the needs, goals, and experiences of involved higher-level staff. A person who fulfills this "linking-pin" (42) function is not only a bridge between the two levels of the organization, but also a full member of both, and thus uniquely able to integrate the goals and priorities and balance the stresses and strains at both system levels. For example, during the development of the UVA/WSH collaboration, faculty who established training wards also served on the hospital's medical staff executive committee, as medical staff officers, and as acting medical director. Having responsibilities at both system levels required them to balance the needs of the training wards with the overall needs of the hospital.

SELF-REGULATION

Open systems are self-regulating: they seek to control their patterns of organization and functioning. Regulated self-renewal has also been termed "autopoiésis," which literally means self-generation (38,43,44). Self-regulation has two principal components: homeostasis and development. Homeostasis is the tendency of a system to maintain stability of key functions and structures over time so as to ensure its survival. Stability is maintained by feedback (cybernetic) regulation: subsystems compare key system parameters to "target" values and generate error signals that lead to actions to correct significant variations. An example of feedback regulation in a health care agency is quality assurance, which monitors and evaluates clinical outcome measures and initiates corrective actions, such as education or counseling, to address identified problems and improve clinical outcomes.

Feedback regulation in each parent organization affects a collaboration because homeostatic mechanisms will detect changes evoked by the collaboration, generating "error" signals, unless organizational goals and indicators, such as budget targets and quality assurance indicators, are modi-
fied to support the collaboration. For example, in the UVA/WSH collaboration, faculty clinicians increased the hospital’s use of lithium carbonate and related laboratory monitoring studies, raising laboratory costs above those budgeted. The hospital was forced to reevaluate and increase its laboratory budget, and eventually obtained the equipment to perform needed studies in house. Collaboration-evoked changes in practice patterns also increased the use of CAT scans and EEG recordings; this was detected by budgetary feedback mechanisms and required alterations in the hospital’s budget to support improved standards of care. Changes in drug-prescribing patterns were detected by both pharmacy and nursing monitoring practices, requiring faculty to revise medication usage guidelines and educate hospital staff about advances in psychopharmacology.

The development of open systems is regulated by “guidance” mechanisms and influenced by environmental factors, including resource availability and both help and competition from other systems. “Anticipatory systems” (31) contain subsystems that 1) predict future conditions based upon specific parameters and their rates of change, 2) model the effects of these anticipated conditions upon the systems, and 3) enable responses to predicted conditions that increase the systems’ viability. For example, anticipating future changes in fiscal policies has prompted many hospitals to develop partial hospital programs. Anticipated staffing needs have been more effectively met through more proactive and competitive recruiting efforts and senior resident rotations. In the UVA/WSH collaboration, awareness of developments in psychopharmacology enabled faculty to become involved in studies of the drug clozapine, gain experience with this drug, and take part in discussions of state policy options prior to the marketing of the drug.

Tendencies toward change (development) and tendencies to resist change (homeostasis) are both inherent properties of systems. They are active, energy-requiring processes because although open systems may be in “steady states,” they are far from being in equilibrium with their environments. Rather, they are actively maintained in unbalanced steady states that can respond nonlinearly to internal and external changes (37,45,46). Positive feedback mechanisms can amplify small changes into significant fluctuations of key system parameters, around which systems can reorganize in a process termed “order through fluctuation” (37). Systems in unbalanced states may also show “metastability,” the occurrence of different patterns of stability (37,46). Therefore, neither a system’s existing conditions nor its homeostatic processes can wholly determine its subsequent evolution, because metastability and amplification of fluctuations lead to various potentially stable system configurations. This concept of “evolutionary feedback” (12) forces a reconsideration of the previous systems concept of “equifinality” (29), which held that system parameters could determine a unique final state from a wide range of system conditions. Complex social systems therefore cannot be analyzed or designed so as to eliminate uncertainty; they must instead be managed toward the more desirable among a range of outcomes (47,48).

To operate, collaboration programs need sufficient resources to provide adequate faculty salaries, logistical and program support, and incentives to promote the programs (19). These needs are aspects of the dependence of systems on their environments. Because collaboration efforts are based upon two systems, both in nonequilibrium states, even minor changes in resource availability may greatly affect them. To minimize perturbations in resource availability, WSH and UVA used existing funded state hospital positions to hire faculty, and they used hospital operating funds that had been released following improved hospital efficiency and census reduction rather than new
or "soft" contractual funds, which were considered less stable.

SYSTEM BOUNDARIES

Every open system is demarcated by a "boundary" subsystem that regulates the movement of energy, material, and information into and out of the system and determines what and who are "inside" and "outside" the system. Boundaries also demarcate the subsystems within a particular system. Because boundaries in organizations serve homeostatic functions that include maintaining the constancy of staff membership and roles, developing collaborations requires the restructuring of organizational boundaries. Modification of system boundaries to increase the interaction between two systems is an example of a coupling mechanism (23–26), a concept discussed in more detail in the conclusion of this article.

The boundaries of organizations include the rules, protocols, assignments, and relationships that govern joining, membership, and the movement of people, resources, and information into and out of the system. Boundaries also have subjective aspects related to common goals and values, identification with the organization and its mission, and degree of staff willingness to subordinate personal needs and goals to those of the organization. Joining an organization includes negotiating the unofficial and subjective aspects of the organization's boundary and often participating in joining rituals or initiations that ease acceptance. It is helpful in a collaboration program, for example, for faculty and agency staff to attend each other's social activities.

Staff attitudes, goals, and priorities are aspects of boundaries of work groups that influence collaborative success (19). State mental health agencies usually give first priority to direct care services, whereas university departments are often expected to give equal priority to training and research. Such differences must be addressed through negotiation, identification of model programs that have academic functions as part of their mission, or other mechanisms that enable the flowering of an academic culture within the public mental health system. Boundaries of work groups must be modified to include staff and values originally identified with each of the two participating agencies. For example, collaboration with UVA was presented to WSH staff as an opportunity to improve patient care, particularly through recruiting psychiatrists, a persistent difficulty for state hospitals (49,50), not as a solution to hospital problems. Emphasizing the shared value of patient care developed a foundation of mutual respect and an inclusive, common attitudinal boundary around both systems.

Joint appointments to state agency staff–university faculty positions enable staff to function within the boundaries of both systems, but role expectations must be clearly stated for a staff member's concurrent functioning as the "agent" of the two systems as they intersect in the jointly appointed staff. The UVA/WSH collaboration gave joint appointments to both faculty recruited by the university to develop training and research programs at the state hospital, and to staff already working at the state hospital to support these programs.

Collaboration also requires balancing the differentiation and flexibility of roles specific to each system versus roles that support the collaboration. The UVA/WSH collaboration assigned multiple roles to key individuals, making them responsible for both academic goals and hospital clinical programs. Faculty who supervised medical student clerkships also served as attending psychiatrists on admission wards; faculty who coordinated psychology intern rotations were also responsible for hospital admissions program functions or overall hospital psychology services.

Another boundary issue derives from differences in agencies' interfaces with the
public. State mental health agencies maintain a reactive public interface, attempting to appear responsive to the public and its representatives, including the media, and to minimize complaints. The state agencies possess what Weber (51) classes as "legitimate" authority, based on the rules of society. Universities' authority is mostly based on a traditional role of intellectual leadership and perceived expertise (2). Maintaining prestige is often more important for universities than for state mental health agencies. Universities maintain a public interface that emphasizes leading rather than reacting, and their relation to the public allows for slower organizational change because their histories and traditions are much more respected than are those of state mental health agencies. These differences in interface with the public and its representatives in the media must be adequately resolved or made to complement each other for collaboration to succeed.

Public boundary issues are highlighted when a state agency undergoes one of the periodic media exposés that these agencies both dread and expect. Whereas state agencies must accept the likelihood of unfavorable media scrutiny, university systems are much more protective of their prestige and are more used to dealing with the media from the position of offering expertise than defending alleged wrongdoing. A scandal severely stressed the UVA/WSH collaboration relatively early in its development when several hospital administrators and collaboration faculty were accused of violating patients' rights and conducting illegal research. Although all charges were eventually proved groundless, they received considerable media attention, which adversely affected the morale of faculty striving to improve hospital conditions. The university department chairman had to find a way to provide support and encouragement for collaboration faculty during this period of strain without publicly endorsing the state hospital's position in the controversy until legal issues were resolved—a difficult balancing act. This example illustrates the need to anticipate how collaboration can expose an academic department to the state agency/public media interface.

THE LEADERSHIP SUBSYSTEM, LEADERS, AND COLLABORATION

Because a collaboration between systems requires change in both, leadership supporting the collaboration must be strong on both sides of the endeavor. Leadership within an organization is not just the role of one person; it is a subsystem responsible for making decisions, setting priorities, integrating homeostatic and developmental needs, balancing flexibility and specificity of roles, and empowering others to carry out tasks. However, certain leadership functions are focused and other issues magnified by identifying leadership with particular individuals. Leaders can crystallize system identity and cohesiveness around staff attitudes and feelings, both positive and negative, about the leader (52); groups can be united in their anger at a leader, yet remain functional if the leader commands respect. Leaders' ability to direct these binding forces has a significant effect on the development and cohesiveness of work groups (53-55).

This can be particularly important for the key developmental task of enabling faculty/staff to identify with the collaboration, and not just with one of the parent agencies. For UVA and WSH, this identification was forged by the university department chairman serving as hospital director during a crucial phase in the collaboration's development.

Leadership in a state-university collaboration must address the homeostatic and developmental needs of each system and find a common ground. Adding several faculty-caliber professionals to a state mental health agency (or unit) changes the local balance of input into decision making. Middle-level clinical and program managers will be called
upon to share their authority.

Middle-level authority subsystems within bureaucracies serve homeostatic functions of assuring compliance with policies and procedures and keeping the organization's functioning predictable. They have an inherent disposition to resist change. Understanding this resistance as the homeostatic property of an impersonal system, rather than as the recalcitrance of short-sighted individuals, helps leaders tolerate inevitable frustrations and allows them to value resistance as the manifestation of the organization's need to survive and to preserve effective functions. The valuing and depersonalizing of resistance reduce the emotional conflict generated by change and allow for affective joining with resistant staff around their commitment to the organization. In the UVA/WSH collaboration, commitment and continuity were both emphasized when nonfaculty hospital program managers and nursing administrators were told by the university department chairman that their help was needed to make the collaboration work, in the form of their continued best efforts to make sure that the hospital fulfilled its primary mission of providing patient care.

Because organizations have extensive homeostatic mechanisms, a collaboration requires leaders to balance these forces with needs for development by discerning each agency's developmental needs, achieving a vision of how each agency can help the other evolve, and creating strategies to realize that vision. Leaders take part in the predicting and modeling subsystems within each agency, enhancing its effectiveness as an anticipatory system. In human resources development, collaboration can assist a state agency with present and future professional manpower needs (56,57) and can help university departments meet future needs for positions, training sites, and research opportunities. In collaboration, leaders in both agencies must plan actively for the future rather than react to maintain the status quo as their organizations are buffeted from crisis to crisis.

Leadership must be aware of the boundaries that are stressed by developing a collaboration, the rules and processes that govern joining each of the two systems, and the ways in which various agency boundaries affect information flow. For example, seeking resources for training and research, increasing clinical staff costs because faculty demand reasonable case loads and adequately staffed programs, and negotiating flexibly with professionals who have more lucrative career options are leadership tasks that require modification of state agency budget and personnel system boundaries. Added resource input results in greater expectations for work output from the parent agency, an example of a system controlling the range of variance of subsystem functioning. Because developing collaboration requires changing organizational boundaries, leaders must continually attend to the integrity of these boundaries to maintain organizational identity and morale.

Leadership must also address the academic/nonacademic boundary as it affects professionals working primarily in a state mental health agency, which is not always considered an image of academia. In the UVA/WSH experience, the University Board of Visitors questioned why the university was involved with a state hospital with a previously poor reputation, and was answered in terms of training and research opportunities and the relevance of state service for a state-funded university. This shows that the boundary change for the department of psychiatry is noticed by the larger university system, and that a common parent agency can facilitate collaboration.

INFORMATION AND COMMUNICATION

Information transfer and processing at system boundaries occur at all system levels and are elements of a "systems" description
of communication (58). In organizations, information may be in the form of discussions, memoranda, reports, budget documents, etc. Disturbances in communication are key aspects of system dysfunction; they include both inadequate rates of information flow for the system to adapt to its environment and excessive rates of information flow that can result in information overload (33). Disturbances in information content include deletion of information, introduction of errors, and translation problems when the coding of information is converted between analog and digital formats, as in attempts to put body language and tone-of-voice messages into words (59).

Shannon (60) demonstrated that communication processes have an intrinsic entropy, or tendency to disorder, that increases with both message complexity and the number of message transmissions. Because every transmission of a message is subject to the introduction of error or “noise,” successive transmissions increase the likelihood of miscommunication. Maintaining message coherence thus requires an amount of energy that increases with both the complexity of the message and the number of transmission steps. Communication also takes place on multiple levels, including the message itself and metacommunication that qualifies the message by addressing the relationship of the parties, thereby introducing the possibility of noncongruence between the message and the metamessage, which would result in paradoxical communication (36).

The foregoing considerations, together with the principle of hierarchical organization, explain certain communication problems observed in organizations. Hierarchical organization and the need to respect system levels (“chain of command”) require communication of messages sequentially across each subsystem/system boundary as messages move up or down the levels of the hierarchy, to avoid the structural pathology of an “end run.” Yet this communication “through channels” introduces multiple opportunities for messages to be distorted not only by the factors mentioned, but also by the tendency for each person in the chain to bias information to manipulate situations to benefit his or her self-concept (59). As the message moves up the hierarchy, people may also distort the message so as to please, or at least not displease, their supervisors. Multiplying these factors by several levels of hierarchy can result in top-level managers receiving information indicating more favorable conditions at the “front lines” than exist in reality. “Action” messages transmitted downward may be distorted through the metacommunication of supervisors asserting authority over their subordinates.

In collaborations, these communication processes are further complicated by the existence of two sets of chains of command, one for each parent agency. These processes can magnify differences between the goals of the parent agencies. Deans of medical schools may be more interested in the research productivity of faculty than are commissioners of mental health, who may be more concerned about length-of-stay trends and untoward incidents. Understanding communication processes allows staff to analyze communications problems as systems problems and build in error-correcting mechanisms such as planned contact and feedback from the front line to higher levels that do not “end-run” the system.

Thresholds for detecting error signals also influence the effectiveness of communication. They should allow reporting of significant variations from desired practice and outcomes but should not result in expectable variations being reported as errors (61). Unless an organization accepts the existence of a normal range of outcomes, staff will waste time analyzing expectable variations in agency function as “errors,” and morale will suffer when their work that is within the normal range of variation is considered a source of error. The setting of thresholds by an organization’s leadership is also a metacommunication to staff about the relative
health or fragility of the organization. Professional staff view increased reporting requirements as an indication that the agency is more fragile and is trying harder to maintain control over its staff because of distrust of their performance.

An example of threshold revision is a change in prescription guidelines by the UVA/WSH collaboration program. Faculty revised drug-prescribing guidelines that had been based on package labeling information so as to incorporate expanded lists of drug indications and dosage ranges based on the current psychiatric literature. This allowed faculty psychiatrists to treat conditions such as affective disorders refractory to lithium, severe disorders of impulse control, and nonresponsive psychoses with a variety of drugs that have been proved effective for these conditions, but that were not labeled for these indications, without generating an error signal.

Maintaining appropriate mechanisms for detecting errors is vital in organizations that seem to run from crisis to crisis: stress and strain can change thresholds for error signals. Staff question how critical problems must be to receive attention and can become desensitized through seeing problems judged not serious enough to receive attention and correction. Problems of comparable severity soon are not reported, and eventually, perhaps, not even noticed. This desensitization is a resetting of feedback sensor functions that reduces the information forwarded to leaders. For example, the adult psychiatric census of WSH began to increase in 1987, requiring temporary beds for patients not anticipated in hospital operating plans. Staff were very disturbed by the first such use of temporary beds and worked hard to change programs to accommodate the increasing census. However, continued census growth for a period of months that turned into years led to the use of “temporary” beds becoming accepted as the new status quo and no longer generating the same level of distress in the hospital, even as staff-to-patient ratios continued to decrease. This resetting of sensor thresholds adversely affected the collaboration as leaders showed progressively less awareness of and concern about the effect of decreasing staff-to-patient ratios on faculty and staff morale.

Resetting of thresholds may be necessary, however, when operating under conditions of information overload, which can also impair system performance. In such circumstances, “filtering” of messages is necessary to minimize interference with decision making and to prevent leaders from becoming so immersed in day-to-day reactive problem solving that they fail to adequately address the organization’s longitudinal developmental needs. Setting appropriate thresholds for error signals is yet another example of a leadership task that serves a regulatory function.

**CONCLUSION: COLLABORATION AS COUPLED SYSTEMS**

Developing state-university collaboration is the generation and shaping of mechanisms to couple two systems in a way that benefits both. Coupling occurs when changes in one system affect the other, and it is “direct” when they act upon each other across a common boundary. Coupling can be characterized on a continuum from “tight” to “loose” based on the magnitude of the effect of changes and the number of intervening factors. Loose coupling may help systems adapt to rapidly changing environments (24,62). Organizations can be coupled by formal arrangements that specify the terms of mutual interaction, such as contracts, joint appointments, dual-role positions, committees, and budgetary linkages. Organizations also use less formal coupling devices such as peer networks and verbal agreements. More formal arrangements have the advantage of stability, whereas less formal mechanisms may be more flexible.

The UVA/WSH collaboration illustrates a variety of coupling mechanisms,
beginning with the joint recruitment of faculty for joint appointments by the Department of Behavioral Medicine and Psychiatry and the WSH administration. Training psychiatry residents and medical students at WSH helped in faculty recruitment. The training wards served linking functions, meeting hospital clinical needs as well as university needs for additional training opportunities and faculty expansion. A clinical research unit met hospital needs for treating medically complex patients as well as the university’s needs for research productivity. Conducting research and educational programs that facilitated faculty to “be academic” at WSH and hiring faculty into state positions allowed tighter coupling than could be attained by developing collaboration on a consultative basis, or by having the major academic components at separate sites.

Tighter coupling of UVA and WSH resulted from appointing the department chairman as facility director. This dual role enhanced the chairman’s ability to effect system change by increasing his authority, because the director holds the greatest legitimate and traditional authority (51) in a state hospital. The arrangement enhanced the collaboration’s status and credibility in the Virginia Department of Mental Health’s Mental Retardation and Substance Abuse Services, emphasized the importance of public psychiatry at UVA, and aided in recruitment of faculty to WSH. More enduring structural coupling mechanisms include the clinical WSH Division within the Department of Behavioral Medicine and Psychiatry, headed by the WSH director of medical services, for clinical, research, and training issues, and the Administrative Division, supervised by the WSH facility director, for training in mental health administration. Faculty have been appointed to other WSH leadership roles, including director of clinical services, director of psychology, and chairs of medical staff and hospital committees.

The coupling of systems can lead to emergent properties in each of them, which further affects their coupling and leads to new emergent properties, in a recursive loop. Coupling that results in such reciprocal influence has been termed a “servoemergent relationship” (63), signifying that feedback mechanisms (“servo”) lead to new emergent properties which then modify the feedback coupling mechanisms, leading to further emergent system changes, and so on.

The development of state-university collaboration programs illustrates both servoemergence and nonlinearity. The impact of collaboration programs on both state agencies and universities is not a linear function of the number of persons involved or the dollar value of contracted services, but rather increases greatly after key thresholds of involvement are attained. These thresholds include specific accomplishments of the collaboration as well as the subjective sense of the enterprise “turning a corner.” We have termed the number and/or proportion of faculty or staff needed to reach such thresholds a “critical mass.” Attaining critical mass shifts both the state agency and the university department to new steady states of functioning, not all of which are predictable.

In the UVA/WSH collaboration, the development of new clinical and administrative structures within the department and hospital illustrates the concept of emergent phenomena, new forms of order arising from the managed fluctuations of the collaboration process. Other emergent phenomena include the attainment of accreditation for WSH by the Joint Commission on the Accreditation of Healthcare Organizations and the development of clinical research programs that elucidated the syndrome of polydipsia, hyponatremia, and intermittent psychosis and its treatment (12, 64–68). The collaboration has also accomplished the training of over 80 psychiatry residents and over 600 medical students in public-sector psychiatry over the past 12 years and has facilitated the recruitment of over 30 faculty in psychiatry, internal medicine, and psy-
psychology to WSH during that time (12).

Threshold phenomena in a collaboration are not truly reversible, although they can be undone. The emergence of a functioning collaboration changes the history of both parent agencies. If the collaboration should eventually fail, the agencies would not return to conditions identical to those in place before the collaboration was initiated, but would then have the history of their failed efforts, which could significantly affect any subsequent attempts at collaboration. In this regard, it is far more practical for organizations to learn from the experiences of others that have experienced difficulty or failure (17,18,21), than to try again after failing themselves. Although failed attempts at collaboration may prove instructive as to the requirements for success, they also engender expectations of failure at such an endeavor.

Because collaborations must be developed in organizational conditions that are far from equilibrium, they remain vulnerable to environmental perturbations, such as changes in state financial status. Collaboration programs will therefore continue to need strong leaders who are able to anticipate changing conditions in the social, economic, and political environments and who are able to actively plan and manage the programs’ advancement in order to keep them within a desired range of developmental courses as political priorities vary and competition for state resources increases.

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The Development of the Psychodynamic Psychotherapist in Supervision

Jane Thorbeck, Ed.D.

Supervision is a fundamental component of every clinical training program that teaches psychodynamic psychotherapy. However, the development of the psychodynamic therapist in supervision has been a relatively unexplored area. This article identifies nine areas of development of the psychodynamic psychotherapist in supervision, with an emphasis on the beginning trainee. The areas explored include aspects of the therapist’s understanding of the patient and aspects of the therapist’s use of himself or herself in the psychotherapy. Consideration of the trainee in each of these areas helps the supervisor better understand the specific strengths and weaknesses that the trainee brings to their work together and enables the supervisor to be more skillful in the difficult business of psychotherapy supervision.

Supervision is a fundamental component of every clinical training program that teaches psychodynamic psychotherapy. Further, a reputation for good supervision may attract trainees to a particular program (1). Supervision is the oral tradition of our field, yet it is an area in which even experienced supervisors tend to function intuitively. Although many supervisors have a general understanding of what a 1st-, 2nd-, or 3rd-year trainee ought to know, specific areas of development of the psychodynamically oriented therapist have not been well articulated. As detailed in what follows, an appraisal of the trainee in each of nine areas will aid the supervisor in better understanding the specific strengths and weaknesses that the trainee brings to their work together.

The question of what is productive supervision goes back to the psychoanalytic training institutes of the early twentieth century. Early Hungarian psychoanalysts emphasized the importance of the analysis of the trainee’s personal thoughts and feelings about his or her patient. To this end, the student in psychoanalytic training in Budapest worked with one person who served as both analyst and supervisor. The Psychoanalytic Institute of Vienna, on the other hand, advocated that its students learn from various teachers who were not the trainee’s personal analyst. In the last 30 years, most of the literature on supervision has focused on two questions that hark back to Budapest and Vienna: 1) What is the most useful topic of the supervisory hour? and 2) What kind of atmosphere or relationship can be created so that the trainee feels able to reveal fully the material pertaining to this topic?

Authors who have explored the developmental and learning needs of the trainee therapist have generally arrived at similar points of inquiry. The importance of the “atmosphere” or “relationship” between the supervisor and the trainee was addressed by Ekstein and Wallerstein (2) and later by

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Fleming and Benedek (3) in discussions of the "learning alliance." Maltzberger and Buie stated that "successful supervision demands the establishment of a supervisory alliance" (4, p. 66). This in turn depends on the supervisor's ability to understand areas of "interference" in the trainee's learning and the defense mechanisms used by the trainee in those areas. Ekstein and Wallerstein (2) highlighted the need for the supervisor to recognize the existence of "problems about learning" that may affect the trainee's ability to work in supervision and with patients. A systematic approach to assessment of the trainee's learning needs was done by Fleming and Benedek, who discussed an approach to the trainee's "learning problems" as well as the usefulness of an "educational diagnosis" of the trainee. Recent authors writing on psychiatry residency training have advocated greater specificity and replicability of the skills necessary to function as a good psychotherapist (5); clearcut national standards for clinical psychiatric skills, including psychotherapy skills (6,7); and the development of a curriculum for the teaching of psychodynamic psychotherapy (8). Friedman (9) has written on the inevitable difficulties of learning and practicing psychotherapy. Most authors writing on supervision have emphasized potential problems in the supervisor/trainee relationship or learning problems in the trainee that need to be understood and addressed in the supervision. The "supervisor in developmental perspective" was discussed by Alonso (10, p. 51), but the complementary topic, the trainee in developmental perspective, has not been adequately addressed. This article addresses the development of the psychodynamic psychotherapist in supervision in specific cognitive and affective areas.

Three theoretical models are discussed in the literature on supervision of psychodynamic therapy. Most supervisors purposely or intuitively use a combination of the three. The first is what might be called the educational model. Like the earlier psychoanalytic supervisor of the Vienna Society, the supervisor in this model is an instructor or educator, someone whose purpose is didactic, who passes on a body of knowledge, and who uses supervision as a means to uphold the institution's standards and protect the patient. Within this model the supervisor functions as a traditional teacher and does not explicitly address unconscious reactions of the trainee. The supervisor employing this model resolves the basic "teach or treat" dilemma inherent in supervision in the direction of "teach" (11).

The second model of supervision is oriented in the direction of treatment. This model uses a more psychotherapeutic approach that is similar to the early Hungarian school of thought. It attends to countertransference and the trainee's associative processes; to the trainee's responses as well as inhibitions in response; to identifications with the patient or failures in empathy; and to transference of the trainee to the supervisor that might impede learning. The need for treatment for the trainee is discussed if it seems indicated. In other words, the supervisor gives therapeutic attention to the trainee therapist (10).

The third model of supervision has been described as the parallel process model (2), in which the trainee unconsciously repeats with the supervisor the same resistances, affects, and behavior style that existed in the therapy hour itself. For example, it is fairly common in the treatment of a borderline patient for the trainee to come into supervision feeling at his or her wit's end, helpless and angry at the patient, and discouraged about his or her therapeutic abilities. This, of course, is akin to what the borderline patient feels and then engenders in the therapist through the interactive aspect of projective identification. And therein lies the subject of the supervisory hour.

These are useful divisions for purposes of discussion. Good supervision usually integrates all three of these dimensions, but to promote maximum learning, the supervisor
must do more than take a didactic or a therapeutic stance, pay attention to the parallel process, and use intuition in understanding the trainee. The supervisor must also assess the learning needs of the trainee.

THE LEARNING ASSESSMENT IN SUPERVISION

At the beginning of supervision, the supervisor commonly makes a "learning assessment," that is, a judgment about the general level of clinical development of the trainee. Then, usually in a more intuitive way, the supervisor begins to assess more specific strengths and weaknesses in the trainee's work as cases are discussed. Differences exist in the learning needs of trainees at several levels, such as medical students who are often having their first exposure to psychiatry; psychiatry residents and psychology interns who have begun their work as psychotherapists and are somewhat overwhelmed; and the more advanced students of psychotherapy and psychoanalysis found in various postgraduate training programs and in private supervision. The following discussion will emphasize the knowledge and skills that are characteristic of beginning therapists.

Areas of development of analytically oriented psychotherapists, which are especially observable in those beginning to practice psychotherapy, pertain to the therapists' understanding of their patients and to their understanding of themselves. Nine areas of development are identifiable that, when considered together with regard to any one trainee, will help the supervisor better understand the trainee's learning needs:

1. Grasp of basic descriptive psychiatry
2. Grasp of psychodynamic formulation
3. Understanding of the course of psychotherapy
4. Recognition and understanding of transference
5. Recognition and understanding of defense and resistance
6. Affect tolerance
7. Recognition and understanding of countertransference
8. Use of language in psychotherapy
9. Mastery of theory

In the course of an extended supervision (a year or more), an understanding by the supervisor of the trainee's level of competence in each of these areas can be especially useful and is not unlike the therapist's need to accurately diagnose and formulate a treatment plan for a patient. A working alliance is then built upon the supervisor's capacity to understand accurately the trainee's limitations and difficulties, to clarify them, and to develop a partnership aimed at the remediation of the mutually understood problems. Of course, the problems and learning needs of trainees will vary. What must be learned and how long this will take is a product of natural abilities, prior training, personal maturation, and the trainee's experience in his or her own psychotherapy or psychoanalysis.

NINE AREAS OF DEVELOPMENT

Assessment of the trainee's learning needs can proceed along the above areas of development. In any of these areas, the supervisor must know what represents basic knowledge and basic skills appropriate for a young trainee as well as what is indicative of a more complex level of learning (3,8).

Descriptive Psychiatry

Diagnosis begins with observation. Reliably made observations are the foundations of descriptive psychiatry. Herein lies the beginning for all trainees. The nuts and bolts of psychiatry, its basic data, are the signs and symptoms that are clustered into recognizable syndromes. These syndromes are clearly articulated in DSM-III-R. The student of descriptive psychiatry engages in
The supervisor, therefore, introduces the trainee to the idea that there is an informed body of knowledge that articulates a way of knowing (i.e., diagnosing) the organization of the mind. Psychodynamic diagnosis has been approached through four principal schools of thought: drive psychology, ego psychology, object relations psychology, and self psychology. Though each school of thought offers a distinctive view of how the mind operates, they do not exclude one another. In fact, the schools complement and deepen our understanding of human psychology.

In teaching psychodynamic formulation, the supervisor poses the question, "What kind of internal vulnerability has been stressed by the current misfortunes of the patient’s life to sufficiently destabilize him and require treatment?" The answer to this question is the psychodynamic formulation (14). Data from a wide variety of sources are integrated into the formulation, including present illness, psychopathology, developmental history, diagnostic classification, and prognosis (15). The supervisor assesses whether the trainee understands the various types of data needed for the psychodynamic formulation and stresses to the trainee that these clinical and developmental data are to be continuously sought and reflected upon. The aim is to identify the central psychological problems with which the patient is struggling and to understand how recent circumstances would have evoked these core vulnerabilities and conflicts.

Formulation is hypothesis building. For example, the supervisor may pose a hypothetical question, such as "Why has the death of a mother resulted in handwashing in one patient, bereavement in another, pathological grief in yet another, or even psychoses in certain patients?" Supervisors need to emphasize the hypothesis-building approach rather than reinforce a sense of premature or artificial certainty about the formulation. Supervisors need to convey the difficulty of trying to make sense of such gathering data: the chief complaint, a past and present symptomatic history, the mental status, and the physical examination. The supervisor emphasizes precision in observation and description to establish reliability of diagnosis, which is a central tenet of the descriptive school of thought. Concurrently, trainees must be taught a language and nosology that describes and categorizes what has been seen or elicited from the patient.

The supervisor teaches descriptive psychiatry by repeatedly asking the trainee to verbalize what observations he or she has made in the examination, such as observations on patient appearance, behaviors, affects, and thoughts, in a manner structured by the traditional psychiatric examination and case report. The supervisor explains descriptive terms, categorical distinctions, and diagnostic concepts as the trainee provides the raw material. The supervisor helps the trainee work toward a multiaxial descriptive diagnosis and consequent treatment plan that is frequently biobehavioral in its emphasis (12,13). Beyond these basic skills lies greater refinement in reliable diagnostic observation. With the more advanced trainee, the supervisor may introduce questions on the validity and reliability of the process of inquiry and on the symptomatic and syndromal data obtained. This becomes the basis for understanding research methodology and its application.

Psychodynamic Formulation

Beyond the clinical diagnosis, and complementary to it, is the psychodynamic formulation. The psychodynamic formulation adds questions of meaning, and the attendant questions of drive and motivation, to the picture of symptoms and syndromes already painted by the descriptive diagnosis. In the psychodynamic, or psychoanalytic, model the data are less observable than in the descriptive psychiatry model. Motivation and conflict are understood (largely inferred) from a working model of the mind.
large amounts of data, both observed and inferred, conscious and unconscious. It is indeed an iterative, "supervision-long" project for the supervisor-trainee dyad. One trainee reported that she did not know whether to be relieved or overwhelmed when told by a supervisor that learning to formulate is a lifelong project.

Understanding of the Course of Psychotherapy

Like all processes, psychotherapy has a beginning, middle, and end. Within each stage are identifiable elements for the trainee to understand and master (16). The beginning stage of psychotherapy is, of course, the stage most familiar to the trainee. In the beginning stage, trainees will regularly encounter patients who are unsuitable for analytically oriented therapy. The supervisor can help the trainee recognize these patients, who demand quick results, experience significant secondary gain from their illness, or lack the cognitive capacity for this type of treatment. With respect to patients who do proceed, the supervisor can help the trainee understand the possible objectives of treatment: symptom relief, resolution of pressing problems, and characterological change. As discussed previously, the therapist must collect an adequate history to continue building a formulation to guide the treatment. Even the most sophisticated of patients must be educated in the opening phase of treatment about the process, methods, and goals of psychotherapy. The patient and therapist must begin to struggle with the anxieties of getting to know each other, not the least of which is performance anxiety on the part of the trainee. Patient-therapist "match" can become evident early in the treatment and is a variable that should be nondefensively examined in the supervision (17).

As treatment develops, patients must begin to endure the demands and painful confrontations with themselves that are an inevitable part of the middle phase of psychotherapy. The patient's conscious and unconscious fears (resistances) of therapy emerge. The novice therapist must learn to recognize and work through these critical developments. One trainee, for example, reported a patient's fear that the trainee would try to turn her into a high-functioning professional type like her parents and siblings, and, as the supervisor pointed out, even like the trainee herself. Once articulated by the therapist, this fear was acknowledged by the patient and the treatment moved ahead. As the therapy unfolds, a deepening of the alliance as well as the transferences will occur. This, in turn, will require the trainee to understand how to use each of these elements to advance the treatment. The supervisor will, for example, show the trainee how a transference interpretation might be made that could not have been offered earlier in the treatment. Regressions also occur that may require changes in the trainee's stance. For instance, the supervisor may guide the trainee to a more active stance with an acting-out patient. As conflicts are clarified and defenses are identified, the trainee must appreciate continually the importance of psychic equilibrium and defense and come to understand when and how to work with this material.

Finally, the trainee must learn and convey to the patient the essential role of termination and the working-through of the loss, ambivalence, anxiety, and hope attendant to this crucial phase of psychotherapy. The supervisor may help the trainee see signs of the termination phase, from symptom relief if that is the goal, to greater autonomous ego functioning and improved relationships. It is unfortunate that few trainees have the opportunity to experience the work of a clearly planned termination, which is generally not possible within an institutional training schedule. The fortunate trainee who can see a case to its conclusion will discover how often it is that we never fully know a patient's story until the very end (18).
Recognition and Understanding of Transference

Transference is the unconscious expectation the patient brings to the psychotherapy. Supervisors must prepare therapist trainees for this unexpected encounter through the recognition and understanding of transference. Trainees have heard it is important to "work with the transference" but find its recognition elusive. They may feel themselves to be the object of the patient's feelings but are unable to recognize this as the transference. Transference often is brought into supervision by the trainee who describes, sometimes in passing, a behavior or a pattern of the patient that has caught the trainee's attention or roused some thought or feeling. This is an important moment for the supervisor to emphasize. The supervisor may encourage the trainee to put this into words. For example, the trainee might say, "I don't know what's going on here. Whatever I do, she does nothing." The supervisor then helps the trainee recognize that this statement has a name: for example, "That is just the way the patient always reacted to her controlling mother. That is the mother transference." Finally, the trainee and the supervisor may develop a strategy for whether, when, and how to clarify or interpret the transference to the patient. That is, they arrive at a way of technically approaching the transference.

There is a logic and an order in learning about transference. With the momentous discovery of transference, Freud established the basis of psychodynamic psychotherapy as we know it (19). The discovery is in its own way momentous for each therapist trainee as he or she actually experiences and recognizes transference for the first time, typically with the help of a supervisor. Only from that point can the trainee go on to learn about the concepts of positive transference, negative transference, idealizing transference, transference neurosis, and transference resistance. The supervisor labels these transferences as they emerge in case material. Reading material can be recommended that will enable the trainee to appreciate the contributions of different theorists on transference: Kohut on the mirror transference and the selfobject transference (20), Adler (21) and Kernberg (22) on borderline transferences, and Balint on transference in the area of the "basic fault" (23).

Recognition and Understanding of Defense and Resistance

A fifth area of learning, recognition and understanding of defense and resistance, is similar to that of transference in that it involves noticing a particular behavior (often the source of irritation or frustration), reacting to it, putting it into words, labeling it, and finally developing a way technically to approach the behavior in therapy. Defense mechanisms are unconscious intrapsychic processes that serve to provide relief from anxiety and emotional conflict (24). Because defenses are for the most part unconscious, they are unknowable to the patient and elusive for the therapist. It is useful, therefore, for supervisors to encourage, if not require, that trainees bring process notes into the supervisory hour. This gives the supervisor the opportunity to point out exactly where in the material the patient's defenses are operating (25).

The supervisor needs to assess whether the trainee knows that defenses are necessary, adaptive, and worthy of respect. On the other hand, the supervisor needs to assess whether the trainee feels unnecessarily timid about clarifications, confrontations, or interpretations of defensive operations because of a fear of violating the patient's defenses and inducing regression or even suicidal behavior. The trainee must learn how and when the defense is the patient's friend and when it is the patient's enemy. This is a crucial learning task that highlights the paradox of defense, namely that it is both adaptive and symptomatic. The supervisor helps
the trainee find noncritical ways to express both the adaptive and the maladaptive functions of a defense in discussion with the patient. The supervisor might suggest specific interventions such as, “No wonder you do that” or, “That has helped you cope and survive your whole life but at the expense of alienating your friends.”

Just as there are many forms of transference, there are also many forms of defense. The therapist trainee will go through the process of first reacting to, then recognizing, and finally working out a technical approach to each one of the classic psychological defenses. Intellectualization and rationalization are relatively easy to recognize. Projective defenses are more perplexing because they engage the therapist in the defense process (26). A psychology intern commented on her own confusion, “I am seeing the importance of understanding if this is a projective defense or my issue. I am learning to respect what the patient is doing to me. It is useful information not to hide.” Another trainee came to supervision in a great deal of distress. A homosexual patient had yelled at him that he was “homophobic.” The resident expressed his anxious doubting (“Am I homosexual? Am I not? How would I know?”). His reaction made it hard to consider what deeper meaning this accusation might have for the patient. Once the resident understood that he was the object of a projection, he was able to point out that the patient himself had some ambivalent feelings about his sexuality that he was not facing. The patient gradually grew quiet, sad, and slowly began a process of painful exploration of an aspect of deep feeling about himself that he could not tolerate previously.

There are several helpful sources for the beginning trainee who needs to learn more about defenses. Anna Freud’s The Ego and the Mechanisms of Defense (27) is the classic. Vaillant, in Adaptation to Life (28), presents a hierarchical system of higher-level and lower-level defenses. Finally, Kernberg (29) provides an object-relations based typology of defense that is especially useful in understanding character-disordered patients.

Resistance is a specific form of defense evoked in the psychotherapy situation as the therapeutic process threatens to disturb the patient’s psychic equilibrium and induces anxiety. The patient unconsciously blames the therapist and the therapeutic method for disturbing this balance and causing anxiety (30). The patient manifests a reluctance to go deeper into the psychotherapy or may want to discontinue therapy. Resistance is commonly personalized by the therapist trainee. The trainee feels inadequate or as if he or she were providing poor treatment or doing something wrong to make the patient feel unhappy or threaten to leave. For example, a trainee presented a case in which he felt inadequate in the face of his patient’s regular complaints that the therapy was expensive, time-consuming, and no longer seemed helpful. When the trainee was gradually able to see these persistent complaints as the patient’s way of keeping a distance from the therapist, as he distanced everyone else, the trainee relaxed. He then was able to ask the patient why he kept him at such a distance, what he was afraid of. Trainees are educated and relieved as the supervisor helps them understand the patient’s distress, complaint, or need to flee as elements of resistance.

Affect Tolerance

Affect tolerance, yet another area of development, refers to the trainee’s conscious awareness and capacity to tolerate the patient’s affect. In practice, the supervisor begins the work with affect by identifying the existence of basic emotions as the patient displays them and helping the trainee extract them from the material. Attention is then paid to less apparent feelings such as shame or longing or, to quote Semrad, to those feelings that are “central but elusive matters of the heart” (31, p. 17). Some of the work of affect management is quantitative.
Patients may present the therapist with more intense affect, or with less affect, than the therapist has ever felt in his or her life. The hostility or murderous rage of a borderline patient is frequently intimidating to a beginning therapist. The supervisor may point out to the therapist trainee when he or she has protectively moved away from the patient’s intense affect. Tolerance for the lack of feeling and inability to relate seen in schizophrenic patients does not come easily to many trainees. The supervisor may suggest a comment that would deepen the affect of the seemingly indifferent patient.

Throughout supervision, the trainee is not left alone with the patient’s affects. The supervisor models an approach of sensitivity and compassion in the relationship with the trainee that supports the trainee and, in turn, the patient. Beginning child therapists, for example, frequently comment on the difficulty of bearing the child’s sadness or the provocativeness of the adolescent. At times supervisors may comment on the difficulty of the work or may offer an example of painful learning from their own early work. Supervision can expand the trainee’s tolerance for affect and thereby his or her empathic capacities. However, some of the greatest gains in this area are accomplished in the trainee’s own psychotherapy or psychoanalysis in which unconscious fears and resistances to particular affects can be explored fully.

Recognition and Understanding of Countertransference

Related to the therapist trainee’s tolerance of the patient’s affect is, of course, the trainee’s response to his or her own affects, especially unconscious affects. Countertransference is defined here as the therapist’s emotional responses to the patient’s manner of relating to him or her, responses that may be realistic or pathological, conscious or unconscious.

In their study of countertransference, Malsberger et al. (32) reported that, “Some of the therapist’s countertransference response may specifically arise from the way the patient behaves in the specific therapeutic relationship, and some of it may stem from the disposition of the therapist to react in certain ways either to all patients or to patients of a certain type” (p. 625). Women therapists who are starting their careers, for instance, can have trouble being comfortable with high levels of aggression or sexuality in male patients. Male therapists are sometimes uncomfortable with inaction in the face of powerful feelings and have trouble maintaining a neutral stance. One male trainee commented, “I realize I find myself so eager to do for someone, I just can’t sit still.” A male therapist also may be unfamiliar and uncomfortable with yearnings for comfort or a motherly response (e.g., a pre-oedipal maternal transference), which may be more familiar and tolerable for many women therapists.

Sometimes the supervisory task is to identify a subtle countertransference that, if acted out in any way, would not be in the patient’s best interest. For example, a trainee admitted with some self-consciousness in supervision that she had prolonged the last few therapy hours with her 62-year-old female patient. The trainee could only say that she was “reluctant to let the hour end on a bad note.” The extra time, however, had no effect. Her patient remained as self-punitive as ever and continued to complain about her plight, adding forcefully that the therapy was not really helping her. The trainee was not fully aware of the level of her annoyance with her patient. In some ways the therapist may have been “killing her with kindness.” With help from supervisory attention to the trainee’s annoyance, she was able to see the transference interaction in which she was the recipient of subtle passive-aggressive maneuvers by her patient. The trainee’s annoyance, which was managed by reaction formation, had brought the treatment to a standstill. It was not clear why the trainee
had been having so much trouble with this transference. What was important was that the supervisor helped her recognize that, in fact, she was having this difficulty. The trainee could then use this clarification of countertransference to remedy the therapeutic impasse.

Use of Language in Psychotherapy

"Words," writes Havens, "bring abstract understandings into relationship with experience; the persons involved become the conveyance" (33, p. 8). A psychotherapist who effectively engages his or her patient does so with language that is not jargon or encumbered by technical phrases but with the language of everyday life. For example, "Your reaction is characterized by viewing me as your aggressive mother," is not going to achieve the same result as, "You think I am going to push you around like others have"; Moreover, "Your aggression is expressed in masochistic behaviors," is far less understandable and humane than "You're very hard on yourself." The therapist who informs the patient that his or her moves toward self-sufficiency are a reaction formation to her passive dependent longings probably is not going to be heard. The therapist who says, "You try so hard so as not to have to ask for help," is likely to be heard.

Beginning therapists need reassurance to talk like the real people they are. More sophisticated therapists need help in phrasing complicated or painful issues in everyday language. The supervisor may demonstrate alternative ways of making the same interpretation or explain how to pitch a comment to the appropriate cognitive and emotional level of a particular patient. In effect, the supervisor models various interventions to use as the trainee develops his or her own style. Time, experience, and training, both in work as a therapist and in real life, are needed to learn to speak to the unconscious—to speak the language of grief, envy, passion, or murderous impulse.

Mastery of Theory

The final area of development, mastery of theory, is increasingly important for beginning therapists because there are limits to even the best intuitive capacities. The developing therapist must be exposed to and learn specific concepts and bodies of theory apart from any particular patient. Among those bodies of theory are drive psychology, ego psychology, object relations psychology, and self psychology (34,35). Even advanced students are commonly confused about these different psychologies of the mind. Each of these psychologies or theories has occupied a particular era in the unfolding of psychoanalytic theory in this century. Each has its particular contributions and limitations that the supervisor imparts when teaching theory. Usually more compelling to the therapist trainee is the appreciation of how one of these theories, with its emphasis on a particular facet of psychopathology, can be more useful than the others in understanding a particular case. The following case examples illustrate this point:

1. Freud's tripartite model of the mind (i.e., ego, id, and superego) was most useful in thinking about conflict between impulse and conscience (i.e., id and superego) in a 34-year-old married man who was struggling between the emotional and sexual aliveness he felt in an affair as opposed to the guilt he felt in betraying his marriage.
2. The concept of separation-individuation was the best theoretical anchor during many years of work with a dependent, phobic, panicky female patient who feared dying if she was left alone.
3. The concept of the selfobject transference was useful in working with a proud but failing businessman who had suffered repeated narcissistic injuries in the past and present, accompanied by intense feelings of shame.
Throughout these schools of thought are key concepts such as separation, fusion, narcissism, supportive psychotherapy, transference, resistance, and defense. Although these concepts are often employed in rounds, case conferences, and less formal clinical settings, they are defined and used in many ways. In fact, the major concepts have been used in diverse ways, by various theorists, to illustrate rather different ideas or types of pathology. Trainees can feel more confident when they understand the history, evolution, and the varied applications of such concepts. This can best be accomplished through a combination of didactic seminars and readings with concurrent illustration of the applicability of these theories and concepts to particular patients in supervision.

CONCLUSION

The development of trainees in all of the areas addressed will contribute significantly to their empathic capacity. The recognition of, and curiosity about, the "meaning" of the patient's behavior is a significant first step in developing empathy for pathological behaviors and attitudes that would otherwise be experienced as alien or distressing. Empathic abilities are further enhanced by training in the (unconscious) interactive aspects of psychotherapy, namely transference, countertransference, and projective defenses. The supervisor's explanations of how patients immerse us in complex and affectively charged interactions is a major contribution in fostering empathic rather than reactive responses.

There is considerable pressure on the trainee in supervision: the struggle to comprehend; the regular confrontation with his or her inadequacies; the need to maintain self-esteem in the process of developing a professional identity; the pressure created by demanding, angry, or high-risk patients; and the enormous work load. These stresses, unfortunately, can be heightened in the supervisory setting where the need to feel competent is great and where revelation of both professional and personal weaknesses is often part of the process (36,37). Learning never proceeds smoothly, but it can be enhanced by an understanding of the trainee's general level of development as well as his or her strengths and weaknesses.

Formal didactic training, personal treatment, and supervision form the basic foundation of the professional preparation of an able psychotherapist. This discussion of the development of the psychodynamic psychotherapist in supervision attempts to make explicit areas of supervision that are ordinarily implicit. Although it does not offer a formal assessment instrument to measure the trainee's progress, the approach described in this article identifies nine areas of development that are important for every psychodynamic psychotherapist. A consideration of the trainee's growth in each of these areas offers a structure for the trainee's formal written evaluation as well as a structure for periodic evaluation meetings with the trainee.

References

Trends in the Teaching of Analytically Oriented Psychiatry and Psychotherapy

David M. MacDonald, M.D.

For several years there has been ongoing discussion in the psychiatric literature of a presumed decline in the teaching of psychodynamic psychiatry in psychiatry residency training programs. Studies that have quantitatively focused on this subject are reviewed in this article. The author presents the results of a 1988–1989 survey of directors of psychiatry residency training programs dealing with this subject and related questions. The findings of the study are analyzed and discussed.

Over the past 10 or more years the psychiatric literature has contained an increasing number of articles on a supposed decline in the teaching of psychodynamic psychotherapy and the diminishing influence of psychoanalysis in the training of residents in psychiatry (1–4). It remains unclear, however, what changes have actually taken place in the teaching of analytically oriented psychiatry and dynamic psychotherapy in psychiatry residency programs in recent years. Several studies have touched specifically on this question.

Coryell (5) analyzed four nationwide surveys of psychiatry residents who were about to complete their training, covering the period from 1976 to 1986. An average of 313 graduating residents completed each survey. Coryell found no significant changes over the 10-year period in the percentages of residents who selected training in psychoanalysis (just under 20%) or who perceived psychoanalytic psychotherapy to be essential (47%).

In 1986, Tasman and Kay (6) surveyed training directors in an effort to determine, among other things, the amount of time devoted to clinical assignments and the prevailing theoretical model for outpatient psychotherapy instruction. Their survey shows that 79% of the reporting programs identified their primary outpatient psychotherapy orientation as psychoanalytic. However, the study also found that the clinical experiences of a number of programs were of relatively short duration.

Altshuler (7) reported on a 1989 survey designed to determine primarily the range, frequency, and duration of psychotherapy conducted in the 3rd and 4th years of residency training. Of the 163 programs that responded, over 60% indicated that either a frequency of only once per week was required or no frequency requirement existed. Less than 40% required a psychotherapy experience of twice per week or more. Altshuler concluded that "intensive psychotherapy has lost ground and favor in psychiatry residency training programs and research."

There have been a variety of other articles published in recent years that indicate a
decrease in psychoanalytic orientation and teaching in training programs throughout the country (8–10). However, there has been insufficient study of whether an overall decrease has in fact occurred and, if so, to what degree.

In this study, a survey of all adult psychiatry training program directors throughout the country was undertaken using a questionnaire designed to measure the changes in teaching and resident case loads that may have occurred over a 10-year period. The increasing emphasis on psychopharmacology over the past 25 or more years may have resulted in a shift in teaching time away from analytically oriented teaching in favor of biological and pharmacological psychiatry. A 10-year period was chosen for study because it was considered unlikely that accurate information could be obtained using a longer period of time. In addition, it was assumed that any significant shift in teaching would have been somewhat delayed and if present would have made its appearance primarily in more recent years.

### METHODS

A questionnaire was constructed using a number of questions (see Table 1) designed to elicit information about changes that may have taken place over the past 5 and 10 years with regard to time devoted to analytically oriented teaching and analytically oriented resident case loads. Training directors were asked to respond to each question in relation to three time frames: the present, 5 years ago, and 10 years ago. In addition questions were asked regarding the directors' perceived importance of analytically oriented teaching and case supervision by analytically trained supervisors in their programs. The involvement of residents in personal analysis and/or psychoanalytic training was surveyed. An effort was made to determine the current and past orientation of the faculty and the department chairperson.

The term “analytically oriented” rather than “psychodynamic” was used throughout the questionnaire. The terms are generally regarded as synonymous in the

<table>
<thead>
<tr>
<th>TABLE 1: Questionnaire about changes in psychoanalytic orientation and teaching in psychiatric training programs</th>
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<tbody>
<tr>
<td>1. What percentage of teaching time (other than individual supervision) during the course of the residency training program is devoted to psychoanalytic or analytically oriented subject matter?</td>
</tr>
<tr>
<td>2. What percentage of the average resident's case load consists of patients in psychoanalytically oriented psychotherapy?</td>
</tr>
<tr>
<td>3. Rate the degree of importance your program places on the role of psychoanalytic or analytically oriented courses in the training of a general psychiatrist.</td>
</tr>
<tr>
<td>4. Rate the degree of importance your program places on the role of case supervision by analytically trained supervisors in the training of a general psychiatrist.</td>
</tr>
<tr>
<td>5. What percentage of your faculty currently have an orientation that is primarily one of the following: psychoanalytic, behavioral, cognitive, interpersonal, other psychological therapies, pharmacological?</td>
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<tr>
<td>6. What has been the primary orientation of your department chairman or director (per question #5)?</td>
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<tr>
<td>7. What percentage of your faculty are graduates of a psychoanalytic institute?</td>
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<tr>
<td>8. Are residents permitted to undergo psychoanalysis during the course of their residency?</td>
</tr>
<tr>
<td>9. What percentage of residents entered personal analysis either during or before starting their residency?</td>
</tr>
<tr>
<td>10. Are residents permitted to enter psychoanalytic training during the course of their residency?</td>
</tr>
<tr>
<td>11. Please estimate what percentage of residents enter psychoanalytic training either during or shortly (within 3 months) following the completion of their residency.</td>
</tr>
<tr>
<td>12. Does your program have an affiliation with a psychoanalytic institute?</td>
</tr>
<tr>
<td>13. Please comment on any of the above questions or issues if you wish. (Use reverse side if needed.)</td>
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</tbody>
</table>
literature. "Analytically oriented" was felt to be preferable to "psychodynamic" because the concepts used in this form of psychotherapy (e.g., transference, countertransference, resistance, conflict, defense mechanisms, etc.) are derived from psychoanalysis. In addition, except in relatively "nonanalytic" areas, it would seem likely that the majority of faculty involved in the teaching and supervision of dynamic or analytically oriented psychotherapy have had a personal analysis and many have completed analytic training.

In 1988–1989, the 207 adult psychiatry training program directors in the United States listed in the 1988 Directory of Psychiatry Residency Training Programs (11) were surveyed. A second mailing was sent to nonresponders; 163 (78.7%) program directors responded.

Because results for the 5- and 10-year periods were not significantly different throughout the survey, only the results for the current and 10-year periods will be reported here. Current and past rates were compared using chi-square analysis.

RESULTS

The change in percentage of time devoted to psychoanalytic or analytically oriented teaching was most dramatic in the programs devoting more than half of their time to this subject matter (Figure 1). Of the programs that reported data for 10 years ago, 26% were devoting more than 50% of their teaching time to analytically oriented subject matter, whereas currently only 5% reported devoting more than 50% of their teaching time to this subject matter (P < 0.001).

There were corresponding increases over time in the programs devoting 25%–50% of their time to analytically oriented teaching. Forty-one percent of the programs reported that they currently devote 25%–50% of their time to analytically oriented teaching; only 26% of the programs reported devoting this amount of time 10 years ago (P < 0.001).

Overall, of the 133 programs reporting both the current amount of time devoted to these subjects and the amount of time devoted 10 years ago, 37% had decreased, 38% had remained the same, and 24% had increased the amount of time devoted to these subjects.

There was a substantial decline in the number of programs reporting resident case loads that were more than 50% analytically oriented. Whereas 10 years ago 22% of the programs with data reported this level of intensity, only 7% reported it currently (P < 0.001). The number of programs reporting analytically oriented case loads of 25%–50% or < 10% remained essentially the same over the 10-year period, whereas those with case loads of 10%–25% showed a significant increase from 22% to 41% over the 10 years (P = 0.001; Figure 2).

Forty-two percent of the programs reporting data on the primary orientation of the department chairperson or director had leadership 10 years ago that was analytically oriented, compared with 29% currently (P = 0.024). There were complementary in-
creases in the proportion of programs with psychopharmacologically and biologically oriented leadership (16% vs. 24%) over the last 10 years and in those where the chairperson or director is described as eclectic (22% vs. 28%; Figure 3).

The percentage of faculty who were graduates of a psychoanalytic institute showed a significant change in the programs devoting more than half their time to analytically oriented teaching. For those programs with data in this group, the percentage of faculty who were graduates of an institute declined from 9% to 3% over 10 years ($P = 0.013$). Of the 130 programs with data on past and current percentages, 25% decreased, 67% remained the same, and 8% increased in the percentage of faculty who were psychoanalytic institute graduates over the past 10 years.

The percentage of programs reporting more than 25% of their residents in personal analysis, during or before their training, declined from 18% to 8% over the same period ($P = 0.011$). Eighty-two percent of programs with data permitted their residents to begin psychoanalytic training at some point during their residency. However, the proportion of programs with more than 25% of their residents in training declined from 13% to 3% over the 10 years ($P < 0.001$). Of the 126

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**FIGURE 2.** Percentage of residents' case load devoted to analytically oriented treatment

<table>
<thead>
<tr>
<th>Percentage of residents' caseload</th>
<th>10 years ago ($n = 130$)</th>
<th>Current ($n = 163$)</th>
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<tbody>
<tr>
<td>&gt; 50%</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>25-50%</td>
<td>20</td>
<td>20</td>
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<tr>
<td>10-25%</td>
<td>30</td>
<td>30</td>
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<tr>
<td>&lt; 10%</td>
<td>10</td>
<td>10</td>
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</tbody>
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**FIGURE 3.** Orientation of department chairman or director

<table>
<thead>
<tr>
<th>Orientation of department chairman or director</th>
<th>10 years ago ($n = 124$)</th>
<th>Current ($n = 152$)</th>
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</thead>
<tbody>
<tr>
<td>PA</td>
<td>40</td>
<td>40</td>
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<tr>
<td>Cog</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>IP</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Other Psych</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Pharm</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Eclectic</td>
<td>20</td>
<td>20</td>
</tr>
</tbody>
</table>

*Note: PA = psychoanalytic; Cog = cognitive; IP = interpersonal.*
programs with known levels 10 years ago, 21% had decreased, 76% had remained the same, and 3% had increased the proportion of residents in analytic training over the 10 years (Figure 4).

With regard to their current attitude toward analytically oriented courses, an impressive 91% of responders viewed such courses as moderately or very important. Eighty-three percent felt that the use of analytically trained supervisors was moderately or very important. Twenty-five percent of the programs reported an affiliation with a psychoanalytic institute.

A limitation of this study is indicated by an additional question that was asked in the second mailing (N = 49) to ascertain the number of years responders had served as directors of the training programs. Only 8 (16%) of this group had been in this position for the entire 10 years. Thus, it seems apparent that for the most part the answers to the questionnaire as they relate to 10 years ago are estimates, presumably based on discussions with colleagues who were present during that time.

**DISCUSSION**

Perhaps the most significant and consistent finding of this survey is that most of the programs that devoted the greater proportion of their time (i.e., more than 50%) to psychoanalytically oriented instruction and case loads 10 years ago now give considerably less time to both.

Our findings confirm the impression that analytically oriented teaching and supervision play less of a role in some programs now than 10 years ago, primarily in those programs that devoted the greater percentage of their time to these activities. Also to be noted, however, is the finding that almost 25% of the programs described an increase in analytically oriented teaching over the 10 years. It is interesting to note also that 45% of the programs in which chairpersons were currently designated as pharmacologically oriented described an increase in analytically oriented teaching, compared with only 18% of programs that had leadership with other orientations. In this regard, it is possible that the new generation of biologically oriented department chairpersons may respect the importance of analytically oriented teaching even though they do not have this orientation.

These shifts suggest that programs that were previously strongly analytic in orientation have had to accommodate the growing nonanalytic subject matter. However, it is also apparent that many of the programs that have been biologically/psychopharmacologically oriented have increased the percentage of time devoted to analytic instruction and supervision. There would, therefore, appear to be a shift toward more of an overall balance between analytically oriented and biological teaching in psychiatry residencies than there was 10 years ago.

One measure of the degree of analytic
orientation of a program is the percentage of residents who enter psychoanalytic training either during or shortly after completion of their residency. Although in recent years this has been a small group, the fact that programs reporting that more than 25% of their residents entered analytic training declined from 13% to 3% over the 10-year period may have some significance. However, rather than suggesting simply a decline of interest in analytically oriented psychotherapy or analytic training, this finding may be indicative of the increasing burden of debt shouldered by current psychiatry residents. The decline in the number of departmental chairpersons or directors who are analytically oriented over the 10-year period (42%-29%) may be of greater significance.

However, other findings were at variance with the shifts that have taken place; 91% of the programs currently view analytically oriented subject matter as moderately or very important, and 83% gave the same positive rating to supervision by analytically trained supervisors. These findings are not consistent with the assumption of a significant decline in interest in the psychodynamic approach in psychiatric education.

**CONCLUSION**

Although questions about the efficacy and scientific basis of psychoanalysis and analytically oriented psychotherapy continue (12), the fact is that since the 1920s successive generations of American psychiatrists have been exposed to and influenced by such psychoanalytic concepts as conscious and unconscious conflicts, defense mechanisms, resistance, transference, and countertransference (10).

Mohl et al. (13), representing a joint task force of the Association for Academic Psychiatry and the American Association of Directors of Psychiatry Residency Training, recently made a strong case for the role of psychodynamic psychotherapy in residency training. They listed 10 major reasons for continuing such teaching, the first of which was the statement, “Psychoanalytic psychotherapy is an effective treatment for many mental disorders, and all well-trained psychiatrists should be familiar with its principles and techniques and should achieve a basic level of competence.”

The question, of course, is how does one define what is meant by a basic level of competence. The Accreditation Council for Graduate Medical Education (14), for example, specifies that requisite skills in PGY-2 through PGY-4 should include, “experience and competence in the major types of therapy including short- and long-term individual psychotherapy, psychodynamic psychotherapy, family therapy, group therapy, behavior therapy, crisis intervention, pharmacological and other somatic therapies, and drug and alcohol detoxification.”

One can legitimately question whether it is in fact possible in the course of 4 years of training to become competent in all these approaches or whether what is involved is rather a broad survey of all the modalities available. Many psychiatrists who practice primarily dynamic psychotherapy would probably say that competence or proficiency in psychotherapy is actually a life-long goal and would view the diminution in the number of programs offering a greater emphasis of training in this area as a loss. Others will see the shifts that have been described as indicative of a better balance between the psychodynamic and biological approaches.

For the past 20 years, the teaching of biological, behavioral, and other non-psychodynamic aspects of psychiatry have undoubtedly occupied an increasing amount of time in most training programs. As one responder to the questionnaire put it (C. Nadelson, personal communication), “We value training in psychoanalytically oriented psychotherapy. However, because so many other necessary subjects compete for the limited teaching time available in a residency program, we can no longer devote as much time to this important area.”
question remains whether the balance, and perhaps what can be viewed as an accommodation, between the various approaches that has now been arrived at can be maintained. The other possibility is that a continued increase in the time devoted to teaching of neuroscientific subject matter and nonanalytic forms of psychotherapy will eventually result in the relegation, to a large degree, of analytically oriented subjects and psychotherapy to a period of postgraduate training after residency, permitting those psychiatrists who so desire to make more effective use of an analytic orientation in their understanding and treatment of patients.

The author is indebted to Catherine Viscoli, Ph.D., for her assistance in analyzing the data and for her suggestions regarding the manuscript and to Denise Acampora, M.P.H., for her helpful comments.

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References

Cognitive Therapy Training in U.S. Psychiatry Residency Programs

E. Cameron Ritchie, M.D.
Randall White, M.D.

Cognitive therapy (CT) is a relatively new mode of psychotherapy that is effective in the treatment of depression and other psychiatric disorders. The training directors of all U.S. general psychiatry residency programs were surveyed on the amount of time offered in teaching and supervision of CT and in other treatment modalities. Of the 127 responders, 91% offer some classroom instruction in CT, 54% offer trainees supervised clinical experience, and 23% require such experience. The ranges of instructional time offered and number of patients treated per resident are broad. Thirty-seven percent of training directors consider graduating residents as qualified to practice CT, and 11% consider graduating residents as qualified to supervise others in CT. The authors conclude that little standardization exists in CT training, and they propose a minimum requirement.

Cognitive therapy (CT) is a short-term, nonpharmacological treatment that is effective in the treatment of depression and several other common mental disorders. In 1979, Beck et al. (1) published the detailed treatment manual, Cognitive Therapy of Depression. Other books on CT have been published, for both therapists and patients, such as those by Meichenbaum (2) and Burns (3). Clinical research has documented the efficacy of CT for treating appropriately selected depressed patients (4), and its utility in treating other conditions, such as anxiety disorders (5), bulimia nervosa (6), and personality disorders (7), is under active investigation.

Because CT has been documented to be effective in treating depression, a very common psychiatric disorder that causes great morbidity and mortality (8), we considered it important to determine the extent to which psychiatry residents receive training in CT. Many psychotherapies compete for curriculum time, including supportive, psychodynamic, behavioral, group, family, and marital psychotherapies. Both the Group for the Advancement of Psychiatry (9) and Mohl et al. (10) have discussed the model psychotherapy curriculum, but neither specifically addresses CT. We attempted through a survey to characterize the teaching of CT within residency programs, to determine the amount of CT taught on average and in different types of programs, to determine the number and discipline of CT supervisors, and to determine if graduates are considered competent to practice or to supervise CT. We also inquired into the amount of curriculum time devoted to all other types of psychotherapy and pharmacotherapy.

Dr. Ritchie is assistant chief, Inpatient Psychiatry, Department of Psychiatry, Walter Reed Army Medical Center, Washington, DC; and Dr. White is staff psychiatrist, Department of Psychiatry, Silas B. Hays Army Community Hospital, Fort Ord, CA. Address correspondence to Dr. Ritchie, Department of Psychiatry, Walter Reed Army Medical Center, Washington, DC 20307.
METHODS

A 14-item questionnaire was sent in late 1989 and early 1990 to all psychiatry residency program directors in the United States as listed in the American Medical Association's Directory of Graduate Medical Education Programs (11). Surveys were sent to directors of both 3- and 4-year programs. A total of 205 questionnaires were mailed to general psychiatry program directors, each with an individualized cover letter explaining the nature and purpose of the survey. A follow-up letter was sent to all program directors who did not initially respond; the total response was 127 (62%).

The questionnaire focused on the number of didactic curriculum hours devoted to CT, all other forms of psychotherapy combined, and pharmacotherapy. We also asked for the number of clinical supervision hours available for CT and for other psychotherapies combined. Additional questions included 1) the year(s) in which CT is taught; 2) whether experience, either required or optional, in treating patients with CT is available; 3) the availability, discipline, and training of supervisors; and 4) if graduates are considered qualified to practice and/or supervise CT. Other data recorded included geographic location of the program and program affiliation (i.e., medical school/university, public, private, or military). All questions had multiple-choice answers, which we surmised would increase the ease of responding and consequently the rate of response.

In our cover letter we specified that by “cognitive therapy” we meant the general techniques delineated by Beck et al. (1). We did not, however, indicate that residents need employ their treatment manual to be learning CT. We deliberately avoided defining what was meant by “qualified to practice CT.” In this way we allowed a rather broad interpretation of our inquiries because we had no generally acknowledged standard of practice to use as a criterion for qualification.

RESULTS

Response

Questionnaires were returned from 127 (62%) training programs. The response rate was analyzed by geographic area, showing a low of 46% on the West Coast and a high of 86% in the Southwest ($X^2 = 11.65$, $df = 4$, $P < 0.05$). Analysis by program affiliation found that 68% of university programs, 60% of public and private programs, and 50% of military programs responded ($X^2 = 1.37$, $df = 1$, $P > 0.10$).

Didactic Time for CT

The amount of didactic (classroom) time devoted to cognitive therapy varies from 0 hours in 9 programs to more than 20 hours in 7 programs (see Figure 1). Forty-two programs offer between 1 and 5 hours, 41 offer between 5 and 10 hours, and 26 offer between 10 and 20 hours. Overall, 91% of responding programs offer some instruction in CT, although the mode of instruction time in our sample is only 1–5 hours.

Much more time is devoted to all other psychotherapies, although the range of instruction time is quite broad: from 50–100 hours to more than 250 hours (over three training years), with a mode of 100–150 hours. The training time for pharmacotherapy varies widely also, with 5% of the programs teaching less than 20 hours and 22% teaching more than 100 hours (see Figure 1).

We found no statistical association between the amount of didactic time available for CT and that available for pharmacotherapy or that available for CT and for other psychotherapy.

Clinical Experience

The majority of psychiatry residents learn something about CT. An important question to us, however, was whether they actually practice it. Twenty-three percent of
responding programs require that residents treat patients using CT techniques. Fifty-four percent of the remaining 101 programs offer CT experience as an option. Thus the majority (77%) of the programs have clinical experience available to trainees. Twenty-three (18%) of the responding training directors do not know if residents are treating patients with CT.

The estimate of the number of patients each resident treats using CT ranges from 1 or 2 to more than 10. The typical resident in 84% of the responding programs treats fewer than 5 patients with CT.

We investigated the effect of program affiliation on clinical CT training. A distinct trend toward university programs requiring CT experience is evident: 27% vs. 12% of nonuniversity programs ($\chi^2 = 3.2, df = 1, P < 0.07$). We found no clear relationship between program affiliation and the amount of didactic time that was devoted to CT or other psychotherapies.

### Supervision

The amount of clinical supervision in CT ranges from 0 hours to more than 50 hours for the average resident over the 3 years of training (see Figure 2). Of the responding programs, 20% have no CT-designated supervisors. Most have one or two, and 8% have more than five. In 44% of programs providing CT supervision, psychiatrists and psychologists share the task. In 23% of the programs, psychologists alone supervise, whereas in 13%, psychiatrists alone do. Clinical social workers are less frequently employed as supervisors (13% of programs) and usually along with psychiatrists and psychologists. There is no significant relationship (i.e., $P > 0.05$) between the discipl-

<table>
<thead>
<tr>
<th>Number of Hours</th>
<th>Number of Programs</th>
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Note: CT = cognitive therapy; OTHER = other psychotherapies; PHARM = pharmacotherapy.
ine of the supervisor and the amount of didactic instruction, number of supervisors, program affiliation, or program director's judgment of competence.

The number of supervisors in a program has a significant effect on the amount of supervisory time available. Sixty-one percent of the responding programs with more than three supervisors have 15 or more hours of supervisory time available, whereas only 36% of those with two or fewer supervisors do ($\chi^2 = 14.6, df = 1, P < 0.006$).

The number of supervisory hours in turn is related to the average number of patients treated per resident. Of the programs with more than 15 hours of supervision, 81% of them residents treat three or more patients, whereas in programs with less than 15 hours of supervision, in only 47% do residents treat three or more patients ($\chi^2 = 9.6, df = 2, P < 0.02$).

Among the 27 programs that require CT clinical experience, significantly more clinical supervisory time is available than in the programs that do not have a requirement: 26% of the former programs offer more than 30 hours, whereas only 7% of the latter do ($\chi^2 = 9.55, df = 2, P < 0.008$).

We inquired into the formal training of the CT supervisors, specifically asking if any had been trained at a center for CT, such as the Institute for Cognitive Therapy in Philadelphia founded by Beck. Fifty-one percent of the responding training directors indicated that no supervisors had such training, and in only 5% of the programs have three or more supervisors had such training. Eleven percent of program directors do not know about the supervisors’ training.

Competence of Graduating Residents to Practice and Supervise

The training directors were asked to judge whether their graduates are competent to practice and/or to supervise CT. Thirty-seven percent of responders believe that their residents are qualified to practice CT, 49% believe that they are not, and 14% wrote in responses such as “somewhat qualified” or “some graduates are.” Eleven percent believe that their residents are qualified to supervise CT, whereas 7% are equivocal.

Training directors who consider graduates qualified to practice CT offer significantly more supervisory time than those

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**FIGURE 2.** The number of supervision hours devoted to cognitive therapy and other psychotherapies in U.S. psychiatry training programs

<table>
<thead>
<tr>
<th>Number of Hours</th>
<th>Number of Programs</th>
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<tbody>
<tr>
<td>5-15</td>
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<td>15-30</td>
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*Note: CT = cognitive therapy; OTHER = other psychotherapies*
who do not: 26% of the former group offer more than 30 hours of supervisory time per resident vs. 3% in the latter group ($\chi^2 = 12.1$, $df = 2, P < 0.002$). It is interesting to note that 34% of the training directors who consider their graduates qualified to practice have only 5–15 hours of supervision available to each resident. There is also a strong relationship between the number of patients treated per resident and the training directors’ judgment of residents’ competence; 85% of the residents considered qualified to practice treat three or more patients with CT ($\chi^2 = 22$, $df = 2, P < 0.001$).

**DISCUSSION**

This study attempts to characterize the current status of CT training among psychiatry residency programs in the United States through analysis of a 14-item, multiple-choice questionnaire sent to all training directors of active programs in late 1989 and early 1990. We undertook this effort because of increasing evidence of the efficacy of CT in treating depression and its utility in the management of certain other mental disorders.

The vast majority (91%) of responding training directors report that their programs provide some classroom instruction in CT, with a mode of 1–5 hours. Most programs (77%) also have some supervised clinical experience available. The didactic time for other forms of psychotherapy ranges from 50 to more than 250 hours; however, more instruction in other kinds of psychotherapy does not significantly correlate with more instruction in CT, indicating that psychotherapy-intensive programs may emphasize more “traditional” approaches disproportionately. More university-based programs require clinical CT experience than do public and private programs, perhaps reflecting more attention to psychotherapy outcome research in the academic setting. The discipline of supervisors seems to have no impact on availability of CT training, since in most programs with any supervision both psychiatrists and psychologists participate.

As expected, programs with more CT supervisors or a requirement for clinical experience have more supervision available to residents. More supervisory time correlates with more patients treated per resident and a greater likelihood of directors considering graduates competent to practice CT. These findings are reassuring, yet we found it surprising that as many as 37% and 11% of program directors believe their graduates are competent to practice and to supervise CT, respectively. The majority of these graduates have treated five or fewer patients with 30 hours or less of supervision. Beck recommends 6 months to 2 years of weekly case supervision (1). Although some residents could be obtaining this amount of training, no more than 20%–30% of responding programs routinely provide even Beck’s minimum recommended supervision time.

We have pooled 127 different methods of judgment of competence, which was necessary because of the absence of any accepted universal standard. This same uncertainty would arise in a survey of training in psychodynamic psychotherapy. As Beck has suggested for CT, an analyst would suggest rigorous guidelines for training in psychodynamic therapy. Curriculum time does not permit such training in all treatment modalities. Still, we believe that CT, like psychodynamic therapy, has a place in psychiatry residency. Psychotherapy is noteworthy among treatments used by physicians as eluding quantification and rigorous trials of safety and efficacy, and the devotion to particular methods in this field sometimes verges on the irrational. Training in any method of psychotherapy that has empirical support should be available to all psychiatrists during their residency.

Our data show that didactic instruction in CT is, in fact, becoming standard, but as with any skill, learning requires practice. Training directors probably need not make
rigorously defined competence a goal but might keep in mind that psychotherapy practice of the future may include hybrids and admixtures of techniques (12). CT will likely be among these.

This survey has limitations to be considered in interpreting the results. Multiple-choice responses decrease the precision of the data. The sample may be skewed because nonresponding programs may have ignored our inquiries because they teach little or no CT. The geographic maldistribution of responders may have caused additional sampling error. Finally, variable interpretations of particular terms, such as “qualified to practice,” make the comparability of some responses uncertain. The strong trend, however, to introduce CT into the psychiatry residency seems clear.

We suggest that psychiatry residency programs include, as a minimum, a didactic course in CT theory that includes the cognitive models of depression and anxiety along with a review of psychotherapy outcome research. Each resident should then treat at least two depressed patients individually, or several in a group, under a competent CT supervisor. Our findings suggest that having designated CT supervisors may be crucial for successful clinical training. However, if few are available, group therapy could be especially efficient by allowing, for instance, two residents to treat six patients under one supervisor. A more ambitious program could include CT for patients with various diagnoses. The addition to the ever-expanding curriculum would be small but would give residents the capacity to enlarge their skills in the future as necessary, a universal goal of medical training.

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The views expressed in this article are those of the authors and do not necessarily reflect those of the U.S. Army or the Department of Defense.

References

Psychiatry Residents’ Attitudes Toward Personal Involvement in Research

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Mark A. Fine, Ph.D.

This study explored residents' attitudes toward referring subjects to other residents' research studies and toward conducting their own research projects. With respect to referring subjects to other research investigations, the ease of the referral mechanism and potential benefits to patients were of prime importance to residents. With respect to participating in their own research projects, the learning opportunity provided by working with a faculty mentor was rated as the key motivator. A lack of available time and an abundance of other clinical demands discouraged research activity. Suggestions are offered for residency training programs that wish to increase resident interest and participation in research projects.

The role of research in the curriculum of psychiatry training programs remains elusive despite the general consensus that it is important. There is some evidence that research does not have a strong foundation in psychiatry training programs, although there is a paucity of current research in this area. For example, less than 5% of U.S. psychiatry training programs made research a requirement in their training curricula in 1977 (1), whereas 73% of Canadian psychiatry residents had favorable attitudes toward research as a requirement (2). Research in a specialty field such as psychiatry is important for its growth (1,3), and medical student (4) and resident exposure to research promotes interest. This article focuses on factors that encourage or discourage resident participation in research activities.

The available literature has identified a variety of factors that promote resident involvement in research. The importance of faculty mentors has been frequently underscored (3,5). Faculty mentors may have a significant impact not only interpersonally, but also by promoting resident authorship, facilitating presentation of an article, and fostering interaction with members of the research community (5). These mentors may naturally gravitate to university settings. About 77% of National Institute of Mental Health research grants are awarded to only 10% of psychiatry departments, all of which are university based (3). These data parallel the finding that residents in universities are more likely to publish than those in other settings (1).

There are also other factors that seem to encourage resident participation in research. As was noted previously, exposure to re-
search at the medical student and resident level seems to be an important factor (1,3,6,7). The opportunity to directly experience and present research proved useful for veterinary residents (8). Finally, financial support for research (1,6,9) is an essential factor; it is perhaps particularly so for fledgling specialty programs (10). Financial support may be complicated by fluctuations in federal and state funding that regionally affect research output (11).

There are a variety of factors that appear to discourage research activity among residents. In general, residents face several stressors in training that may preclude sufficient time and energy for research (12). The amount of clinical work, clinical faculty opposition to research, lack of availability of trained faculty, pressure to do clinical electives to secure later employment, and failure of program leadership to encourage residents to pursue research have all been cited as deterrents (5).

Several investigators have acknowledged a shortage of skilled mentors in the field of psychiatry (1,3,9). For example, academic psychiatrists are less likely to have participated in research (6) and are likely to have had less training in research (3) than their counterparts in other academic medical departments. Strauss et al. (1) reported that there was a lack of faculty mentors in nearly 50% of surveyed psychiatry programs. Expectations regarding the role of faculty in research may need to be tempered, in part by what some perceive to be increasing clinical responsibilities in psychiatry departments (13).

In summary, there are data available on factors that encourage and discourage research participation among residents. However, much of this evidence has not considered the attitudes of residents. The following study explores residents' perceptions of research from two very different perspectives: 1) residents as referral sources of subjects and 2) residents as participants in a research project.

**METHODS**

**Procedure**

The training directors or chief residents of all psychiatry residency training programs in Ohio were contacted by telephone to inform them of the project and to request their cooperation in distributing the instrument to residents in the program. Mailings that contained copies of the instrument were then sent to the person who had been contacted by telephone. Of the 253 psychiatry residents in Ohio at the time of the study, 112 (44.27%) returned completed inventories. Due to the anonymous nature of the data collection, no data were available on nonresponders.

**Subjects**

Subjects were 112 psychiatric residents in Ohio residency training programs. Their mean age was 32.98 years, 52% were male, and they were at the following PGY levels: 17.0%, PGY-1; 25.0%, PGY-2; 29.5%, PGY-3; 21.4%, PGY-4; and 7.1%, PGY-5 or higher. The general emphasis placed on research in these training programs was fairly nondescript, with a median response of 3.0 on a 1 (very little) to 5 (very much) scale. Approximately one-third (31.3%) indicated that their training program required residents to do research and 62.5% reported that they had participated as a researcher in a project. The explicit nature and extent of “participation” (e.g., type of research, publication status) was not requested in the questionnaire.

**Instrument**

The Research Attitudes Among Residents Inventory was developed by two of us (J.M., R.A.S.) to assess factors that encourage or discourage residents’ referral of subjects to other residents’ research projects and factors that encourage residents to participate themselves in research studies. The inven-
tory has 36 items that are divided into four sections: 1) 5 items that assess the importance of factors encouraging the referral of subjects to another resident's research project, 2) 8 items that assess the importance of factors discouraging the referral of subjects to another resident's research project, 3) 13 items that assess the importance of factors encouraging participation in a research project, and 4) 10 items that assess the importance of factors discouraging participation in a research project. Items measured a broad range of factors, including ethical, financial, practical, and therapeutic issues (see Tables 1 and 2).

For each item, subjects responded on a 1-5 scale, with 1 indicating that the factor either had "no effect" or was "very unimportant" and 5 indicating that the factor "would highly encourage (or discourage) me" or was "very important." Thus, high scores indicate that the factors are important in encouraging or discouraging residents' referral of subjects to other residents' research projects and that the factors are important in encouraging or discouraging residents' participation in their own research projects.

On the first two sets of items, statements were worded in similar ways to assess their reliability. For example, an item in the first set asked residents to rate the importance of a personal relationship with the researchers in encouraging referral of subjects to another resident's research project. A similar item in the second set asked residents to rate the importance of a lack of a personal relationship in discouraging referral of subjects. To determine their reliability, Pearson's correlation coefficients were computed between each pair of similar items. These correlation coefficients ranged from 0.28 to 0.49 (all P < 0.01). This suggests that responses to these parallel items were generally consistent but that the items assessed different constructs. The moderate size of the correlation coeffi-

<p>| TABLE 1. Response frequencies and medians of items related to residents' referral of subjects to other residents' research projects |</p>
<table>
<thead>
<tr>
<th>Factors encouraging referral of subjects to another resident's research project</th>
<th>Percentage of responders ratings on a scale of 1-5</th>
<th>Median</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal relationship to the researchers</td>
<td>1 2 23 55 19</td>
<td>4.0</td>
</tr>
<tr>
<td>Interest in specific topic studied</td>
<td>0 2 20 54 24</td>
<td>4.0</td>
</tr>
<tr>
<td>Ease of referral mechanism</td>
<td>0 0 9 51 39</td>
<td>4.0</td>
</tr>
<tr>
<td>Personal investment in research</td>
<td>1 9 34 41 14</td>
<td>4.0</td>
</tr>
<tr>
<td>Potentially positive impact on patient in therapy</td>
<td>0 4 14 50 33</td>
<td>4.0</td>
</tr>
</tbody>
</table>

Factors discouraging referral of subjects to another resident's research project

| Lack of personal relationship to the researchers | 12 28 40 17 4 | 3.0 |
| Lack of interest in specific topic studied | 11 24 32 22 11 | 3.0 |
| Referral mechanism potentially time consuming | 1 3 22 40 35 | 4.0 |
| Lack of personal investment in research in general | 16 41 33 10 1 | 2.0 |
| Negative relationship to the researchers | 5 11 35 24 24 | 3.0 |
| Concerns regarding potential lapses in confidentiality | 6 8 20 24 41 | 4.0 |
| Potentially negative impact on patient in therapy | 1 6 5 23 64 | 5.0 |
| Unable to be a part of the research team | 32 46 14 7 1 | 2.0 |

Note: Values are percentages. Number of subjects studied, N = 112. For factors encouraging referral of subjects, 1 = very unimportant, 2 = unimportant, 3 = neutral, 4 = important, and 5 = very important. For factors discouraging referral of subjects, 1 = no effect, 2 = very little effect, 3 = would somewhat discourage me, 4 = would moderately discourage me, and 5 = would highly discourage me. Due to rounding error, percentages may not sum to 100%. 
coefficients justifies considering both sets of items in the analyses reported below.

RESULTS

The results are presented below for the entire sample of responding residents. Subgroup comparisons (those residents who had participated in a research project vs. those who had not and those whose training programs required research participation vs. those whose programs did not) on individual items yielded nonsignificant differences. Thus, the findings below appear to be reflective of the entire sample of responding residents regardless of whether they had participated in research or whether their programs required them to do so.

Importance of Factors Related to Referring Subjects to Another Resident

Table 1 shows response frequencies and medians for items that assessed the importance of factors encouraging or discouraging residents' referral of subjects to other residents' research projects. As shown in Table 1, all five of the factors that encouraged referral of subjects were judged as "important."

| TABLE 2. Response frequencies and medians on items related to residents’ participation in research projects |
|-------------------------------------------------|---------------------------------|--------|--------|--------|--------|--------|
| Factors encouraging participation in a research project | Percentage of respondents ratings on a scale of 1–5 | 1  | 2  | 3  | 4  | 5  | Median |
|-------------------------------------------------|---------------------------------|--------|--------|--------|--------|--------|
| Economic incentives (e.g., grants)               | 4  | 12 | 33 | 41 | 11 | 4.0 |
| Residency program’s commitment to research      | 2  | 4  | 30 | 55 | 9  | 4.0 |
| Available faculty committed to research         | 1  | 0  | 9  | 43 | 47 | 4.0 |
| Developing a relationship with a faculty mentor | 0  | 3  | 9  | 44 | 45 | 4.0 |
| Learning about research process                 | 0  | 1  | 20 | 50 | 30 | 4.0 |
| Developing curriculum vitae                     | 0  | 7  | 33 | 47 | 13 | 4.0 |
| Developing prestige within resident peer group  | 9  | 16 | 40 | 31 | 4  | 3.0 |
| Prerequisite for a future academic position     | 7  | 8  | 31 | 36 | 18 | 4.0 |
| Developing groundwork for future collaborative research | 4 | 3 | 33 | 49 | 11 | 4.0 |
| Establishment of espirit de corps with a research group | 1 | 11 | 42 | 40 | 26 | 4.0 |
| Personal initiation and development of the project | 1 | 2 | 17 | 56 | 24 | 4.0 |
| Training program’s encouragement of research    | 1  | 3  | 17 | 62 | 17 | 4.0 |
| Past experience in conducting research          | 3  | 9  | 31 | 50 | 7  | 4.0 |

Factors discouraging participation in a research project

| Factors discouraging participation in a research project | Percentage of respondents ratings on a scale of 1–5 | 1  | 2  | 3  | 4  | 5  | Median |
|-------------------------------------------------|---------------------------------|--------|--------|--------|--------|--------|
| Lack of economic incentive                       | 20 | 25 | 30 | 17 | 7  | 3.0 |
| Unfamiliarity with grant application process     | 5  | 12 | 33 | 35 | 15 | 3.5 |
| Lack of adequate time                            | 4  | 0  | 12 | 27 | 57 | 5.0 |
| Lack of personal investment in research          | 5  | 15 | 36 | 26 | 18 | 3.0 |
| Absence of a faculty mentor                      | 4  | 3  | 28 | 33 | 33 | 4.0 |
| Interests do not coincide with program’s orientation | 8  | 14 | 33 | 30 | 15 | 3.0 |
| Too many other professional responsibilities     | 2  | 3  | 21 | 41 | 33 | 4.0 |
| Lack of personal research skills                 | 4  | 13 | 43 | 32 | 9  | 3.0 |
| Lack of perceived relevance to residency training experience | 10 | 22 | 29 | 30 | 9  | 3.0 |
| Lack of relevance of research to future practice style | 8  | 22 | 27 | 28 | 15 | 3.0 |

Note: Values are percentages. Number of subjects studied, N = 112. For factors encouraging participation in research, 1 = very unimportant, 2 = unimportant, 3 = neutral, 4 = important, and 5 = very important. For factors discouraging participation in research, 1 = no effect, 2 = very little effect, 3 = would somewhat discourage me, 4 = would moderately discourage me, and 5 = would highly discourage me. Due to rounding error, percentages may not sum to 100%. 

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To further illustrate the findings, Table 1 presents the response frequencies and medians for items assessing the importance of factors encouraging or discouraging residents' referral of subjects to another resident's research projects. As shown in Table 1, all five factors were judged as "important," indicating their significant role in residents' decision-making processes.
A within-subjects analysis of variance (ANOVA) was computed to test whether the factors differed in their relative importance. The within-subjects independent variable was factor (levels were the five factors that encouraged referral of subjects to research projects) and the dependent variable was the numerical rating of the extent to which the factor was perceived as encouraging. The effect for factor was significant \( (F = 11.13 [4,107], P < 0.0001) \) and Tukey's honestly significant difference (HSD) post-hoc tests were conducted to determine which factors significantly differed (level of significant difference was set at \( P < 0.05 \)) from which others. Tukey's HSD test revealed that "ease of the referral mechanism" was rated as significantly more important than the other factors and "personal investment in research" was rated as significantly less important than were the other factors.

Compared with the factors that encourage referral of subjects, there was greater variability in responses to the items that assessed factors that discourage the referral process. A within-subjects ANOVA was computed where the independent variable was factor (levels were the eight factors that discouraged referral of subjects to research projects) and the dependent variable was the numerical rating of the extent to which the factor was perceived as discouraging. The ANOVA yielded a significant effect for factor \( (F = 82.02 [7,103], P < 0.0001) \).

The primary concerns reported by respondents were related to patient welfare and personal time demands. Tukey's HSD test showed that "potentially negative impact on patient in therapy," "concerns regarding potential lapses in confidentiality," and "referral mechanism potentially time consuming" were rated as significantly more discouraging than were the other factors. Considerations that were least discouraging related to personal matters. Tukey's HSD test revealed that "unable to be a part of the research team," "lack of personal investment in research in general," "a lack of interest in the specific topic studied," and "lack of personal relationship to the researchers" were rated as significantly less discouraging than were the other factors.

Importance of Factors Related to Participation in a Research Project

Table 2 presents response frequencies and medians for items that assessed factors that encouraged or discouraged residents' participation in a research project. As shown in Table 2, most of the factors encouraging participation in a research project were rated as "neutral" to "important." A within-subjects ANOVA was computed where the independent variable was factor (levels were the 13 factors that encouraged participation in research projects) and the dependent variable was the numerical rating of the extent to which the factor was perceived as encouraging. The ANOVA revealed a significant effect for factor \( (F = 20.63 [12,98], P < 0.0001) \).

The two most important encouraging factors were related to faculty; Tukey's HSD test showed that "available faculty committed to research" and "developing a relationship with a faculty mentor" were rated as significantly more encouraging than were the other factors. "Developing prestige within resident peer group" was rated as significantly less encouraging than the other factors.

A final within-subjects ANOVA was computed where the independent variable was factor (levels were the 10 factors that discouraged participation in research projects) and the dependent variable was the numerical rating of the extent to which the factor was perceived as discouraging. The ANOVA indicated that there were significant differences in the extent to which factors were judged to discourage residents' participation in research projects \( (F = 24.00 [9,102], P < 0.0001) \).

Time demands placed on residents were rated as particularly discouraging of re-
search participation. Tukey's HSD test revealed that "lack of adequate time" and "too many other professional responsibilities" were judged to be significantly more discouraging than the other factors. "Lack of economic incentive," "lack of perceived relevance to residency training experience," and "lack of relevance of research to future practice style" were rated as significantly less discouraging of research participation than the other factors.

DISCUSSION

These data suggest that a variety of factors may facilitate resident referrals to research projects. The ease of the referral mechanism is of prime importance. In introducing projects to residents, it may be particularly useful to accentuate the potentially positive benefit for the referred patient, patients in the future, or the type of problem being explored by the project (e.g., borderline personality disorder). Research areas of mutual resident interest may also encourage referral of subjects as well as safeguards that ensure patient confidentiality. Personal factors appeared to be less significant.

Educational benefits (e.g., participating with faculty committed to research, developing a relationship with a faculty mentor, learning about the research process) are key motivators in engaging residents to participate in research efforts. As with referral, personal factors such as economic incentives or developing prestige within the peer group are apparently not strong motivators. On the other hand, the lack of available time and an abundance of other clinical responsibilities discourage research activity. The primary incentive to become involved in research appears to be the interpersonal learning experience with an "expert."

This information supports the value of exposure and mentorship and underscores the multiple time demands and stressors experienced by residents. For residency training programs interested in eliciting resident interest in research, the following would seem useful: 1) the availability of supportive mentors in the area of research, which is not unlike the regimen required in psychotherapy training; 2) the opportunity for exposure to the process of research; and 3) adequate time to develop a project and complete it.

A variety of limitations exist in this study. The survey format lends itself to imprecision by structuring responses and being self-reporting in nature. The response rate was moderately low, which could imply that the various programs' acknowledgement and distribution of questionnaires was faulty. In addition, residents may have been uninterested or too busy to participate in this project. Further, it is possible that the residents who had participated in research projects were particularly likely to complete and return the questionnaire, which may partially explain the high percentage (62.5%) of respondents who reported that they had contributed to research projects.

In addition, the selected sample (Ohio residents) may not be generalizable to all Ohio residents or the larger population of U.S. psychiatry residents. Again, the high level of self-reported participation in research projects reinforces this caveat.

Finally, the structure of the questionnaire may have been confusing for some responders because of the changing focus of the sections of the instrument. However, by incorporating these different perspectives (i.e., referral and participation) to explore similar processes, one might have a better estimate of the reliability of the findings.

Several recommendations follow from the findings in this study. Training programs can initiate residents into the research process by offering journal club formats (14,15), seminars (7), opportunities to present at research conferences (8), didactic course work on behavioral statistics and the critical evaluation of research (16), cultivation of resident ideas into research designs, and an environment in which the research process is active and ongoing.
With respect to project development and completion, residents need to be supportively educated about the "natural" course of research. In our experience, projects generally take more time and effort than anticipated by residents. A longitudinal time investment on a part-time basis is both practical and desirable. Finally, support and reassurance from candid faculty mentors can be useful, particularly when frustrations arise.

These data add depth to the current literature in the area of psychiatry residents' attitudes toward personal involvement in research. The information about referral dynamics is clinically valuable for residents wishing to garner support for subject referrals within the resident group. The findings about the factors encouraging or discouraging residents' participation in research projects is consistent with previous literature. Based upon these findings, the suggestions for consolidating a research presence in training programs seem relevant. It is hoped that research in residency programs is here to stay; the challenge will be to facilitate the experience.

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Comparison of Child Psychiatry Residents’ and Training Directors’ Perceptions of Training for Alcohol and Substance Abuse Treatment

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Richard H. Schwartz, M.D., Thomas N. Wise, M.D.
George W. Bailey, M.D.

Residents and directors of accredited child and adolescent psychiatry programs (N = 117) in the United States were surveyed (with a response rate of 89% and 76.9%, respectively) to determine the extent and adequacy of training offered for the identification and management of substance abuse disorders. Of the responders, 24% of the residents indicated some exposure (≥ 1 hour) to an adolescent drug abuse treatment facility during their training. In contrast, 46% of the directors reported that their residents had such exposure. Residents consistently reported training to be less adequate than did directors. Only half of the residents reported that they felt adequately prepared to identify and initially manage a substance-abusing adolescent, whereas a somewhat higher percentage of the directors (59%) felt that their residents were adequately prepared for this function.

There clearly is a need for child psychiatry training programs to train future child and adolescent psychiatrists to identify and manage youths who have substance abuse disorders. According to a 1989 nationwide survey of high school seniors sponsored by the National Institute on Drug Abuse, 39% of responders had used an illicit drug in the previous year (1). Of equal concern is that adolescents undergoing treatment for psychiatric disorders in a variety of clinical settings often use illicit drugs (2). Consequently, substance abuse is an important factor in the treatment of these various clinical populations.

Studies of general psychiatry residency programs have shown that most offer at least some training in the management of alcohol and substance abuse disorders (3–5). In a recent survey of child and adolescent psychiatry training directors, we reported that most child and adolescent psychiatry pro-

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grams allot didactic time for this topic; clinical training, however, was lacking. Further, only 59% of these training directors felt that their residents were adequately educated to identify and at least initially manage a substance-abusing adolescent (6). This lack of clinical training is perhaps not surprising since substance abuse teaching is not even included among the Accreditation Council for Graduate Medical Education’s (ACGME) Special Requirements for Programs in Child Psychiatry (7).

Training directors are commonly surveyed on various aspects of graduate medical education. However, although there have been numerous surveys of resident physicians’ perceptions of their clinical work, various rotations, and different patient types (e.g., the elderly, the poor, patients with acquired immune deficiency syndrome, and the terminally ill), few surveys have attempted to elicit resident physicians’ perceptions of the extent and adequacy of the training they are receiving.

To further elucidate ways in which child and adolescent psychiatry residency training programs could best prepare their graduates to meet the challenge of identifying and managing substance abuse, we surveyed a resident representative from each accredited child and adolescent psychiatry residency training program in the United States on the substance abuse curriculum offered by that program and the resident’s perception of the adequacy of training in that area. This article presents the results of that survey. For purposes of comparison, we also examined the pooled responses of the child and adolescent psychiatry residents with our previously reported pooled responses of the training directors (6).

**METHODS**

We developed a questionnaire covering many issues in substance abuse training culled from previous studies of general psychiatry residency programs (3-5,8). Individuals with expertise in substance abuse education or adolescent substance abuse reviewed drafts of the instrument, and their comments were incorporated into the final questionnaire. The questionnaire requested information on the size and demography of the training program, training sites, faculty composition, didactic and clinical experiences, and extent of training in specific topics. Questionnaires were sent to the training directors of each of the 121 child and adolescent psychiatry programs accredited by the ACGME in 1989. The same questionnaire was sent to the child and adolescent psychiatry resident listed in the American Psychiatric Association’s Directory of Psychiatry Residency Training Programs (9) as the resident representative for the program. According to the directory, resident representatives should be knowledgeable about their entire training program so they can review their training director’s program description for accuracy. Repeat mailings were made to nonresponders.

Of the 121 programs surveyed, 117 currently met ACGME accreditation standards. The remaining 4 programs had been discontinued or did not have the required minimum of four residents enrolled. Ninety (76.9%) of the child and adolescent psychiatry resident representatives and 104 (89%) training directors responded to the survey. All data were pooled into resident and training director responses and compared for similarities and differences.

**RESULTS**

**Program Composition and Sites**

The types of child and adolescent psychiatry programs with which responders were affiliated are shown in Table 1. The percentages of responses for directors and residents at the various types of programs were quite similar; thus, it was deemed that the two groups were comparable samples. The average number (mean ± SD) of child
and adolescent psychiatry residents per year per program, as reported by the residents, was 3.5 ± 1.9.

Table 2 lists the training sites in which the residents received clinical exposure to youths with substance abuse problems. There was marked discordance between the perceptions of the two groups as to whether the regular adolescent inpatient unit is used as a training site for substance abuse teaching. Although 21% of the training directors indicated that this setting is used as a training site for this purpose, less than 4% of the residents were in agreement.

Faculty

With regard to faculty resources, 43.2% of the residents (compared with 64.4% of the directors) indicated that there was a faculty member who had special interest or expertise in drug abuse ($\chi^2 = 7.8, df = 1, P < 0.01$).

Training Experiences

Only 24% of the child and adolescent psychiatry residents indicated at least some exposure (defined as 1 hour or more) to an adolescent drug/alcohol abuse treatment facility; 46% of the residency directors, by contrast, reported that child and adolescent psychiatry residents in their training programs spent time in such a facility ($\chi^2 = 6.7, df = 1, P < 0.01$). Fifteen percent of residents, compared with 20% (NS) of the directors, reported a required clinical rotation in chemical dependency in their training program.

Seventy-seven percent of the child and adolescent psychiatry residents reported that at least 1 scheduled didactic hour was specifically allotted to the topic of alcohol/drug abuse during the residency. The median number of didactic hours scheduled was 4. The mean number of printed reference materials suggested by clinical staff specifically relating to drug abuse was 3.9 ± 3.4. This is significantly less than the 7.2 printed references reported by residency training directors ($t = 4.2, df = 140, P < 0.001$).

Curricula

Subjects were asked whether they believed that they had received adequate training in a variety of specific substance abuse topics (see Table 3). The percentage of responding residents reporting that the instruction was adequate in the various substance abuse topics was less than that of the directors in all areas surveyed. The trends in perceived adequacy of instruction

| TABLE 1. Composition of child psychiatry programs responding to a survey of child psychiatry residents' and training directors' perceptions of alcohol and substance abuse training |
|---------------------------------|--------|--------|
| Program                        | Residents | Training Directors |
| University hospital            | 64      | 67      |
| Private for-profit hospital    | 11      | 6       |
| County hospital                | 2       | 5       |
| State hospital                 | 5       | 4       |
| Military hospital              | 3       | 3       |
| Other                          | 15      | 15      |

*Note: Values are percentages.*

| TABLE 2. Composition of training sites for clinical exposure to substance abuse problems |
|---------------------------------|--------|--------|
| Training Site                  | Residents | Training Directors |
|                                 | (n = 90) | (n = 104) |
| Regular adolescent inpatient unit | 4        | 21      |
| Adolescent chemical dependency inpatient unit | 13      | 16      |
| Outpatient chemical dependency program | 5        | 6        |
| Other                           | 1        | 6        |
| Does not apply                  | 77       | 51      |

*Note: Values are percentages.*
of curricular topics were, however, similar for both the groups.

In response to a summary question, only 50% of the child and adolescent psychiatry residents reported that they were adequately educated to identify and at least initially manage a drug-abusing adolescent, whereas 59% of the training directors believed that the residents were adequately prepared.

Characteristics of Programs Offering "More" and "Less" Adequate Instruction

We examined some characteristics of residency programs that gave more instruction vs. those that gave less instruction, as reported by the residents, by first adding the affirmative responses on Table 3 and then calculating a median split. We compared programs that scored above the median with those that scored below it. Programs with more instruction (i.e., those with seven or more affirmative responses) were more likely to have a required clinical rotation related specifically to chemical dependency ($\chi^2 = 10.4, df = 1, P < 0.01$) and to have this rotation in an adolescent chemical dependency inpatient unit ($\chi^2 = 11.6, df = 3, P < 0.01$). These programs also were more likely to require residents to spend at least 1 hour in an adolescent drug abuse treatment unit ($\chi^2 = 4.1, df = 1, P < 0.05$) and to observe group therapy for adolescents in treatment for drug abuse ($\chi^2 = 8.5, df = 1, P < 0.01$). Residents from these programs were also more likely than those from the programs offering less instruction to indicate that they were adequately educated to identify and manage a drug-abusing adolescent ($\chi^2 = 8.5, df = 1, P < 0.01$). There was no relationship between the size or type of residency program and the amount or adequacy of substance abuse instruction given.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Residents (n = 90)</th>
<th>Training Directors (n = 104)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSM-III-R criteria for drug abuse/dependency</td>
<td>76</td>
<td>90</td>
</tr>
<tr>
<td>Specific drugs of abuse mimicking mental disease</td>
<td>58</td>
<td>79*</td>
</tr>
<tr>
<td>Intervention with a drug-abusing adolescent</td>
<td>48</td>
<td>70*</td>
</tr>
<tr>
<td>&quot;Carving&quot; (self-harm) vs. suicide</td>
<td>54</td>
<td>69*</td>
</tr>
<tr>
<td>Community resources for the teenage drug abuser</td>
<td>44</td>
<td>65*</td>
</tr>
<tr>
<td>Pharmacology of specific drugs of abuse</td>
<td>47</td>
<td>61 NS</td>
</tr>
<tr>
<td>Acquired immune deficiency syndrome and mental symptoms</td>
<td>51</td>
<td>62 NS</td>
</tr>
<tr>
<td>Stages of progressive chemical dependency</td>
<td>47</td>
<td>59 NS</td>
</tr>
<tr>
<td>Adult Children of Alcoholics</td>
<td>28</td>
<td>58 NS</td>
</tr>
<tr>
<td>Emergency management of toxic reactions to phencyclidine</td>
<td>37</td>
<td>54*</td>
</tr>
<tr>
<td>Management of withdrawal from benzodiazepines</td>
<td>54</td>
<td>55 NS</td>
</tr>
<tr>
<td>Laboratory tests for drugs of abuse: pitfalls in interpretation</td>
<td>28</td>
<td>45*</td>
</tr>
<tr>
<td>Alcoholics Anonymous and 12-step programs</td>
<td>39</td>
<td>41 NS</td>
</tr>
<tr>
<td>The role of the drug abuse counselor</td>
<td>30</td>
<td>38 NS</td>
</tr>
<tr>
<td>The impaired physician</td>
<td>28</td>
<td>29 NS</td>
</tr>
<tr>
<td>Michigan Alcohol Screening Test</td>
<td>13</td>
<td>22 NS</td>
</tr>
</tbody>
</table>

Note: Values are percentages. Resident and training director responses compared using chi-square analysis.
$^*P < 0.05; ^{**}P < 0.01; ^{***}P < 0.001; NS = not significant.$
DISCUSSION

Although the residents' responses mirrored the directors' responses on every item surveyed, fewer child and adolescent psychiatry residents than training directors perceived their substance abuse training to be adequate. The best overall concordance between residents and training directors was seen in relation to the responses regarding didactic teaching of substance abuse. The concordance was less evident in matters relating to the clinical aspects of training. Consequently, it is not surprising that only 50% of the trainees felt that they were adequately trained to diagnose and clinically manage a substance-abusing adolescent.

Fewer residents than directors reported adequate training on every item surveyed. There are a few possible explanations for this. The training directors may have been biased toward the quality of their program and thus may have exaggerated the adequacy of training in this area. The residents, uncertain of their developing clinical skills and frustrated by their attempts to work with substance-abusing populations, may have believed that they had inadequate training in this area. Further, although supposedly knowledgeable about their programs, the residents queried were still in training and may not have rotated through a substance abuse program at the time of the rating. Finally, training directors may not have been the most knowledgeable faculty members to query. Perhaps if we had requested that the questionnaire be passed along to the faculty member who directed the substance abuse training, fewer discrepancies would have been noted.

There are several ways to encourage greater emphasis on training experiences related to substance abuse: 1) increase the awareness among those involved in academic medicine of the magnitude of the problem; 2) include substance abuse training in the ACGME's special requirements for child and adolescent psychiatry training programs; 3) offer model training programs, such as proposed by Halikas (10), that can assist other programs in implementing effective training; 4) include questions on the Child and Adolescent Psychiatry Board examination on this topic; 5) continue to ask for feedback from residents; 6) offer incentives through funding support and stipends; and 7) increase research in child and adolescent substance abuse, which may further stimulate academic interest in this area.

The findings in this article suggest that substance abuse teaching is a weak area in child and adolescent psychiatry training. It is recognized that the field of child and adolescent psychiatry is expanding rapidly and that the ever-increasing residency requirements are pressing the capacity of the 2-year residency to accommodate and teach the essentials in sufficient breadth and depth (11,12). However, given the widespread incidence of substance abuse in the clinical populations seen by psychiatrists who treat adolescents and the considerable morbidity of adolescent substance abuse, it would seem provident for this to be a major area of teaching.

References
8. Davis AK, Cotter F, Czechowicz D: Substance abuse units taught by four specialties in medical schools and residency programs. Journal of Medical Education 1988; 63:739-746
In this volume, David Livingston Smith, a psychotherapist in London, presents an overview of Robert Langs's communicative approach to psychoanalysis. The author illustrates the communicative approach with many clinical examples and a commentary on the processes underlying the case studies. He provides a critique of traditional psychoanalytic theory and practice and responds to some of the philosophical objections to psychoanalytic theory.

The author's diatribe against psychoanalysis is more true of psychoanalysis as it was taught and practiced 25 years ago. He seems unaware of the changes in both theory and practice in psychoanalysis in the last quarter century. He does not distinguish, for example, between the theories Freud advanced and the ones being taught in psychoanalytic institutes around the world today.

In the first four chapters of the book Smith attempts to lay the groundwork for his presentation of Langs's theory through demonstrating the scientific poverty of such fundamental psychoanalytic concepts as transference. In Chapter 1 he argues that the theories of unconscious fantasy that Freud used early in this century to substitute for the seduction theory are deeply flawed. In Chapter 2 he takes a critical look at transference and concludes that it is deeply and probably irreparably incoherent. Here again, the author has not done his homework. In his discussion about the psychoanalytic theory of transference, he almost completely overlooks the writings of the past several decades. Though I agree with his criticisms of Freud's causal explanatory theory of transference, I do not see the merit of dropping the concept. As a descriptive term, the word "transference" does have some value. Freud's causal explanatory theory of transference was based on his theory of cognition, and it derived from his effort to explain how past experiences impact the present. With the collapse of that theory, his explanatory theory of transference also collapses (1,2). Freud believed that patients experienced intense emotional responses to their analyst because they have displaced psychic energy from an unconscious parental image onto a preconscious image of the analyst. This explanation of transference, in light of our present knowledge of cognition, is incorrect.

One of the major contributions made by Langs and articulated by Smith is a new view of the unconscious mind. The notion that the unconscious mind is capable only of wishing, fantasizing, and hallucinating has little if any empirical support in its favor. Langs's persuasive argument that the unconscious mental system is capable of deploying sophisticated cognitive and perceptual processes is well supported by experimental psychology and cognitive science. Chapters 3 and 4 trace the history of the theory of unconscious perception in Freud's writings and early psychoanalytic writings. The neglected concept of unconscious perception, Smith argues, is a powerful alternative to the discredited theory of transference, which he and Langs reject. Smith proposes that a paradigm shift from transference to unconscious perception would rule out notions of the patient's resistance, transference, and fantasies. The communicative approach involves a shift from the standard psychoanalytic theory of transference, he almost completely overlooks the writings of the past several decades. Though I agree with his criticisms of Freud's causal explanatory theory of transference, I do not see the merit of dropping the concept. As a descriptive term, the word "transference" does have some value. Freud's causal explanatory theory of transference was based on his theory of cognition, and it derived from his effort to explain how past experiences impact the present. With the collapse of that theory, his explanatory theory of transference also collapses (1,2). Freud believed that patients experienced intense emotional responses to their analyst because they have displaced psychic energy from an unconscious parental image onto a preconscious image of the analyst. This explanation of transference, in light of our present knowledge of cognition, is incorrect.

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alytic stress on fantasy to a new concern with interpersonal reality, and with this comes the concern with the unconscious impact of the here and now situation beyond the patient's remembered and reconstructed past.

The second part of the book contains six chapters describing Langs's communicative approach to psychoanalysis and traces out some of its theoretical, therapeutic, and philosophical implications. The author provides a history of Langs's gradual development of the communicative approach and the generally hostile response it received from psychoanalysts in the United States and Europe. Langs's writings were not so much maligned as they were more often ignored.

According to Langs, the deep unconscious system is able to make bewildering rapid and highly accurate inferences about the unconscious modes of defense and implications of behavior. Patients' unconscious communications, as expressed in an encoded fashion through derivatives, express the real implications of the therapist's behavior. The unconscious mind is primarily an organ of adaptation. Unconscious derivatives are not as Freud, Klein, or others would have it, infantile or fantasy distortions of reality. Derivatives can usually be identified by their formal properties. They are statements that are specific, concrete, and easily visualized.

In Langs's system, validation of therapist interpretations occur when the patient responsively produces positively toned, constructive derivative imagery reflecting unconscious appreciation and positive insightful qualities of the intervention.

Chapter 7 gives an account of Langs's theory of the frame and traces the history of this concept from Freud through Milner and Winnicott to the present. The author gives clinical examples of departures from the secure frame and their consequences for the patient. Although other psychoanalytically oriented professionals follow most of the same elements in the frame, few ascribe to the frame as much importance, both theoretically and technically, as do Langs and communicative therapists.

Chapters 8 and 9 use case studies to illustrate the basic principles of communicative psychotherapy. Chapter 9 is devoted to detailed accounts of communicative sessions conducted by two British practitioners who made transcripts of their sessions available to the author. The communicative approach is fundamentally concerned with the active interpretation of derivative messages consisting of transformed, coded, unconscious information. In his view, there must be a set of translation rules for first identifying derivative material and then for translating it. Langs's approach involves translating the derivatives of the patient's unconscious perception of the therapist. Unlike other psychoanalytic schools and approaches, there are only a small number of interventions that are consistent with the communicative approach. These are frame management, interpretation, and silence. Other kinds of interventions, such as clarification, questioning, confrontations, and the like, are seldom if ever permissible.

In summary, although the author has provided a valuable summary of Langs's communicative approach, his book is marred by his unfair and uninformed criticisms about contemporary psychoanalysis. This volume is recommended for those mental health professionals who want an introduction to the new and controversial communicative approach to psychoanalytic theory and practice.

Dr. Dorpat is Clinical Professor of Psychiatry, University of Washington School of Medicine.

References
Mini-Reviews

Adult Children of Divorce
By Edward W. Beal, M.D., and Gloria Hochman
New York, Delacorte Press
$18.95, 347 pages

Reviewed by Neil Blumberg, M.D.

Adult Children of Divorce is a highly readable, clinically oriented book on the long-term impact of divorce. This work combines a review of the literature, the authors' clinical experience, and case vignettes to convey the profound but often overlooked chronic difficulties that follow divorce. The book is useful for clinicians and patients alike, along with being a powerful reminder for the forensic psychiatrist of the consequences of divorce. Overall, I would highly recommend this book.

Putting On the Brakes
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How to Win as a Step Family
By Emily B. Visher, Ph.D., and John S. Visher, M.D.
New York, Brunner/Mazel
$13.95, 205 pages

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The authors describe clearly the problems that may arise and the adjustments that may be necessary when parents remarry. The authors offer practical strategies for success. This is a helpful handbook for those who are entering step-family life. I would also recommend the book to family therapists who work with such blended families.

Equilibration, Mind, and Brain:
Toward an Integrated Psychology
By E.J. Parkins
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Educational Abstracts

Dorthea Juul, Ph.D.
Abstract Editor


Perhaps everyone involved in medical education has at some point worried about being sued as a result of making a negative decision about a medical student or resident. In these four articles, Helms and Helms review legal cases involving medical students and residents for the period 1950–1989, and their reports, while generally reassuring, suggest that such faculty concerns are not unwarranted.

Helms and Helms used computerized legal research services to identify relevant state and federal cases. The authors emphasize that the product of such searches, while allowing identification of broad trends, represents “only the tip of the litigation iceberg.” Each article addresses three issues: the volume of litigation, the issues giving rise to litigation, and the prevailing party.

For medical students, 110 cases were identified, 51 of which dealt with general academic issues and 59 of which dealt with the finance of medical education. In both areas the number of cases increased dramatically over the 40 years studied, a period of expansion in medical school enrollment, tuition increases, and growing reliance on student loans.

The general academic cases were broken down into 25 dismissal cases, 9 admissions cases, and smaller numbers of cases involving issues such as cheating, readmissions decisions, and requirements to repeat courses or tests. Medical students prevailed in only 12 (24%) of the 51 cases.

The authors suggest that medical schools successfully responded to legal challenges, particularly in the area of admissions, by adopting appropriate procedural standards, and conclude that “the case law data sustain the idea that faculty have little reason to fear judicial intervention in upholding academic standards” (p. 5).

They go on to point out, however, that this history of institutional success does not mean that the number of suits will go down. Rather, the focus moves to other levels of decision-making with, for example, a student charging discrimination by faculty in the evaluation process rather than in the dismissal process.

The authors specifically recommend that schools review their policies with regard to leaves of absence and conditions for readmission, requirements for retaking work, and cheating. Although there has yet to be a case in which a medical student claimed failure to educate on the part of a medical school, the authors predict that
other issues of negligence, such as teaching preventive measures for exposure to acquired immune deficiency syndrome, will be a cause for legal action in the future. Finally, only one case in which a student was sued for malpractice (the patient won) was discovered, which is probably explained by the relatively clear-cut responsibility that supervising faculty have for patient care.

Almost half (29) of the 59 cases involving financial issues were disputes over performance of service obligations, primarily to the National Health Service Corps. Twenty-three cases involved bankruptcy procedures, four involved medical school eligibility for aid in financing their programs or students, and three were student challenges to increases in tuition or fees.

Medical students have not been successful in challenging their service obligations, nor have the courts been willing to discharge debts incurred for medical education. The authors suggest that students be carefully counseled about the consequences of the service and financial obligations into which they enter.

Helms and Helms predict that suits in this category will continue to grow, as will challenges to adverse academic decisions, as the economic consequences of dismissal from programs increase. Although litigation about financial and service obligations may not affect most faculty directly, indebtedness has been cited as a cause for sub-specialization at the expense of primary care and as placing a particularly heavy burden on minority students.

A total of 174 cases involving residency training were discovered, 38 of which centered on general programmatic issues and 136 of which were malpractice issues. As with litigation at the level of undergraduate medical education, there was a dramatic increase in the volume of cases at the residency level over the period of study.

Of the 38 nonmalpractice cases, 31 involved academic administration issues such as dismissal and admission, 3 involved collective bargaining issues, 3 involved taxation or reimbursement issues, and 1 was a case of wrongful interference with contractual obligations (a supervising physician sued a resident who had provided testimony against him to the hospital's peer review committee).

The resident prevailed in 24% (9/38) of the cases, the party opposing the resident prevailed in 63% (24) of the cases, and no winner could be determined in the remaining 5 cases. Generally, the courts have considered residents to be students with faculty having the right to make decisions based on academic performance, as with medical students. However, when dealing with issues of compensation, residents have been viewed as employees, and contract law prevails. The authors predict that litigation because of dismissal will continue to increase as indebtedness increases.

With regard to other issues, the courts have upheld the right of states to impose regulations on training programs (e.g., duty hours) and the authority of the Accreditation Council for Graduate Medical Education to regulate training programs. One case emerged in which a resident who was sued for malpractice in turn sued his residency program, claiming educational malpractice; that claim was denied.

A substantial proportion of the 136 malpractice suits involved the allocation of responsibility between the hospital and attending physicians when substandard care was provided by a resident. Other issues were judicial procedures, immunity from liability, breach or causation, and informed consent. The increase in these suits followed national trends in malpractice litigation.

The residents were on the side of the prevailing party in less than half (44%) of the cases, and the authors note that this is probably somewhat less favorable than for malpractice cases in general. They also point out that during the study period the standard of care for residents evolved from "that level of
performance expected of an 'average' resident at a comparable state of training" to the expectation that the resident "perform as a physician, competent by professional standards to practice in his or her specialty area" (p. 720). This standard is considered reasonable based on the high level of supervision expected of attending physicians.

The authors conclude that malpractice will continue to be the key legal issue facing residency programs and emphasize the importance of clear policies about faculty supervisory responsibility, an issue that becomes especially complex when training programs are involved in cooperative arrangements with a number of sites.

In summary, the years 1950–1989 saw a dramatic increase in the volume of litigation involving medical students and residents. Generally, once schools and training programs adopted appropriate procedural standards, they were the prevailing party as the courts upheld the right of faculty to make decisions about trainees on the basis of academic performance.

Helms and Helms predict that, nonetheless, litigation will increase, particularly as the economic stakes increase and that the grounds for suits will broaden to other areas and different levels of decision-making. For residency programs, malpractice litigation will continue to be the primary concern.

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**CHAIR, DEPARTMENT OF PSYCHIATRY**

The School of Medicine and Biomedical Sciences, State University of New York at Buffalo is seeking candidates with demonstrated leadership abilities and administrative experience to direct the teaching, research, and service programs of the Department of Psychiatry. The Department has a major role in the Academic Health Center, its eight teaching hospitals, the University PET Center, and maintains important relations with other community facilities and agencies.

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The Sexuality Curriculum in Residency Training

SIR: The following areas of human sexuality research seem particularly relevant to the training of psychiatry residents:

1. Psychosexual development
2. Sexual functioning and psychophysiology
3. Treatment of sexual dysfunctions
4. Sexual orientation: heterosexual, homosexual, and bisexual lifestyles
5. Gender identity: sex roles, transvestism, transsexuality
6. Diversity of sexual expression and paraphilias
7. Forensic sexology: child sexual abuse, sexual assault and rape, sexual exploitation in professional relationships, treatment of sex offenders
8. Psychiatric illness and sex: effect of mental illness on sexual responsiveness, chronic mental illness and sexual behavior (including family planning behavior), effect of drugs and medications on sexual behavior
9. Sexually transmitted diseases: psychosocial aspects of HIV

In addition to attending didactic lectures, the resident needs to learn clinical skills, such as taking a sex history, evaluating a person's sexual lifestyle or gender identity concerns, and providing basic sexual counseling to psychiatric patients (1).

There is a paucity of data available on the human sexuality curriculum in psychiatry training programs (2). Therefore, I conducted a brief survey to obtain some basic data.

Methods

A questionnaire was mailed out to the members of the American Association of Directors of Psychiatric Residency Training who were specifically identified in the 1990-1991 membership directory as general program directors. Other members, such as directors of child psychiatry programs, were excluded. To maximize the return rate, the questionnaire was kept extremely brief, requiring only a couple of minutes to fill out. A numbered return envelope was included, allowing identification of responders.

The questionnaire addressed two issues: 1) the formal teaching of human sexuality in didactic lectures and 2) the clinical training and supervision available to residents. To evaluate the clinical training and supervision available, training directors were asked whether the program offered required or elective rotations in a sex therapy clinic or sexual problems program and whether some of the residents' supervisors were specifically identified as having an interest and expertise in issues related to human sexuality.

To evaluate the formal didactic curriculum, a list of 11 specific topics (see Table 1) was presented, and training directors were asked—for each topic—to answer three questions:

1. "Is this topic covered in your regular, formal didactics?" Answer choices were "yes," "no," and "yes, but." The last choice was used to indicate that the topic is not covered as a distinct part of the didactics but incidentally, such as during lectures on other subjects.
2. "In your opinion, should this topic receive more, less, or the same emphasis in the future?"
3. "In your opinion, did this topic receive more, less, or the same emphasis back in the 1960s and 1970s?"

Results

Of the 205 training directors surveyed, 137 (67%) returned a completed questionnaire.
The availability of clinical training opportunities in sexual counseling appears limited. Only 57% \((n = 71)\) of the training directors reported that they had a sexual problems program available for resident rotations. Also, although 75% \((n = 98)\) of the directors indicated that some of their program’s supervisors were interested in sexual issues, 25% \((n = 33)\) of the directors indicated that there were either no supervisors with special interest in human sexuality or these supervisors were not identified as such to the residents. The data on the didactic lectures are summarized in Table 1.

The first column in Table 1 represents the respondents who reported the topic as currently part of formal didactics. (Only the “yes” answers, indicating specific lectures, are listed. The “yes, but” answers, indicating incidental training, may not be very reliable. Adding up the percentages of “yes” and “yes, but” answers invariably totals 75% or more.) Most topics are taught in 50%-75% of the programs, with only “psychosexual development” standing out on the high end of the scale (94%) and “sexual assault and rape” (48%) and “effect of mental illness on sexual behavior” (37%) standing out on the low end of the scale.

The second column in Table 1 shows the percentage of responders who thought the topic was taught less in the past. Except for “psychosexual development,” “paraphilias,” and “sexual response cycle,” training directors indicate that there is currently more emphasis on teaching sexuality than in the 1960s and 1970s.

The third column in Table 1 lists the percentage of responders who favored more emphasis on each topic in the future. For five topics, more than 50% of the directors indicated that residents should be taught more about the following: 1) sexual assault and rape (66%), 2) psychosocial and ethical issues of acquired immune deficiency syndrome (AIDS; 63%), 3) effect of mental

<table>
<thead>
<tr>
<th>Area of Human Sexuality</th>
<th>Currently Part of Formal Didactics (n(%))</th>
<th>Was Taught Less in the Past (n(%))</th>
<th>Should Receive More Emphasis in the Future (n(%))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosexual development</td>
<td>126 (94)</td>
<td>24 (19)</td>
<td>17 (14)</td>
</tr>
<tr>
<td>The sexual response cycle</td>
<td>71 (53)</td>
<td>52 (42)</td>
<td>49 (40)</td>
</tr>
<tr>
<td>(Treatment of) sexual dysfunctions</td>
<td>98 (74)</td>
<td>71 (56)</td>
<td>54 (45)</td>
</tr>
<tr>
<td>Sexual orientation: homosexual, bisexual, lesbian issues</td>
<td>72 (55)</td>
<td>92 (74)</td>
<td>69 (54)</td>
</tr>
<tr>
<td>Gender identity: transsexuality</td>
<td>83 (64)</td>
<td>62 (50)</td>
<td>48 (37)</td>
</tr>
<tr>
<td>Paraphilias</td>
<td>78 (61)</td>
<td>59 (47)</td>
<td>49 (38)</td>
</tr>
<tr>
<td>Effect of mental illness on sexual responsiveness and behavior</td>
<td>47 (37)</td>
<td>79 (63)</td>
<td>80 (61)</td>
</tr>
<tr>
<td>Sexual side-effects of medication</td>
<td>93 (71)</td>
<td>90 (72)</td>
<td>46 (36)</td>
</tr>
<tr>
<td>Psychosocial and ethical issues of AIDS prevention</td>
<td>79 (61)</td>
<td>116 (93)</td>
<td>82 (63)</td>
</tr>
<tr>
<td>Child sexual abuse</td>
<td>103 (78)</td>
<td>109 (87)</td>
<td>69 (53)</td>
</tr>
<tr>
<td>Sexual assault and rape</td>
<td>62 (48)</td>
<td>91 (73)</td>
<td>80 (66)</td>
</tr>
</tbody>
</table>
illness on sexual behavior (61%), 4) sexual orientation issues (54%), and 5) child sexual abuse (53%).

Almost no one proposed less training in any of the topics. Indeed, the percentages of responders expressing a preference for less training range from 0% to 4% with the mode being 2%. Thus, for any given topic, one arrives at close to 100% of the responders by adding up the percentage of those who want more emphasis and the percentage of those who want the same emphasis on this topic in the future. The percentages preferring the same emphasis are not summarized in Table 1. However, subtracting from 100% the percentage of responders who want a given topic to receive more emphasis yields approximately the percentage of those who want the same emphasis on this topic in the future.

Discussion

Few psychiatrists would deny that sexuality is a central feature of the human experience and that knowledge about this area is exceedingly relevant for psychiatrists. From this survey, one can draw the general conclusion that many programs fail to teach a broad range of sexuality issues and that expert supervision and clinical training opportunities are often lacking. The responding training directors did express the opinion that these issues are important and need to be emphasized more.

Interestingly, most of the issues singled out by training directors as definitely needing more training emphasis are presently the focus of public debate. There is a growing awareness among the public about the incidence and the serious consequences of child sexual abuse and of sexual assault and rape. There is the almost irrational public fear of AIDS and other sexually transmitted diseases. Homosexuals, lesbians, and bisexuals are “coming out” and demanding social recognition. These issues stir up emotional debate but are also generating interesting research (3–5). Consequently, a program that strengthens its sexuality curriculum is likely to find itself more in tune with current social concerns and to enjoy the excitement of new discoveries.

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1993 AADPRT Peter Henderson Memorial Award

The American Association of Directors of Psychiatric Residency Training (AADPRT) is pleased to announce the 1993 Peter Henderson Award. The Association will award a $500 prize for the best unpublished paper in the area of child and adolescent psychiatry written by a current general psychiatry resident, child and adolescent psychiatry resident, or an individual who has graduated from a general or child and adolescent psychiatry training program within the prior two years. The prize will be presented at the AADPRT’s winter meeting (January 14–17, 1993 in San Diego), and the winner will be invited to attend the meeting at the Association’s expense.

The Award has been established to memorialize Dr. Peter Henderson, a Past-President of AADPRT who was specifically interested in nurturing and developing an effective link between child and general psychiatry. Because of initiatives developed by Dr. Henderson, the majority of child and adolescent psychiatry programs are now represented in the AADPRT, enhancing and expanding the scope and integration of graduate psychiatric education.

Submitted papers must have been written while the author was a general psychiatry resident or child fellow and cannot have been published previously. If the paper is co-authored, the resident submitting the paper must be the senior author for publication purposes. It must be a scholarly paper of at least 15 pages that contributes to the field of child and adolescent psychiatry.

Papers should be submitted before September 30, 1992, to:

Executive Secretary
AADPRT Executive Office
The Institute of Living
400 Washington Street
Hartford, CT 06106

1993 AAP Psychiatric Education Award

Nomination are being requested for the 1993 AAP Psychiatric Education Award. Since 1988 the AAP has presented at its Annual Meeting an award for an outstanding psychiatric educator in even-numbered years and an award for an outstanding psychiatric educational project in odd-numbered years.

Responding to the current crisis of declining numbers of medical students choosing psychiatry as a career, the 1993 AAP Annual Meeting will focus on medical student education. In line with this focus, the 1993 Psychiatric Education Award will be presented to an individual who has developed an outstanding program or project in psychiatric education for medical students (i.e., an innovative curriculum or course, a new approach to clinical education, etc.) that has stimulated recruitment into psychiatry. Criteria for evaluation will include the originality, soundness of design, effectiveness, timeliness, generalizability, applicability, and reproducibility of the nominee’s psychiatric educational program.

The winner will be invited to present a paper on his/her program at the AAP Annual Meeting in Charleston, South Carolina, March 10–13, 1993, and to submit the paper for review for publication in Academic Psychiatry. In addition, the winner will receive a plaque, an honorarium, and support for travel to the Annual Meeting.

Nominations may be made by either an individual or an institution. The deadline for the receipt of nomination is July 1, 1992. Requests for nomination forms and inquiries should be addressed to:

AAP Psychiatric Education Award
Association for Academic Psychiatry
Mount Auburn Hospital
Department of Psychiatry, Wyman 2
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