In This Issue:

Pregnancy During Psychiatry Residency
A Study of Attitudes
By Devra Braun, M.D.
Virginia L. Susman, M.D.

Continuing Education in Psychotherapy as a Method to Attract and Involve Voluntary Faculty in an Academic Department of Psychiatry
By Hillel I. Swiller, M.D.
Kenneth L. Davis, M.D.

The Journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry
Proudly Announces
The International Review of Psychiatry

Published in Conjunction With
The 9th World Congress of Psychiatry

Edited By
Jorge Costa e Silva, M.D., and Carol C. Nadelson, M.D.

Section I—Psychiatric Nosology:
The Impact of ICD-10 and DSM-IV
Section Editor: Juan Mezzich, M.D., USA.
Contributors: Assen Jablensky, M.D., BULGARIA, Ahmed Okasha, M.D., EGYPT, Thomas Widiger, Ph.D., & Timothy J. Trull, Ph.D., USA, Carlos Berganza, M.D., GUATEMALA, Marianne C. Kastrup, M.D., Ph.D., DENMARK, Arthur Kleinman, M.D. & Ladson Hinton, M.D., USA.

Section II—Psychopharmacology
Section Editors: Otto Benkert, M.D., GERMANY, David J. Kupfer, M.D., USA.
Contributors: Stuart Montgomery, M.D., UK, Ellen Frank, Ph.D., USA, H. Wetzel, GERMANY, Samuel J. Keith, M.D. & Nina Schooler, Ph.D., USA, Malcolm Lader, M.D., UK, Carl-Gerhard Gottfries, M.D., SWEDEN.

Section III—Neurobiology
Section Editors: Nancy Andreasen, M.D., Ph.D., USA, Mitumoto Sato, M.D., JAPAN.
Contributors: Ming Tsuang, M.D., USA, Yves Lecrubier, M.D., FRANCE, Shinichi Niwa, JAPAN, Bernhard Bogerts, M.D., GERMANY & Jeffrey Lieberman, M.D., USA.

Section IV—Addictions
Section Editor: Marc Galanter, M.D., USA.
Contributors: Ulf Rydberg, M.D. Ph.D., SWEDEN, Marc Galanter, M.D., USA, Claudio Naranjo, M.D., CANADA, Marcus Grant, SWITZERLAND.

For Registration & Travel Information
Call 1-800-722-9501
Ask For International Review Information

The Official Airline for the 9th World Congress of Psychiatry

Published in Conjunction With The 9th World Congress of Psychiatry
Edited By Jorge Costa e Silva, M.D., and Carol C. Nadelson, M.D.

Section I—Psychiatric Nosology: The Impact of ICD-10 and DSM-IV
Section Editor: Juan Mezzich, M.D., USA.
Contributors: Assen Jablensky, M.D., BULGARIA, Ahmed Okasha, M.D., EGYPT, Thomas Widiger, Ph.D., & Timothy J. Trull, Ph.D., USA, Carlos Berganza, M.D., GUATEMALA, Marianne C. Kastrup, M.D., Ph.D., DENMARK, Arthur Kleinman, M.D. & Ladson Hinton, M.D., USA.

Section II—Psychopharmacology
Section Editors: Otto Benkert, M.D., GERMANY, David J. Kupfer, M.D., USA.
Contributors: Stuart Montgomery, M.D., UK, Ellen Frank, Ph.D., USA, H. Wetzel, GERMANY, Samuel J. Keith, M.D. & Nina Schooler, Ph.D., USA, Malcolm Lader, M.D., UK, Carl-Gerhard Gottfries, M.D., SWEDEN.

Section III—Neurobiology
Section Editors: Nancy Andreasen, M.D., Ph.D., USA, Mitumoto Sato, M.D., JAPAN.
Contributors: Ming Tsuang, M.D., USA, Yves Lecrubier, M.D., FRANCE, Shinichi Niwa, JAPAN, Bernhard Bogerts, M.D., GERMANY & Jeffrey Lieberman, M.D., USA.

Section IV—Addictions
Section Editor: Marc Galanter, M.D., USA.
Contributors: Ulf Rydberg, M.D. Ph.D., SWEDEN, Marc Galanter, M.D., USA, Claudio Naranjo, M.D., CANADA, Marcus Grant, SWITZERLAND.

For Registration & Travel Information
Call 1-800-722-9501
Ask For International Review Information

The Official Airline for the 9th World Congress of Psychiatry

Published in Conjunction With The 9th World Congress of Psychiatry
Edited By Jorge Costa e Silva, M.D., and Carol C. Nadelson, M.D.

Section I—Psychiatric Nosology: The Impact of ICD-10 and DSM-IV
Section Editor: Juan Mezzich, M.D., USA.
Contributors: Assen Jablensky, M.D., BULGARIA, Ahmed Okasha, M.D., EGYPT, Thomas Widiger, Ph.D., & Timothy J. Trull, Ph.D., USA, Carlos Berganza, M.D., GUATEMALA, Marianne C. Kastrup, M.D., Ph.D., DENMARK, Arthur Kleinman, M.D. & Ladson Hinton, M.D., USA.

Section II—Psychopharmacology
Section Editors: Otto Benkert, M.D., GERMANY, David J. Kupfer, M.D., USA.
Contributors: Stuart Montgomery, M.D., UK, Ellen Frank, Ph.D., USA, H. Wetzel, GERMANY, Samuel J. Keith, M.D. & Nina Schooler, Ph.D., USA, Malcolm Lader, M.D., UK, Carl-Gerhard Gottfries, M.D., SWEDEN.

Section III—Neurobiology
Section Editors: Nancy Andreasen, M.D., Ph.D., USA, Mitumoto Sato, M.D., JAPAN.
Contributors: Ming Tsuang, M.D., USA, Yves Lecrubier, M.D., FRANCE, Shinichi Niwa, JAPAN, Bernhard Bogerts, M.D., GERMANY & Jeffrey Lieberman, M.D., USA.

Section IV—Addictions
Section Editor: Marc Galanter, M.D., USA.
Contributors: Ulf Rydberg, M.D. Ph.D., SWEDEN, Marc Galanter, M.D., USA, Claudio Naranjo, M.D., CANADA, Marcus Grant, SWITZERLAND.
In the last quarter century, psychiatric administrators have experienced enormous changes in service delivery, funding of services, monitoring of activities, and regulation. From preparing a budget, to recruiting staff, to setting standards for quality assurance, this text shares the experiences of 37 administrators nationwide.

Textbook of Administrative Psychiatry provides the clinician-administrator with an overview of such need-to-know issues as:
- cost containment
- managed care
- physicians' payment reports
- legislation affecting the profession
- personnel administration
- financing of services
- and criminal law

Contents:
- Basic Concepts.
- Program Development.
- Management.
- Legal and Ethical Issues.
  Civil law. Criminal law. Ethical issues.
- Evaluation of Psychiatric Services.


To Order Call Toll-Free
1-800-368-5777
9 am – 5 pm EST, Monday – Friday

American Psychiatric Press, Inc.
1400 K Street, N.W.
Washington, DC 20005
In Appreciation

As the year ends we again wish to express our appreciation to the devoted readers, authors, reviewers, editorial board members, sponsoring organizations, and American Psychiatric Press professionals who together make *Academic Psychiatry* possible. Over the last 4 years the journal has been gratifyingly successful in attracting high-quality articles, providing rapid feedback and “teaching reviews” to our authors, gradually, but continually, increasing its circulation, and hopefully adding something enriching to the academic psychiatry environment.

As always, we solicit your best work to share with your academic psychiatry colleagues around the country and, increasingly, in other parts of the world. *Academic Psychiatry* will be as good as you make it. We applaud your efforts and appreciate your ongoing ideas and support.

Jonathan F. Borus, M.D., Editor  
William H. Sledge, M.D., Deputy Editor

Gerald Adler, M.D.  
Anne Alonso, Ph.D.  
George W. Arana, M.D.  
James C. Ballenger, M.D.  
Richard Bellitsky, M.D.  
Jules R. Bemporad, M.D.  
Eugene V. Beresin, M.D.  
David Bienefeld, M.D.  
Susan Block, M.D.  
Joseph D. Bloom, M.D.  
Charles L. Bowden, M.D.  
Malcolm B. Bowers, Jr., M.D.  
Andrew W. Brotman, M.D.  
Simon H. Budman, Ph.D.  
Robert Cancre, M.D.  
Carlyle H. Chan, M.D.  
Sara C. Charles, M.D.  
Steven A. Cohen-Cole, M.D.  
Cynthia D. Conrad, M.D., Ph.D.  
Arnold M. Cooper, M.D.  
Miles K. Crowder, M.D.  
Robert S. Daniels, M.D.  
Tom Dial, Ph.D.  
Martin J. Drell, M.D.  
Steven L. Dubovsky, M.D.  
Mina K. Dulcan, M.D.  
Michael H. Ebert, M.D.  
Larry R. Faulkner, M.D.  
Beverly Fauman, M.D.  
Theodore B. Feldmann, M.D.  
Donald C. Firel, M.D.  
Paul Jay Fink, M.D.  
Lois T. Flaherty, M.D.  
Janice L. Forster, M.D.  
Richard J. Frances, M.D.  
Russell Gardner, Jr., M.D.  
Ira Glick, M.D.  
Marcia K. Goin, M.D.  
Richard J. Goldberg, M.D.  
Laurence B. Gottmacher, M.D.  
David Greenfeld, M.D.  
Ezra E.H. Griffith, M.D.  
Frederick G. Guggenheim, M.D.  
Robert E. Hales, M.D., M.B.A.  
James A. Halikas, M.D.  
Seymour L. Haleck, M.D.  
Irwin N. Hassenfeld, M.D.  
Marvin I. Herz, M.D.  
Jeffery L. Houpt, M.D.  
Michael S. Jelinek, M.D.  
Peter S. Jensen, M.D.  
David I. Joseph, M.D.  
Allan Mark Josephson, M.D.  
Dorthea Juul, M.D.  
Nancy B. Kaltreider, M.D.  
John M. Kane, M.D.  
Jerald Kay, M.D.  
Donald S. Kornfeld, M.D.  
Ronald F. Krasher, M.D.  
John M. Kulda, M.D.  
Donald G. Langsley, M.D.  
Ellen Leibenluft, M.D.  
Alan I. Levenson, M.D.  
Don R. Lipsitt, M.D.  
James Lomax II, M.D.  
Earl L. Loschen, M.D.  
Jeffrey Lustman, M.D.  
Kenneth L. Matthews, M.D.  
Layton McCurdy, M.D.  
Gerald A. Melchiode, M.D.  
Arthur T. Meyerson, M.D.  
Paul D. Mohl, M.D.  
Barry Morenz, M.D.  
Richard L. Munich, M.D.  
Carol C. Nadelson, M.D.  
Theodore Nadelson, M.D.  
Henry A. Naarallah, M.D.  
John C. Nemiah, M.D.  
Malkah T. Notman, M.D.  
Howard J. Ososky, M.D., Ph.D.  
H. Rowland Pearsall, M.D.  
Linda F. Pessar, M.D.  
Linda G. Peterson, M.D.  
Harold A. Pincus, M.D.  
Edward Pinney, M.D.  
Michael K. Popkin, M.D.  
John Racy, M.D.  
Nyapati R. Rao, M.D.  
Anthony Reading, M.D.  
Ronald O. Rieder, M.D.  
Louis F. Rittelmeyer, Jr., M.D.  
Lauri R. Robertson, Ph.D., M.D.  
Carolyn B. Robinowitz, M.D.  
Paul Rodenhauser, M.D.  
Eugene H. Rubin, M.D., Ph.D.  
Stephen L. Ruedrich, M.D.  
William H. Sack, M.D.  
Michael H. Sacks, M.D.  
Richard M. Sarles, M.D.  
Stephan Scheiber, M.D.  
John Schowalter, M.D.  
Harvey J. Schwartz, M.D.  
James H. Scully, M.D.  
Stephen B. Shanfield, M.D.  
Steven S. Sharfstein, M.D.  
Shawn C. Shea, M.D.  
Phillip R. Slavney, M.D.  
Marcia Slomowitz, M.D.  
Gary W. Small, M.D.  
Donald J. Smelzter, M.A.  
Jeanne Spurlock, M.D.  
Stefan Stein, M.D.  
Alan Stoudemire, M.D.  
Gordon D. Strauss, M.D.  
Paul Summergrad, M.D.  
Zebulon Taintor, M.D.  
John A. Talbott, M.D.  
Kenneth Tardiff, M.D.  
Allan Tasman, M.D.  
Bryce Templeton, M.D.  
Ole J. Thiemann, M.D.  
Troy L. Thompson, II, M.D.  
Gary J. Tucker, M.D.  
Arnold Werner, M.D.  
Daniel K. Winstead, M.D.  
Ronald M. Winthob, M.D.  
Michael G. Wise, M.D.  
Thomas N. Wise, M.D.  
Sherwyn M. Woods, M.D., Ph.D.  
Philip Woolcott, M.D.  
Lawson R. Wulson, M.D.  
Joel Yager, M.D.
Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,

Name ____________________________
Signature __________________________
Department __________________________

Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,

Name ____________________________
Signature __________________________
Department __________________________

Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,

Name ____________________________
Signature __________________________
Department __________________________

Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,

Name ____________________________
Signature __________________________
Department __________________________

Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,

Name ____________________________
Signature __________________________
Department __________________________

Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,

Name ____________________________
Signature __________________________
Department __________________________

Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,

Name ____________________________
Signature __________________________
Department __________________________

Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,

Name ____________________________
Signature __________________________
Department __________________________

Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,

Name ____________________________
Signature __________________________
Department __________________________

Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,

Name ____________________________
Signature __________________________
Department __________________________

Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,

Name ____________________________
Signature __________________________
Department __________________________

Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,

Name ____________________________
Signature __________________________
Department __________________________

Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,

Name ____________________________
Signature __________________________
Department __________________________

Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,

Name ____________________________
Signature __________________________
Department __________________________

Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,

Name ____________________________
Signature __________________________
Department __________________________

Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,

Name ____________________________
Signature __________________________
Department __________________________

Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,

Name ____________________________
Signature __________________________
Department __________________________

Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,

Name ____________________________
Signature __________________________
Department __________________________

Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,

Name ____________________________
Signature __________________________
Department __________________________

Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,

Name ____________________________
Signature __________________________
Department __________________________

Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,

Name ____________________________
Signature __________________________
Department __________________________

Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,

Name ____________________________
Signature __________________________
Department __________________________

Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,

Name ____________________________
Signature __________________________
Department __________________________

Dear Librarian:

I would like to recommend acquisition of Academic Psychiatry, the journal of the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry, published quarterly by American Psychiatric Press, Inc.

Thank you,
Features

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

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

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

4 Letters to the Editor provides a forum for the presentation of pilot studies in psychiatric education and for lively debate of published articles.

5 Medical Education Abstracts condense articles most relevant to academic psychiatry from prominent journals in medical and psychiatric education.
IN APPRECIATION

177 In Appreciation

REGULAR ARTICLES

178 Pregnancy During Psychiatry Residency: A Study of Attitudes
   Devra Braun, M.D., Virginia L. Susman, M.D.

186 Continuing Education in Psychotherapy as a Method to Attract and Involve
   Voluntary Faculty in an Academic Department of Psychiatry
   Hillel I. Swiller, M.D., Kenneth L. Davis, M.D.

192 Psychiatry Residency Accreditation and Measuring Educational Outcomes
   Paul C. Mohl, M.D., Deborah Miller, Ph.D., John Z. Sadler, M.D.

199 Are We Teaching Psychiatrists to Be Ethical?
   John H. Coverdale, M.B., Ch.B., Timothy Bayer, M.D., Patricia Isbell, M.D.,
   Steven Moffic, M.D.

206 Use of a Matrix in Designing Training Experiences: Experience in a Rural
   Child and Adolescent Training Program
   Robert J. Racusin, M.D., Henry Cretella, M.D.

BOOK FORUM

212 Trauma and Recovery: The Aftermath of Violence From Domestic to Political
   Terror, by Judith Lewis Herman, M.D.
   Reviewed by Suzanne Witterholt, M.D.

213 Incest-Related Syndromes of Adult Psychopathology, edited by Richard Kluft, M.D.
   Reviewed by Norma Safransky, M.D.

214 Concise Guide to Consultation Psychiatry, by Michael G. Wise, M.D.,
   and James R. Rundell, M.D.
   Reviewed by Susan Williamson, M.D.

215 Psychiatry for Medical Students, 2nd Edition, by Robert J. Waldinger, M.D.
   Reviewed by Robert A. Bashford, M.D.
EDUCATIONAL ABSTRACTS

Abstracted by Dorthea Juul, Ph.D.

217 Do house officers learn from their mistakes?
217 A review of studies concerning effects of sleep deprivation and fatigue on residents' performance
218 A new rating form for use by nurses in assessing residents' humanistic behavior
219 Changes in self-evaluations during third-year clinical rotations

LETTER

220 The Well-Read Psychiatrist
    Claudia L. Greene, M.D., Deborah A. Miller, Ph.D.

DEPARTMENTS

225 Index to Volume 16
234 Information for Contributors
Regular Articles

Pregnancy During Psychiatry Residency

A Study of Attitudes

Devra L. Braun, M.D.
Virginia L. Susman, M.D.

Fifty-eight residents at two training sites at Cornell University Medical College responded to our questionnaire on attitudes toward pregnant peers. Male respondents were more likely than female respondents to believe that pregnancy interfered with work performance and to anticipate personal inconvenience from a peer’s pregnancy. When residents of each gender were asked to estimate the opposite gender’s responses to the same questions, men more accurately hypothesized what their female peers would say. Women overestimated the degree of negative male responses and underestimated male willingness to provide special considerations such as schedule changes for their pregnant colleagues.

The increasing numbers of women in psychiatry residencies and the coincidence of residency training with the prime years for childbearing have combined to make pregnancy during training a frequent and important educational and administrative issue (1). Several recent surveys (2,3) of women physicians report that approximately 50% have had one or more children during training. Factors such as maternity leave, part-time work, and parental responsibilities have the potential to interrupt the continuity of patient care, the resident’s participation in ongoing didactic and experiential learning, and the complex unfolding of supervisory and therapeutic relationships. Additionally, the concrete issues of equitably redistributing an absent resident’s work load and determining the amount of training time that can be missed without requiring that it be made up generate controversy and debate.

A number of authors have focused on the impact of a psychiatrist’s pregnancy and maternity leave on herself and her patients (4,5). Others have anecdotally reported the reaction of colleagues and of staff toward pregnant residents (6,7) and other therapists (8). Less attention has been directed toward administrative and educational policy determinations (9). Although it would be impossible to study unconscious conflicts about pregnancy or to quantify the stresses that are generated within a group of colleagues by the pregnancy of a peer, we decided to undertake a more rigorous study of residents’ professed attitudes toward pregnancy during residency.

One focus of the study was the pairing of questions about attitudes toward pregnant residents with questions about the
respondents' expectations of what response peers of the opposite gender would have to the same questions. Divergence between one gender's attitudes and those expected by the other gender would be important to document; such inaccurate expectations could contribute to conflict within the resident group and disagreement about how pregnancy should be officially handled.

METHODS

We devised a 67-item questionnaire that included personal data about age, gender, year of training, pregnancy history, and marital and parental status. General questions followed concerning the emotional state of pregnant women and the likely conflicts facing male and female residents who have children during training. Items addressing work performance, the need for special considerations and scheduling, and the impact of pregnant residents and chief residents on their peers were then presented. The residents were then asked to predict the response that peers of the opposite gender would have to these same questions. The questionnaire concluded with specific items about the respondents' experiences with pregnant residents.

The questionnaire was given to all Cornell University Medical College residents at both the Westchester Division and Payne Whitney Clinic in the spring of 1988 (see Table 1) after obtaining written consent. At the time of this study, neither the Westchester Division nor the Payne Whitney Clinic had clearly articulated parental leave policies. Each pregnancy was dealt with individually, and most residents worked out arrangements with their training directors to combine disability and vacation time such that average leaves were 6–8 weeks long. There was no specific policy or formula dealing with on-call responsibilities. Of note is the fact that both programs involved residents in different classes sharing on-call responsibilities; there also were some call duties shared between the two campuses. Therefore, the pregnancy of a resident at one site could affect residents in other classes and at the other site. Allowing for all such combinations, we ascertained that only 9 of the 58 respondents were not directly affected by a pregnant colleague.

Incidence data (numbers of respondents) were compared by chi-square measures of independence. To analyze these data, the five-point scale used in the questionnaire was collapsed into a three-point scale by eliminating the qualifiers (i.e., strongly agree and agree were grouped together). This maximized the numbers per cell and all degrees of freedom were therefore equal to two. The estimated and actual scale values were compared as differences between means by gender using two-tailed $t$-tests ($df = 56$).

<table>
<thead>
<tr>
<th>TABLE 1. Demographic data of respondents to a survey of residents' attitudes toward pregnancy during the psychiatry residency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Females</td>
</tr>
<tr>
<td>Males</td>
</tr>
<tr>
<td>Respondents</td>
</tr>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Females</td>
</tr>
<tr>
<td>Males</td>
</tr>
<tr>
<td>Response rate</td>
</tr>
<tr>
<td>Marital status</td>
</tr>
<tr>
<td>Married</td>
</tr>
<tr>
<td>Single</td>
</tr>
<tr>
<td>Post graduate year</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>Total pregnancies for resident or spouse</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>Number of children</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>≥2</td>
</tr>
</tbody>
</table>
RESULTS

The questionnaire was sent to all 79 residents; 58 residents returned questionnaires after up to two reminders (see Table 1). Response rate (97%) was higher at the Westchester campus, where the authors work, than at the sister campus (56%). The data were initially analyzed by campus, but responses were not found to differ significantly between campuses. The two campuses were grouped together for further analysis to have a larger, more heterogeneous sample.

The data were separated according to the variables provided by respondents on the first page of the questionnaire. These included age, gender, marital status, number of pregnancies for respondent or spouse, number of children, and postgraduate year. Data analysis revealed that age, marital status, number of pregnancies for respondent or spouse, and postgraduate year had no discernible significant effect on attitude patterns. In addition, gender did not seem to differentiate responses to questions about pregnant women in general. However, gender did correlate significantly with several attitudes about pregnant residents and the accommodations that should be made for them. For this reason, we have chosen to focus the present discussion on the relation-

<table>
<thead>
<tr>
<th>TABLE 2. Residents' attitudes towards pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please rate the following:</td>
</tr>
<tr>
<td>A pregnant female tends to be:</td>
</tr>
<tr>
<td>1. Empathic</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>2. Self-centered</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>3. Introspective</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>4. Emotionally withdrawn</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>5. Irritable</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Agree</td>
</tr>
<tr>
<td>Uncertain</td>
</tr>
<tr>
<td>Disagree</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Note: Values are percentages. Responses in Table 2 did not differ significantly by gender.

<table>
<thead>
<tr>
<th>TABLE 3. Mean male attitudes vs. female estimates of male attitudes of eight variables of resident pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable</td>
</tr>
<tr>
<td>1. Work performance</td>
</tr>
<tr>
<td>2. Interpersonal relationships with other residents</td>
</tr>
<tr>
<td>3. Leadership abilities</td>
</tr>
<tr>
<td>4. Effectiveness in representing residents' needs to faculty</td>
</tr>
<tr>
<td>5. Interest and involvement in administrative duties</td>
</tr>
<tr>
<td>6. Ability to handle stress</td>
</tr>
<tr>
<td>7. Interest and involvement in patient care</td>
</tr>
<tr>
<td>8. Efficiency</td>
</tr>
</tbody>
</table>

Note: Means are based on the following five-point response scale on the questionnaire: 1 = Greatly Enhances; 2 = Slightly Enhances; 3 = No Effect; 4 = Slightly Interferes; 5 = Greatly Interferes.

*P < 0.05 on two-tailed t-test.
ship between gender and attitudes toward pregnant residents. We cannot, however, exclude the possibility that other variables correlated with response patterns that did not achieve statistical significance due to our relatively small sample size.

A series of general questions about pregnant women (see Table 2) and about the effect of pregnancy on different aspects of a resident’s role (items 2–8 in Table 3) yielded responses that did not significantly differ based on the gender of the respondent. They are of interest, however, for the number of areas in which substantial numbers of residents of both genders viewed pregnancy as an interference. Notably, 40% of females and 38% of males felt that pregnancy interferes with interpersonal relationships with other residents; 50% of female and 59% of male residents felt that pregnancy interferes with the ability to handle stress; 23% of female and 33% of male residents believed that pregnancy interferes with efficiency; and 17% of female and 26% of male residents viewed pregnancy as interfering with interest and involvement in patient care.

There are important exceptions to the general similarity of male and female attitudes toward pregnant peers. Seventy-eight percent of male but only 48% of female respondents thought that pregnancy interfered with a resident’s overall work performance, and only 15% of male but 48% of female residents thought that work performance was unaffected by pregnancy (see Figure 1). This pattern of attitudes differs based on the gender of the respondent (P < 0.05). Consistent with this is the finding that significantly more men than women stated that they would be hesitant to refer a patient to a pregnant resident. Eighty-two percent of female but only 50% of male residents said they would not hesitate to refer a patient to a pregnant resident (P < 0.05).

In a series of projective questions, residents were asked to estimate what the majority of residents of the opposite gender would say when asked the same eight questions about work-related attributes that they themselves had answered. Men were more accurate in estimating the responses of their female peers. None of the mean female attitudes on the eight questions listed in Table 3 differs significantly from male estimates of these attitudes. Table 3 illustrates the more striking discrepancy between mean female estimates of male attitudes and actual mean male attitudes. In this table, a numerical mean is given to attitudes, using the five-point scale of the questionnaire. Respondents were asked to use the scale to rate the effect of pregnancy on eight aspects of work performance. The higher the score, the more the respondent viewed pregnancy as interfering with performance. As noted before, actual male and female attitudes did not significantly differ. In all eight areas, however, mean female estimates of male attitudes are numerically higher than actual mean male attitudes. This trend is significant in five of the eight questions (P < 0.05, two-tailed t-test; e.g., the female residents overestimated how often the male residents would state that pregnancy interferes with work-related functions).

When given a series of questions about male vs. female behavior when faced with combining child care responsibilities with
work as psychiatry residents, the majority of both female and male residents felt that it is not difficult to be a good mother or father during residency. A majority of respondents of both genders felt that it was more difficult for a female resident than for a male resident to combine good parenting with residency ($P < 0.01$).

None of the respondents thought it unlikely that female residents with small children would take time off from work for child-related responsibilities, but 25% of male and 28% of female residents thought it unlikely that male residents would take time off for these responsibilities. Residents of both genders predicted that women would be significantly more likely to take time from work for child-related responsibilities ($P < 0.01$).

Residents were also asked about actual inconveniences that had resulted as a consequence of the pregnancy of another resident. Only one-third as many women as men felt that they had been “personally inconvenienced" by the pregnancy of another resident, whereas 87% of the women and 61% of the men denied personal inconvenience ($P < 0.05$; see Table 4). Despite the inconvenience, the majority of residents of both genders felt that pregnant psychiatry residents have a humanizing effect on the residency program, but more women (83%) endorsed this view than men (61%, $P < 0.05$, see Table 4).

In the final section of the questionnaire, residents were asked whether they agreed, disagreed, or were uncertain if particular accommodations should be made for pregnant residents. Seventy-five percent of the male and 80% of the female sample agreed that pregnant psychiatry residents should receive “special consideration.” Ninety-seven percent of women and 75% of men agreed that pregnant residents should receive flexible scheduling as needed, but the subset of residents who disagreed were all male (18% of the male sample). Although men were significantly more likely than women to disagree with providing flexible scheduling ($P < 0.05$), they also were more likely than women to predict the likelihood of significant amounts of sick time before delivery ($P < 0.05$; see Table 4).

Male and female residents had significantly different response patterns to the questions about special consideration, flexible scheduling, and likelihood of prenatal sick time. However, the men were able to accurately estimate what the women's attitudes would be. In contrast, women significantly underestimated the permissiveness of male attitudes toward providing special consideration or flexible scheduling for pregnant residents ($P < 0.01$; see Figure 2).

| TABLE 4. Residents' perceptions of inconvenience resulting from pregnancy and attitudes toward accommodations for pregnant residents |
|---------------------------------------------------------------|-------------|-------------|-------------|
| I have been personally inconvenienced by the actual pregnancy of another resident in this program |
| Female | Agree | Uncertain | Disagree |
| Male | 13 | 0 | 87 |
| 39 | 0 | 61 |
| Pregnant residents in psychiatry |
| have a humanizing effect on the residency program |
| Female | Agree | Uncertain | Disagree |
| Male | 83 | 17 | 0 |
| 61 | 21 | 18 |
| should receive flexible scheduling as needed |
| Female | Agree | Uncertain | Disagree |
| Male | 97 | 3 | 0 |
| 75 | 7 | 18 |
| are unlikely to take significant amounts of sick time before delivery |
| Female | Agree | Uncertain | Disagree |
| Male | 53 | 33 | 13 |
| 21 | 50 | 29 |

Note: Values are percentages. Responses to all questions in Table 4 show significant gender differences. $P < 0.05$. 


Seventy-five percent of the men agreed that pregnant residents should get special consideration and flexible scheduling, but less than 30% of the women anticipated either of these male attitudes.

**DISCUSSION**

Residents of both genders in our study more often viewed pregnancy as interfering with than as enhancing work-related attributes. Male and female views of pregnancy are closely matched in most areas; however, there were some exceptions. Male residents were significantly more likely than female residents to agree that pregnancy interferes with a resident's overall work performance. Male residents were more likely than their female colleagues to anticipate that pregnant residents will take significant amounts of sick time before delivery. Male residents perceived greater personal inconvenience than did female residents as the result of the pregnancy of other residents in their program.

Overall, the male residents were fairly accurate predictors of attitudes of female colleagues. Female residents substantially overestimated the negativity of many male views about the impact of pregnancy on work-related attributes. In addition, female residents substantially underestimated the degree to which male residents would be willing to give special consideration to pregnant peers or to accommodate needs for special scheduling.

Further study is needed to determine whether the attitudes reported here are typical of psychiatry residents in general or are solely held by psychiatry residents in the particular programs or geographic region studied. It is difficult, as well, to evaluate the attitudes vs. the realities of pregnancy's effect on work performance because there is little relevant data available regarding pregnancy's effect on concentration, stamina, mood, and other factors that might interfere with performance. Although psychiatry residents would be less likely than peers in other specialties to have excessive physical stresses such as long periods of standing, on-call responsibilities could result in sleep deprivation, which in turn would serve to compound the fatigue of early and late pregnancy (10). Regardless, there is no reliable way to quantify the physiologic burden of pregnancy and its direct effect on work.

If pregnancy does substantially impair residents' work performance, female residents might be motivated to deny this impairment both to avoid the hostility of others and to prevent future job discrimination against married or pregnant women. Male residents, in contrast, might be tempted to exaggerate their female colleagues' impairment so that they could be adequately compensated for any accommodations that they needed to make because of a colleague's pregnancy. Such phenomena of female denial or male resentment might explain why male residents completing our questionnaire were far more likely than female residents to report that they had been inconvenienced by the pregnancy of a colleague. It is difficult to explain why only 39% of male residents and 13% of female resi-
idents reported that they had been personally inconvenienced by the pregnancy of another resident in their program. In contrast, a study (11) of residents and faculty of mixed specialties at the Medical College of Ohio found that 80% of 140 respondents felt that a pregnant colleague had caused them personal inconvenience. However, their sample was 70% male and responses were not separated by gender.

In the institutions in which our study was done, the maternity leave of any resident usually resulted in other residents being assigned the missing resident's call for an 8-week period. On some occasions, rotation schedules were switched to accommodate residents' needs such as the desire of a pregnant resident not to be assigned to a pediatrics unit during her first trimester. It is possible that some residents were not aware that these scheduling changes were being made. For those who were aware, however, it would seem that the accommodations described above might be considered personal inconveniences; yet, they were not considered so by a majority of male residents and a significantly larger majority of female residents. Data from another survey (12), done at the University of California with residents of mixed specialties, showed some comparable inconsistencies in attitudes: Residents of both genders endorsed the statement, "Residency is too pressured to be a good time for a resident to become pregnant." Yet, female residents, unlike their male counterparts, did not agree that "female residents should postpone their families until after residency."

Another area of male-female disagreement, in which some factual data are actually available, concerns the likelihood of pregnant residents to take sick time before delivery. Data from two retrospective studies (12, 13) of nearly 300 residents of various specialties who were pregnant during their residencies revealed that residents missed on average 1–3 weeks of work prenatally, even though half worked more than 60 hours weekly. A 1990 survey (14) comparing almost 1,000 residents with controls found that overall pregnancy outcome was not affected by the residents' strenuous working conditions. Psychiatrists probably work fewer hours and may take off less time prenatally than residents of other specialties. Staff and resident psychiatrists in a retrospective study (15) done in Canada reported that only 1% of the approximately 50 respondents who had children had taken off more than 4 sick days prior to delivery. In our study, male residents were more likely than female residents to anticipate that pregnant residents would take "significant amounts of sick time before delivery."

This male-female disagreement in the amount of sick time and inconvenience attributed to peers' pregnancies may have its origin in differing definitions. Male and female residents may disagree about the meaning of the idea of "inconvenience" or "significant" amount of sick time. Even a 1-week maternity leave might be considered significant and inconvenient if a male resident had to cover for a peer without compensation. On the other hand, a female resident, herself anticipating pregnancy, might consider covering for a peer during a week's absence to be insignificant in the overall balance of things. Male and female residents might also have different notions about the average expectable amount of sick time associated with pregnancy. Possible psychodynamic and cultural explanations for the disparate views of the two genders may include a male notion of women as the weaker sex or a female tendency to deny the threat of unanticipated pregnancy complications.

It is a matter of speculation why female residents were overly negative in their estimates about male attitudes toward pregnancy during residency. Possible explanations include that men underreport their negative attitudes or that women project overly negative attitudes onto men.

Regardless of the explanation, it is striking that many stated views toward pregnant
residents in this study divide along lines of gender as opposed to age, marital status, number of children, or years in training. The results suggest the existence of differing attitudes that could influence perceptions, group dynamics, and policy determinations. Additional studies should attempt to quantify pregnancy's actual impact on work performance. It would also be interesting to survey psychiatry educators regarding their subjective views, objective experiences, and thoughts about institutional policies regarding pregnancy and residency. Such further studies could help better assess both resident and faculty ideas about the performance of pregnant residents as well as male and female attitudes toward pregnant colleagues.

*Portions of this article were presented at the 1989, 1990, and 1991 annual meetings of the American Psychiatric Association.*

References

Continuing Education in Psychotherapy as a Method to Attract and Involve Voluntary Faculty in an Academic Department of Psychiatry

Hillel I. Swiller, M.D.
Kenneth L. Davis, M.D.

The extraordinary contemporary advances in the neurosciences may have as an unintended and undesirable side effect the relative neglect of psychotherapy within research-driven academic departments of psychiatry. There are many reasons for this. Funding sources greatly favor the development of a full-time academic faculty that devotes the majority of its time to research in neurobiological psychiatry. Although some departments have "lines" for full-time faculty members whose responsibilities are primarily clinical rather than investigatory, these are usually filled by people who are far more involved in the administrative aspects of psychiatry than in providing psychotherapeutic services to patients. As a consequence, few full-time faculty members spend a substantial portion of their time practicing psychotherapy. This situation can be detrimental to an academic department that is seeking a balanced educational program.

Because few full-time members of any academic faculty these days devote a major portion of their time to practicing psychotherapy, developing a critical mass of full-time academic psychotherapists can be difficult. Those few full-time faculty members who are considered outstanding psychotherapists may find themselves supervising a disproportionate number of students at significant cost to their own work and at a cost to the trainees who may be limited in their exposure to alternative styles and points of view.

The traditional as well as efficient and economical resolution to this dilemma requires involvement of the department's voluntary faculty as an additional source of teachers of psychotherapy. These clinicians, who devote the majority of their professional time to the practice of psychotherapy, can be excellent teachers to the next generation of practitioners if they also possess the necessary teaching skills.
tions explore in detail who these clinicians are and how they develop (1), how they function and develop as psychotherapy supervisors (2), and aspects of what it is that they teach (3).

Two questions immediately arise. First, how does a department attract and motivate private practitioners to donate significant amounts of their time to the department's educational enterprise? Second, how does such a department identify those members of the voluntary faculty who are the most knowledgeable and the most skillful teachers of psychotherapy? Finding answers to these questions can be particularly difficult if these voluntary faculty psychotherapists feel alienated from their academic department.

RATIONALE FOR A DIVISION OF PSYCHOTHERAPY

The Department of Psychiatry of the Mount Sinai School of Medicine is based in one of several major medical centers in the New York City metropolitan area. The department has a substantial research program, and its large full-time faculty has a neuroscience focus. The department has a tradition of having a large voluntary faculty; the use of this faculty, however, was haphazard. Prior to the establishment of the Division of Psychotherapy, over 300 psychiatrists had voluntary faculty appointments, but no more than 20% of these faculty members had significant teaching roles and more than half attended fewer than one departmental conference per month. Many members of the voluntary faculty felt disaffected and even some of those giving many hours of supervisory time felt unappreciated and unrewarded.

Approximately 4 years ago, the Department of Psychiatry of the Mount Sinai School of Medicine established a Division of Psychotherapy. A full-time faculty position was allocated for a director (H.I.S.) to develop the Division of Psychotherapy. This division has developed a program for enhanced involvement of the voluntary faculty in the Department of Psychiatry in a manner that enables us to attract, motivate, identify, train, and reward excellent teachers of psychotherapy. The primary goal of the program is to make available to our psychiatric residents the best possible education in psychotherapy. An important set of objectives has been the development in our voluntary faculty of a pool of skilled practitioners of the various modalities of psychotherapy (e.g., individual, group, family, etc.) and the major theoretical orientations (e.g., psychodynamic, cognitive/behavioral, systems, etc.). Being a good psychotherapist is a necessary, but not a sufficient, requirement for being a good teacher and supervisor of psychotherapy; one must also have the requisite skills as an educator. Consequently, a second set of objectives has been to identify potentially valuable supervisors and teachers and to train them to be good educators.

In developing this pool of supervisors and teachers, an assumption was made that members of the voluntary faculty who were most interested in their own continuing professional development were likely to be those who were, or who could be trained to be, good supervisors and teachers of psychotherapy. Such dedication to their own improvement as clinicians can itself be an important lesson to students. Consequently, the development of continuing education programs that were designed to meet the needs of full-time clinicians with a primary interest in psychotherapy was central to the success of this endeavor and the essence of the initial operations of the Division of Psychotherapy. Furthermore, from the outset, we attempted to integrate the teaching of supervisory skills into these continuing education programs. The opportunity to informally evaluate the quality of the participation of specific faculty members in our various conferences, combined with resident evaluations, has helped us identify potentially excellent teachers.
CONTINUING EDUCATION PROGRAM IN PSYCHOTHERAPY FOR VOLUNTARY FACULTY

We began with the central concept that the first responsibility of the Division of Psychotherapy was the continuing education of the voluntary faculty. We hypothesized that by establishing programs that the clinical faculty found useful for themselves, it would be possible to attract, motivate, identify, and train potential teachers of psychotherapy. Membership in the division was open to all on the voluntary faculty who participated in one or more of its weekly programs on a regular (75%) basis. The success of this first step of the enterprise could be evaluated, in part, by measuring the participation of the voluntary faculty in the programs developed by the division and by consideration of their evaluations of these programs. Ultimately, the quality of resident education in psychotherapy would be the most important criterion for success.

An extensive variety of teaching conferences for voluntary faculty was developed. A description of major components of the program follows. In a recent week, more than 70 different faculty members attended at least one major divisional conference; during that week the total faculty attendance was 109.

Psychotherapy Conference

A psychotherapy conference for faculty, now in its fourth year, is held on a weekly basis. This can be thought of as a psychotherapy grand rounds. Speakers present for 30-50 minutes of the 90-minute meeting; the balance of the time is used for active discussion moderated by the division director to ensure participation by as many in attendance as possible. At approximately half of the meetings, different speakers present an article on an issue of relevance to psychoanalytic and clinical psychiatric concepts of borderline, the normative crisis of puberty, evaluation and treatment of sexual disorders, treatment of eating disorders, posttraumatic stress disorders, projective identification, and the nature of psychotherapeutic change. Many of these presentations were statements of theoretical points of view or reviews of current knowledge and practice, based on clinical material from the speaker’s own practice. Approximately one-quarter of the conferences are devoted to case presentations. The balance of the conferences are devoted to the supervision of psychotherapy; most of these are presentations of ongoing supervisory work. At some of these supervisory conferences, the resident supervisees participate in the presentation and the discussion.

Approximately 20% of the speakers are nondepartmental guests who are expert in the field of psychotherapy, and 10% are members of our full-time research faculty. These sessions are intended to encourage good relations between voluntary and full-time faculty and increase the voluntary faculty’s identification with the department’s research endeavors. Most frequently—and most importantly—the speakers are members of the Division of Psychotherapy, clinicians on the voluntary faculty who are in the full-time practice of clinical psychiatry. For many of these clinicians, who do not make frequent presentations at scientific meetings, this conference is the most important opportunity they have to advance their own professional growth by developing the skills and confidence necessary for scientific presentation.

On average, over 40 members of the voluntary faculty attend this meeting each week and many have stated in informal evaluations that it is their most important continuing medical education (CME) activity. There are more CME credits earned by members of the voluntary faculty at this conference than at any other conference offered by the department.
Group and Family Therapy Conference

Once a week there is a parallel, 90-minute conference for faculty that focuses on group and family therapy. Topics presented within the past year included group therapy with incest survivors, couples' group therapy, group work with disruptive elementary school children, the parental alienation syndrome, and the dream in group psychotherapy. The ratios of guest speakers, presenters from our full-time research faculty, and speakers from within the Division of Psychotherapy and of conferences devoted to theoretical issues, clinical presentations, and supervision of group and family therapy are parallel to those in the conference previously described. Even in the New York City metropolitan area there are few, if any, weekly scientific meetings in group or family therapy for experienced psychiatrists. In the past several years, approximately 20 clinicians have been recruited to the faculty as a result of this conference, and it is now attended by an average of 30 group and family therapists.

Continuous Case Conferences in Psychodynamic Psychotherapy

Since its inception, the Division of Psychotherapy has conducted several weekly, 90-minute, continuous case conferences for faculty in psychodynamic psychotherapy, which are presided over by psychoanalysts on our faculty. At these smaller and more intimate meetings, attended by an average of 15 clinicians, faculty members present the process of ongoing psychotherapeutic work for discussion with their colleagues. This not only provides a forum for experienced clinicians to refine their skills, but it is also an opportunity for talented psychotherapists to be identified by the quality of their presentations and their discussion of others' psychotherapeutic work. In these case conferences, psychotherapists are informally evaluated by the division director, the case conference leaders, and other senior supervisors.

Marital and Family Therapy Case Conference

The marital and family therapy case conference is another divisional conference, which focuses on the presentation of ongoing clinical work in marital and family therapy and meets on a biweekly basis. It is attended by approximately 15 voluntary faculty.

Other Faculty Conferences

Two other monthly divisional conferences address issues of forensic psychiatry and the interface of psychopharmacotherapy and psychotherapy. The latter conference for about 20 voluntary faculty provides a forum in which to discuss the clinical ramifications of recent research developments with psychopharmacologists and neuroscientists from our full-time faculty.

Although part of our goal was to identify potentially outstanding teachers, some clinical discussions are clearly best conducted in a setting in which the participants are not concerned about the quality of their work being evaluated by administrative superiors. Therefore, we have also organized several study groups in which discussions are not conducted by a designated leader. These peer supervisory groups, generally attended by 6–12 members of our voluntary faculty, meet once a month and focus directly on the psychotherapeutic or supervisory work of the faculty. Subjects of these study groups have included peer supervision of group psychotherapy, the dream in psychotherapy, and consequences of the Holocaust. A particularly valuable study group, similar to one described by Berger et al. (4) but in our case restricted to voluntary faculty, is devoted to peer supervision of supervision itself. This study group provides a forum for candid discussion of
supervisory topics and problems.

The division has also developed collaborative programs with the Academy for the Humanities and Sciences of the City University of New York. The academy and the division jointly sponsor a monthly conference on psychology and history, under the leadership of a widely published psychiatrist/historian, which is open to the general professional public. A theme is selected for each year's series to promote an in-depth examination of related issues. A recent theme was "Violence: Victims, Survivors, and Perpetrators," and topics discussed included child survivors and the children of survivors, religious fundamentalism, and war in the Middle East. This year the division and the academy have also jointly sponsored a monthly conference on psychoanalysis and have begun an annual colloquium on psychoanalysis and music.

The division has also created an annual week-long visiting professorship in psychotherapy. Dr. Merton Gill, our visiting professor in 1991, conducted conferences for both our residents and the faculty members of the Division of Psychotherapy. In addition, he provided individual supervision for 10 of our senior residents.

Fellowship in Psychodynamic Psychotherapy

In the 1990–1991 academic year, the division implemented a 1-year, full-time, postresidency fellowship in psychodynamic psychotherapy. This program is designed to offer training in long-term, psychoanalytically oriented psychotherapy and psychodynamic group psychotherapy with adult patients. Marital and family therapy are available as options. The major components of the fellowship include supervision of individual, group, and marital and family therapy; participation in the faculty continuous case conferences in psychoanalytically oriented psychotherapy; a theory seminar; supervision of the psychotherapeutic work of a junior trainee under the supervision of the division director; support for the preparation of a publishable clinical or research article; coordination of a biweekly academic conference at an affiliated institution; and participation in as many divisional conferences and study groups as the fellow chooses.

RESPONSE AND EVALUATION

Approximately 100 members of our faculty participate in one or more of these divisional conferences regularly (at least three conferences per month). Many members of the division have expressed that as a result they feel much more integrated into the department. The work of the division has attracted colleagues from other departments in the metropolitan area, and more than 20 senior psychotherapists, including several leading psychoanalysts, have been recruited to our faculty.

Informal evaluations by residents, in discussions with both the residency training director and the departmental chairman, indicate their perception that the quality of their psychotherapy education has substantially increased. At Mount Sinai, resident attendance at the residency's didactic courses is optional. However, attendance at the psychotherapy courses has more than doubled since the establishment of the Division of Psychotherapy. For example, our current PGY-3 class of 18 usually has 15 or more residents at psychotherapy courses. Five years ago the attendance at PGY-3 psychotherapy courses averaged 4–5 residents. The initial two fellows in the psychotherapy fellowship have been positive in their evaluations of the program, and it is now highly sought after by the department's graduating residents.

PLANS FOR THE FUTURE

The Division of Psychotherapy is now in the process of developing a section on psycho-
analysis. In addition to offering conferences in psychoanalysis, the division plans to establish an affiliation with a psychoanalytic institute. This would afford senior residents the opportunity to begin psychoanalytic training while in residency and offer all residents greater exposure to the intellectual benefits of a psychoanalytic institute. It would also diminish the isolation from academic psychiatry experienced by many psychoanalysts. The fellowship in psychotherapy may be expanded to more than one fellow per year. Long-range plans include the establishment of a training program for graduate psychiatrists (and possibly psychologists, social workers, and nurses) in group psychotherapy. We plan to study and more rigorously evaluate the progress of all of our endeavors.

A major problem the division has encountered, which will be familiar to everyone in academic psychiatry, has been generating the necessary funds to keep the program running. The Department of Psychiatry supplies a modest salary for the division director (most of whose income comes from private practice) and a fellowship line. The division's other academic programs are almost exclusively supported by the fundraising efforts of the director. Fortunately, the availability of several endowments has made over $100,000 available for the work of the division. Constant attention will undoubtedly have to be paid to this ongoing need.

The integration of members of the Division of Psychotherapy into our neuroscience-focused department has been enhanced as a result of the programs described above, but more remains to be done. We are working to develop additional conferences of mutual interest to the full-time and voluntary faculty and to improve existing ones.

Although the large-scale program developed at Mount Sinai may be applicable only to medical centers in some large metropolitan areas, we believe our basic concepts apply to any department of psychiatry. If psychotherapy education of residents is neglected and undervalued, the educational resources inherent in voluntary faculty can help rectify this problem. Optimal use of these resources requires that voluntary faculty be attracted and feel committed to the department. Our experience suggests that the development of a Division of Psychotherapy that promotes continuing education in psychotherapy and its supervision can be an important step in the recruitment and nurture of voluntary clinical faculty.

References
Psychiatry Residency Accreditation and Measuring Educational Outcomes

Paul C. Mohl, M.D.
Deborah Miller, Ph.D.
John Z. Sadler, M.D.

During the last decade there has been a shift within accreditation circles toward evaluating educational outcomes as measures of institutional effectiveness in addition to educational inputs and process, which historically have been emphasized. The U.S. Department of Education has incorporated outcome assessment into the regulations required of any accrediting body if funds or recognizes. Although these regulations do not directly apply to accreditation of psychiatry residencies, their impact may be felt indirectly. The authors review some of the educational literature on outcome evaluation and suggest ways psychiatry residencies might be prepared to measure outcomes within their current procedures should the Residency Review Committee move in this direction.

Ever since Flexner (1) revolutionized medical education, the focus of accreditation at all levels has been on educational inputs and process. Institutions and programs have been judged predominantly by their resources, organization, and curriculum. Colwell (2), a contemporary of Flexner, advocated that accreditation be based on outcome, arguing that “the chief aim in fixing any minimum standard should be... the finished product.” In 1988, the U.S. Department of Education (DOE) institutionalized a developing trend toward evaluating outcomes (3) by releasing a series of regulations (4) requiring that accrediting agencies, to be recognized by DOE, place greater emphasis on the assessment of educational effectiveness. This trend is a response to the growing recognition that the educational procedures of institutions and the competence of graduates may not be as highly correlated as previously thought. In the end, it is the competence of graduates that concerns society most.

Accrediting agencies are now required to demonstrate that institutions are documenting the educational achievements of their students in “verifiable and consistent ways.” The regulations suggest evaluation methods such as graduate or professional school test results, graduate school placements, licensing examination results, and employer evaluations to meet this requirement. Postsecondary institutions that are accredited by any DOE-recognized agency are required to meet these regulations. Thus, we can expect greater emphasis on outcome measures in medical school accreditation by the Liaison Committee on Medical Educa-
tion (LCME) in coming years. In fact, the LCME has recently amended its criteria to add a rigorous new requirement using language directly from the DOE regulation (Kassebaum DC, personal communication, 1992). Although the Accreditation Council on Graduate Medical Education (ACGME) is not formally subject to DOE regulations, it will be affected indirectly by evolving concepts in accreditation. As it stands now, there is only one mention of outcome in the current special requirements for psychiatry (5). Item IB3c suggests that programs collect data on their graduates’ performance on certification examinations. Residency Review Committee (RRC) accreditation field site visitors have been known to ask for this information. In addition, the most recent RRC forms specifically request information about publications by recent graduates, another potential outcome measure.

Studies of educational outcomes have often developed a taxonomy, learning model, or set of objectives. Lenning (6), in his review of educational outcomes, describes over 100 studies conducted before 1977. He identified major types of outcomes, including the development of effective methods of thinking, social attitudes, appreciation of aesthetic experiences, social sensitivity, acquisition of important information, and a consistent philosophy of life. Outcome measures included not only educational or cognitive methods of determining educational outcomes, but also lifelong skills, social values, problem-solving ability, and community involvement.

Recently, educators have developed a new measurement concept termed “value-added” as an important element in outcome assessment. Halpern (7) defines this element as the educational gains demonstrated by the additional value students achieve following their educational experience. A certification examination is an “exit-only” measure. Exit-only indicators, used in isolation, have certain limitations. Halpern explains that “highly selective institutions will produce the highest scoring seniors on exit-only tests, regardless of the quality of their programs. The difference between their knowledge and skill levels when they start a program compared with when they complete a degree is a gain (value-added) index that best reflects the effect of an educational program” (p. 182).

Undergraduate medical educators have also shown an interest in outcome measures. Although their focus was not on postgraduate training, they may offer relevant models for thinking about evaluating residency outcomes. Sanazaro (8) divided educational outcomes into three categories. The first was “in-school criteria,” consisting of attrition rates and academic accomplishment as illustrated by standardized test results and assessments of critical thinking skills. The second, “intermediate criteria,” included career choice, interest in research/teaching, internship appointments, and performance on licensure examinations. The third, “long-term criteria,” consisted of the type, duration, and location of residency training, performance on specialty board examinations, career distributions, proportion of graduates in academic careers, professional attributes of alumni, and retrospective judgments of alumni regarding their education. Kane et al. (9) agree on the importance of the “end product” and state that schools must have a clear concept of the desired behavioral outcome as the graduate enters medical practice. They attempted to design an end-product description in terms of three criteria: skills, knowledge, and attitudes.

A report (10) issued in 1984 by educators concerned with the future of medical education stated the need for long-term research and program evaluation. According to this report, "Physicians for the Twenty-First Century," the short-term measures most often employed by medical schools are inadequate for judging the schools' program success in preparing their students for lifelong career skills. "Long-term tracking of graduates as they proceed through their special-
ized graduate medical education into practice should be programmed into the educational research of each institution" (p. 31).

Kassebaum (11) recently noted that this increased attention to outcome measures is a departure from the traditional method of evaluation, which has been based on the assessment of educational process, structure, and function rather than measured results. He agrees that longitudinal assessments should be conducted. Medical schools should first develop goals based on the institutional mission statement, then transform them into assessment objectives. Outcome measures or indicators can then be designed to assess the overall performance of the educational program. His model includes several outcome measures that could be used. These include college grade point averages, Medical College Admission Test scores, National Board of Medical Examiners scores, graduation rates, basic science course performance, student surveys, course evaluations, specialty certification, licensure results, and academic appointments.

According to Martini (12), the ultimate application of outcome assessment in medical education is the examination of competencies necessary for "the professional practice or the results of the practice itself" (p. 1008). The difficulties in implementing such an assessment include problems in defining and measuring professional competencies and in implementing the long-term studies of the many hard-to-control variables that influence the quality of patient care and the practice of medicine. Nevertheless, he believes that the procedures involved with accreditation must emphasize outcomes and be less concerned with resource inputs.

Reports of outcome evaluations of psychiatric residencies have generally responded to specific questions about practice patterns during particular eras or about graduates of particular programs. Scharfman and Grad (13) and Brockman and Marengo (14) addressed the question of private outpatient psychoanalytic psychotherapy vs. other patterns of practice. Salzman et al. (15) and Hamnett and Spivack (16) addressed graduates' preference for public or private psychiatry. Yager et al. (17) documented changing patterns of practice and postresidency training over a 20-year period. Sledge et al. (18) and Mezzich and Leiderman (19) assessed the impact of particular program tracks on subsequent career path. All of these studies used questionnaire responses from their graduates to assess outcome.

In psychiatry, the problem of outcomes assessment is at least as difficult as in any other medical specialty. Yet, it seems clear we will be moving in this direction. Our purpose here is to point out this trend to psychiatric educators and to consider some realistic ways outcome evaluation could become part of residency self-assessment and accreditation.

OUTCOME ASSESSMENT MODEL

When designing a model to be used for the evaluation of a program's graduates, it is imperative to specify the general criteria to be evaluated. It is also important to consider variables that will provide a value-added element. In the model proposed below, Psychiatry Resident In-Training Examination (PRITE) and critical thinking appraisals or other standardized tests most easily lend themselves to a value-added methodology. Various clinical evaluations during the course of residency could also be adapted to a value-added approach, although the methodology would be more complicated because of the lack of standardization across evaluators and across years of training. Table 1 shows a suggested model that divides the criteria into three categories: knowledge, performance, and attitudes/community service. This particular model is not intended to be exhaustive nor comprehensive, but instead to be suggestive of possibilities for residency outcome assess-
We are influenced by the models in the outcome assessment literature already cited, by the traditional tripartite division of educational objectives (i.e., knowledge, skills, attitudes), by common goals implicitly or explicitly discussed by training directors, and by our sense of data that could be readily captured by administratively overburdened training programs.

Knowledge

The first category deals with measures relating to cognitive abilities and the acquisition of concepts and facts. Some of the actual outcome measures that could be used are clinical rotation evaluations (the aspect that reflects knowledge and data base) and PRITE scores. Resident cognitive ability could also be evaluated by pre- and postadministrations of critical thinking instruments (20,21). Critical thinking is a psychological concept that refers to a cluster of higher cognitive functions: comprehension of information, critical synthesis of related concepts, and creative problem solving. After residency, criteria such as American Board of Psychiatry and Neurology (ABPN) Part I performance and others that are listed in Table 1 could be used as measures of knowledge outcomes as well as interest in lifelong learning.

<table>
<thead>
<tr>
<th>TABLE 1. Outcome measures for assessing effectiveness in psychiatric residency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Residency</strong></td>
</tr>
<tr>
<td>Supervisor evaluations</td>
</tr>
<tr>
<td>PRITE</td>
</tr>
<tr>
<td>Pre/post critical thinking appraisals</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Participation in faculty research</td>
</tr>
<tr>
<td>Publications</td>
</tr>
<tr>
<td>Clinical rotation evaluations</td>
</tr>
<tr>
<td>Structured clinical evaluations</td>
</tr>
<tr>
<td>Psychotherapy supervisor evaluations</td>
</tr>
<tr>
<td>Supervisor reports on patient outcomes</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Attitudes/Community Involvement</strong></td>
</tr>
<tr>
<td>Demonstrated regard for issues of medical ethics</td>
</tr>
<tr>
<td>Supervisor evaluations of attitudes</td>
</tr>
<tr>
<td>Leadership/participation in civic organizations</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

*Note: PRITE = Psychiatry Resident In-Training Examination; ABPN = American Board of Psychiatry and Neurology.*
Performance

The second major category of the model, performance, includes clinical abilities, scientific interests, research accomplishments, and professional competency. Resident performance could be evaluated by psychotherapy and site supervisors, mock board-structured clinical evaluations, and others listed in Table 1. Once graduates are in practice, other measures can be assessed, such as ABPN Part II performance, peer review actions, etc.

The entire issue of evaluating performance and clinical outcomes is a thorny one. During residency, emphasis can be placed on observation by experienced faculty supervisors. However, after training it becomes much more difficult, both practically and methodologically. Hojat et al. (22), in a practice-outcome survey of 1,102 graduates of Jefferson Medical College, received a 75% return of completed questionnaires. This study documented differing training and practice patterns between male and female students, such as specialty choice and setting. Ramsey et al. (23), in evaluating the validity of internal medicine board examinations, used patient questionnaires, the opinions of professional associates (i.e., physicians, administrators, and nurses), and reviews of patient records to assess performance in clinical practice.

Attitudes/Community Service

The third category, attitudes/community service, relates to the physician's value system and his or her involvement in the community. Although few programs have explicit objectives for general, volunteer, civic, and professional activities, it is our sense that most programs would be disappointed if their graduates showed little inclination to involve themselves in constructive ways in the broader community, thus representing psychiatry as well as contributing special expertise to organizations that are not overtly involved with mental health issues. Some programs that focus on fostering such values might wish to make this an explicit objective for assessing outcome. Criteria in this category include professional roles and organizations, medical ethics, and community involvement. Specific measures could include practice patterns, leadership in professional organizations, and volunteer work. These criteria can be collected both during residency and later during the professional practice of graduates.

There are several data sources potentially available for assessing these outcome criteria. Routine residency records will include almost all of the data necessary during training. The ABPN has been routinely making performance of graduates available to training directors. All previous studies of psychiatry residency outcome have used surveys of graduates that could provide data on many of the measures during practice. Indeed, simply obtaining an updated curriculum vitae from all graduates every few years would provide data on several practice outcome measures. Ramsey et al. (23) demonstrated that giving questionnaires to peers, colleagues, hospital personnel (including administrators who would have access to peer review records), and even patients is possible. In addition, the American Medical Association (AMA) does an annual census of practicing physicians, and the American Psychiatric Association (APA) periodically updates its biographical directory of members. These data bases contain extensive information relevant to all three areas of our model. Such areas as certification, subspecialization, practice location, type of practice, publications, additional training, professional activities, etc. are readily available from these data sources. Even more germane to performance assessment might be the newly formed National Practitioner Data Bank, which will maintain records of all negative actions against physicians by medical state boards, ethics committees, and courts. Gaining access to this information in an eth-
ical and appropriate manner might prove a problem. Should outcome assessment become a prominent and widely used feature of accreditation, perhaps training directors could collaborate with the APA, AMA, and National Practitioner Data Bank in solving this problem as ABPN and psychiatry training directors did in making board performance scores of graduates available to program directors.

Clearly, any given program would not sample all of these areas. The selection of which measures to use and which variables constitute a good outcome would be strongly influenced by each residency program's stated goals. A program committed to training psychiatrists for the public sector might place more emphasis on site or locality of practice and community involvement in evaluating its outcomes. A program with the goal of producing academicians might be more interested in publications and professional organizational roles.

Many residencies maintain fairly close connections with their graduates and, thus, collecting data in their chosen areas of concern might not be too onerous. Residencies are also fortunate that data on some of the outcome measures are routinely collected as part of the program (e.g., clinical evaluations, PRITE, and board results, etc.).

Although the pressures may not be as direct on the ACGME as they are on the LCME, it is important for psychiatric educators to be mindful of this shift in the accreditation field toward outcome assessment. There is a need to consider ways in which relevant data are already available or could be gathered relatively easily to focus on outcome evaluation in psychiatry residency training.

References

1. Flexner A: Medical Education in the United States and Canada. New York, Arno Press, 1910
2. Colwell NF: The need, methods, and value of medical college inspection. JAMA 1909; 7:512–515
5. American Medical Association: 1990–1991 Directory of Graduate Medical Education Programs, accredited by the Accreditation Council for Graduate Medical Education. Chicago, IL, American Medical Association, 1990
career activity: the experience of the Yale Advanced Track Program. Arch Gen Psychiatry 1990; 47:82–88
Are We Teaching Psychiatrists to Be Ethical?

John H. Coverdale, M.B., Ch.B.
Timothy Bayer, M.D.
Patricia Isbell, M.D.
Steven Moffic, M.D.

The authors conducted a nationwide survey of ethics education during psychiatry residency. Of the 136 program directors and 95 chief residents responding, nearly all agreed that ethics should be a part of the core curriculum. Program directors reported that most programs (60%) did offer a formal seminar series or course. However, 26 programs (19%) had no planned discussion of ethics in any seminar and fewer than 30% of all programs held seminars on the issues considered most worthy of formal attention, including psychiatrist-patient sexual contact, confidentiality, and forced treatment. The discrepancy between what program directors and chief residents believe should be taught and what is actually being taught indicates a need to focus attention on the teaching of psychiatric ethics.

There is little information on how ethics is taught in U.S. psychiatry residencies because reports have focused on single programs only (1-4). This is despite the fact that ethical issues pervade all of psychiatric clinical practice. The ethical behavior of some psychiatrists is also a matter of concern (5). Psychiatrist-patient sexual contact is one example of an issue that recently has received considerable attention. At least 7% of psychiatrists and 1% of senior psychiatry residents report having had sexual contact with patients (6,7). Solid grounding in ethics is also a designated requirement for residency training in psychiatry (8), and a recent report by The Group for the Advancement of Psychiatry refers to a number of cases of ethical interest (9). Further, Paul J. Fink, M.D., in his 1989 American Psychiatric Association (APA) presidential address, pointed to a serious need in training to set standards for the behavior of psychiatrists (10).

Consequently, we thought now was the time to conduct a national survey of ethics education in psychiatry residency. One goal of this research was to measure the attitudes of program directors and chief residents across the United States toward the teaching of ethics in psychiatry. Surveying both...
groups also allowed us to compare the educator and resident perspectives on the importance of teaching ethics in psychiatry and to identify topics they considered important to teach. Other goals included discovering how much ethics was taught and how it was taught.

METHODS

Questionnaires were mailed to all 199 program directors of approved adult psychiatry residency training programs in the United States in February 1989 (obtained from the Directory of Psychiatry Residency Training Programs). Program directors who failed to respond were mailed a second questionnaire in May 1989. Anonymous responses were obtained from 136 program directors (68.3%). One program that was described as a child psychiatry training program only and one program that had been discontinued were excluded from analysis. Twenty-one programs (15.4%) were both general and child psychiatry training programs, whereas the remainder were general psychiatry training programs. The mean ± SD number of residents in training programs was 29.2 ± 15.7.

Questionnaires were also mailed to all chief residents who attended the leadership conference in Tarrytown, NY, in June 1988. After two separate mailings, responses were obtained from 95 chief residents (80.5% of the total sample of 118), who represented 75 different programs. Two programs that were child psychiatry training programs were excluded from analysis. All other programs in which the chief residents were training were general programs. The mean age of chief residents was 31.8 years. Forty-two (44.2%) were male, 22 (23.2%) were female, and the remainder (32.6%) did not specify their gender. For 55 programs, responses were obtained from both the program director and a chief resident.

Program directors were asked to indicate on a five-point scale their views on the importance of teaching ethics in psychiatry (range = "not at all important" to "critically important"). They were also to decide whether they thought psychiatric ethics should or should not be part of the core curriculum. Program directors also described how ethics was taught in their department by choosing one of four possibilities: 1) in a formal ethics seminar series or course; 2) by planned discussion of ethical issues in seminars not primarily identified as ethics seminars; 3) in other forums, specifically grand rounds and journal clubs; or 4) in none of the above forums.

If respondents indicated that their program included a formal ethics seminar series or course, they were asked to describe various aspects of the course including the reasons for starting it and the number and background of individuals involved in teaching. They also listed specific topics taught and indicated on a five-point, Likert-type scale their perception of residents' views of the ethics course's helpfulness. If program directors stated that ethics was taught by planned discussion in seminar series not primarily identified as ethics seminars, they were asked to name these seminar series. Those reporting discussion in other forums were asked whether it occurred during grand rounds or journal clubs. If the program had essentially no planned teaching or discussion of ethics in any of these forums, directors were asked to list reasons why this was the case.

Program directors were also asked to list issues in psychiatric ethics they perceived as being worthy of formal attention by residents and to list ethical problems they thought psychiatry residents in the United States were most likely to have. Questionnaires for chief residents differed in that they were not asked about the ethical problems of U.S. psychiatry residents. Also, their responses on how ethics was taught and how much was taught are not reported because fewer programs were surveyed.

Responses were sorted into various cat-
categories for open-ended questions. These categories were not precisely defined because overlap was necessary between categories (e.g., "duty to warn" and "confidentiality" are categories with common elements). Responses with similar wording were grouped in categories with the same meaning. Vague responses were also not included in specific categories in which the meaning was clear (e.g., "psychiatrist-patient sexual contact" did not include responses such as "sexuality" or "sexual issues").

Percentages of responses to each question were computed with the number of individuals responding as the denominator. The denominator varied according to the number responding to each question. We compared the results of differences in topics chosen by chief residents and program directors by using a test for determining the significance of differences between proportions (11).

RESULTS

Program directors believed that it was important to teach ethics to residents. A total of 121 program directors (89.0%) responded that this was of high or critical importance. Nearly all directors (93.4%) reported that psychiatric ethics should be part of the core curriculum; 2 (1.5%) thought that it should not and 7 (5.1%) did not know. Chief residents responded similarly. Eighty-one (85.3%) thought that teaching ethics was of high or critical importance, whereas 87 (91.6%) thought that psychiatric ethics should be part of the core curriculum.

Program directors were asked to specify how ethics was taught within their training program. In 81 programs (59.6%), ethics was reportedly taught in a formal ethics seminar series or course, including five programs (3.7%) that had one seminar only. Twenty-nine programs (21.3%) reported planned discussion of ethical issues in seminars not primarily identified as ethics seminars. Ten programs (7.4%) had no planned teaching of ethics in any seminar but had at least one grand round or journal club devoted to ethics each year, whereas the remaining 16 programs (11.8%) reported not teaching ethics in any of these forums. Included in these 16 programs were 12 programs in which directors perceived that ethics was of high or critical importance to teach and that ethics should be a part of the core curriculum.

Information about how ethics was taught was obtained from program directors of the 81 programs that had a formal ethics seminar series. Thirty-seven programs (46%) taught ethics at one PGY level only; 24 programs (29%) taught ethics at two PGY levels; the remaining 20 programs taught ethics at three or four PGY levels. Ethics was most frequently taught in PGY-3 (n = 46, 56.8%) and PGY-4 (n = 45, 55.6%). Twenty-nine programs (35.8%) taught ethics at the PGY-1 and 35 programs (43.2%) taught ethics at the PGY-2. Fifty-two programs (64.2%) had taught ethics for 4 years or less, and the most common reason given for starting a course was that there was a recognition of need (n = 19, 23.5%). Most program directors (87.7%) perceived that most courses were at least moderately helpful.

As can be seen from Table 1, individuals from a wide variety of backgrounds teach these courses; psychiatry is the most frequent discipline represented. Table 2 shows

<table>
<thead>
<tr>
<th>TABLE 1. Professions represented by teachers of formal ethics courses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Profession</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Psychiatry</td>
</tr>
<tr>
<td>Ethics</td>
</tr>
<tr>
<td>M.D. (unspecified)</td>
</tr>
<tr>
<td>Law</td>
</tr>
<tr>
<td>Psychology</td>
</tr>
<tr>
<td>Divinity</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

Note: Program directors could list more than one teacher.
a list of the most frequent topics taught in programs that offered a formal ethics course. The mean number of topics provided by program directors was 4.7 ± 2.9; 17 (21.0%) did not respond to this question. The most frequent topics listed included confidentiality, psychiatrist-patient sexual contact, informed consent, discussion of case reports (which includes discussion of ethical issues pertaining to individual cases), the psychiatrist-patient relationship in general (which includes responses such as "gift-giving" and "boundaries between the doctor and patient"), and involuntary commitment.

Information was obtained about programs that did not offer a formal ethics course. For the 29 residency programs in which ethics was taught in seminars not primarily identified as ethics seminars, these seminars were most frequently identified as seminars on psychotherapy (n = 7), law (n = 6), and introductory clinical psychiatry (n = 4). The most frequent reason given for failure to provide planned teaching or discussion of ethics in any seminar was that psychiatric ethics was relatively unimportant (n = 8). Other reasons given included that no one could teach it (n = 4) and that there was little interest in it (n = 4).

Both program directors and chief residents were asked to list topics they thought were worthy of formal attention in psychiatric ethics (see Table 3). Multiple responses were allowed, and program directors provided a mean of 5.4 ± 2.9 responses, whereas chief residents provided a mean of 3.5 ± 1.8 responses. Thirty-nine (28.7%) of the program directors and 25 (26.3%) of the chief residents did not answer this question. Frequently selected responses for both groups included psychiatrist-patient sexual contact; confidentiality; forced treatment, including forced medications; involuntary commitment; and the psychiatrist-patient relationship (general). Responses of the program directors and chief residents were also compared to determine the relative importance each gave to individual topics. There were statistically significant differences between the two groups on the following topics: financial considerations, forensic psychiatry, APA guidelines, psychodynamic theories, and drug treatment (see Table 3).

As another indicator of areas worthy of formal attention in psychiatric ethics, program directors were asked to list the kinds of ethical problems, if any, they thought psychiatry residents most likely might have. Again, multiple responses were allowed. A mean of 2.9 ± 2.0 responses were provided; 45 directors (33.1%) did not answer this question. The most popular responses were confidentiality (n = 32, 35.2%), psychiatrist-patient sexual contact (n = 29, 31.9%), financial considerations or fees (n = 20, 22.0%), psychiatrist-patient relationship (general)

<table>
<thead>
<tr>
<th>Topic</th>
<th>% of Programs Offering a Formal Course (N = 81)</th>
<th>% of All Programs (N = 136)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidentiality</td>
<td>31 ± 48.4</td>
<td>26.1</td>
</tr>
<tr>
<td>Psychiatrist-patient sexual contact</td>
<td>24 ± 37.5</td>
<td>20.2</td>
</tr>
<tr>
<td>Informed consent</td>
<td>20 ± 31.3</td>
<td>16.8</td>
</tr>
<tr>
<td>Case reports</td>
<td>19 ± 29.7</td>
<td>16.0</td>
</tr>
<tr>
<td>Psychiatrist-patient relationship (general)</td>
<td>15 ± 23.4</td>
<td>12.6</td>
</tr>
<tr>
<td>Involuntary commitment</td>
<td>15 ± 23.4</td>
<td>12.6</td>
</tr>
<tr>
<td>Forensic psychiatry</td>
<td>13 ± 20.3</td>
<td>10.9</td>
</tr>
<tr>
<td>Forced treatment</td>
<td>12 ± 18.8</td>
<td>10.1</td>
</tr>
<tr>
<td>Competency</td>
<td>12 ± 18.8</td>
<td>10.1</td>
</tr>
<tr>
<td>Philosophical background</td>
<td>7 ± 10.9</td>
<td>5.9</td>
</tr>
<tr>
<td>AIDS</td>
<td>7 ± 10.9</td>
<td>5.9</td>
</tr>
<tr>
<td>Peer review</td>
<td>6 ± 9.3</td>
<td>5.0</td>
</tr>
<tr>
<td>Patient rights</td>
<td>6 ± 9.3</td>
<td>5.0</td>
</tr>
<tr>
<td>Suicide</td>
<td>6 ± 9.3</td>
<td>5.0</td>
</tr>
<tr>
<td>Autonomy/paternalism</td>
<td>5 ± 7.8</td>
<td>4.2</td>
</tr>
<tr>
<td>Financial considerations</td>
<td>5 ± 7.8</td>
<td>4.2</td>
</tr>
<tr>
<td>Research ethics</td>
<td>5 ± 7.8</td>
<td>4.2</td>
</tr>
</tbody>
</table>

Note: Program directors could list more than one topic. Since not all program directors responded to the question, percentages are calculated on the basis of the number of respondents.
(n = 17, 18.7%), commitment (n = 12, 13.2%), and forced medication or forced treatment (n = 10, 11.0%).

DISCUSSION

Nearly all program directors and chief residents perceive that teaching ethics is of high or critical importance and that it should be part of the core curriculum. However, a lack of uniformity was found in how ethics was taught. Sixty percent of program directors reported that ethics was the subject of a formal seminar series or course, and this included five programs that offered only one seminar in ethics. Twenty-one percent of programs did offer discussion of ethical issues in seminars not primarily identified as ethics seminars. The remaining 19% of programs had no planned teaching of ethics in any seminar. The directors of some of these programs reported devoting at least one grand round presentation or journal club to ethics each year. The finding that 19% of programs do not teach ethics formally stands in apparent contradiction to the perception of nearly all program directors and chief residents that ethics should be a part of the core curriculum. Requirements for residency training may also not be met by programs that do not offer formal teaching (8). Another measure of the difference between what was considered to be important to teach and what was reportedly taught is that topics considered to be most worthy of formal attention, such as psychiatrist-patient sexual contact, confidentiality, and forced treatment, were formally discussed in less than 30% of the programs.

Data obtained from questions in which respondents were asked to list topics were limited by a lack of definition of terms. Pro-

<table>
<thead>
<tr>
<th>Topic</th>
<th>Program Directors (N = 136)</th>
<th>Chief Residents (N = 95)</th>
<th>z*</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrist-patient sexual contact</td>
<td>45</td>
<td>30</td>
<td>0.5</td>
<td>NS</td>
</tr>
<tr>
<td>Confidentiality</td>
<td>44</td>
<td>28</td>
<td>0.7</td>
<td>NS</td>
</tr>
<tr>
<td>Financial considerations</td>
<td>28</td>
<td>4</td>
<td>3.8</td>
<td>0.05</td>
</tr>
<tr>
<td>Forced treatment</td>
<td>24</td>
<td>20</td>
<td>-0.6</td>
<td>NS</td>
</tr>
<tr>
<td>Informed consent</td>
<td>23</td>
<td>10</td>
<td>1.5</td>
<td>NS</td>
</tr>
<tr>
<td>Involuntary commitment</td>
<td>22</td>
<td>14</td>
<td>0.4</td>
<td>NS</td>
</tr>
<tr>
<td>Psychiatrist-patient relationships (general)</td>
<td>21</td>
<td>17</td>
<td>-0.4</td>
<td>NS</td>
</tr>
<tr>
<td>Forensic psychiatry</td>
<td>15</td>
<td>3</td>
<td>2.3</td>
<td>0.05</td>
</tr>
<tr>
<td>Duty to warn</td>
<td>14</td>
<td>9</td>
<td>0.3</td>
<td>NS</td>
</tr>
<tr>
<td>Abandonment of patients</td>
<td>13</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>APA guidelines</td>
<td>12</td>
<td>2</td>
<td>2.2</td>
<td>0.05</td>
</tr>
<tr>
<td>Suicide/right to die</td>
<td>12</td>
<td>7</td>
<td>0.5</td>
<td>NS</td>
</tr>
<tr>
<td>Psychodynamic theories</td>
<td>12</td>
<td>1</td>
<td>2.6</td>
<td>0.05</td>
</tr>
<tr>
<td>AIDS</td>
<td>11</td>
<td>9</td>
<td>-0.3</td>
<td>NS</td>
</tr>
<tr>
<td>Relationship to institutions</td>
<td>11</td>
<td>5</td>
<td>0.9</td>
<td>NS</td>
</tr>
<tr>
<td>Peer review</td>
<td>10</td>
<td>7</td>
<td>0.1</td>
<td>NS</td>
</tr>
<tr>
<td>Drug treatment</td>
<td>10</td>
<td>1</td>
<td>2.3</td>
<td>0.05</td>
</tr>
</tbody>
</table>

Note: More than one topic could be listed by individual respondents. Because not all program directors and chief residents responded to the question, percentages are calculated on the basis of the number of respondents. NS = not significant.

*A test for determining the significance of differences between proportions (10).*
gram directors and chief residents listed many of the same topics as those considered worthy of formal attention during residency. However, topics such as financial considerations, forensic psychiatry, APA guidelines, psychodynamic theories, and drug treatment were listed by a significantly smaller proportion of chief residents than program directors, suggesting that less importance was attributed to these topics by chief residents. Also, none of the chief residents mentioned abandonment of patients. Topics that were not mentioned or mentioned infrequently by both groups included psychiatry's relationship to the pharmaceutical industry and the ethics of advertising. This result is somewhat surprising considering that these are examples of issues that pervade psychiatric practice.

Topics that program directors perceived as most worthy of formal attention in psychiatric training were many of the same topics that figured prominently as likely ethical problems of psychiatric residents. Psychiatrist-patient sexual contact was an area that was considered to be a likely problem. This is consistent with the finding of a previous survey in which 1% of responding senior psychiatric residents reported having had sexual contact with patients (a figure that may be a significant underestimate), which prompted a call for attention to be given to this topic in all psychiatry residency training programs (7).

Many of the formal courses were taught by psychiatrists; ethicists were less frequently involved. We did not determine what type of preparation was obtained by the psychiatrists and ethicists who taught these courses. It might be useful to assess how ethicists compare with psychiatrists as teachers of psychiatric ethics and to explore the qualities and experiences thought to be important in teaching ethics. Further, it is questionable whether teaching ethics makes a difference in ethical behavior (12). However, this was not a concern mentioned by program directors. Instead, the most frequent reason given for not providing formal teaching in psychiatric ethics was that the subject was relatively unimportant.

There are several limitations to our study. First, a possible source of bias is introduced by the 32% of program directors and the 20% of chief residents who did not respond. Also, the chief residents surveyed were those attending a leadership conference and were not necessarily representative of all chief residents. It might also have been useful to examine responses of program directors and chief residents from the same program had we been able to match questionnaires to individual programs. Our data are also limited by the use of self-report and the possibility of bias in the direction of socially desirable responses.

Our survey did not seek to establish the role of individual, one-to-one case supervision or case-oriented tutorials in dealing with ethical problems and the importance of other aspects of role modeling by full-time and volunteer faculty in the learning of ethical attitudes. Thus, when program directors answered that ethics was not taught in any of the forums we had specified, it did not necessarily mean that there was an absence of ethics instruction. We also did not ask about how the various efforts to teach psychiatric ethics might influence distinct outcomes including cognitive, affective, or psychomotor learning outcomes. Indeed, we know of few discussions concerning the advantages and disadvantages of different methods for teaching psychiatric ethics (12).

Despite these limitations, to our knowledge, our survey is the first national survey on psychiatric ethics teaching. Our data show that whereas most psychiatric residency training programs do provide courses on psychiatric ethics, there remains a significant gap between what program directors and chief residents believe is important for residents to learn and what is actually taught. Nineteen percent of programs did not provide formal courses in ethics, and in many programs topics considered most im-
important to teach were reportedly not being taught. Setting standards in the teaching of psychiatric ethics provides one method, along with selection and disciplinary procedures, for helping psychiatrists to practice ethically. Moreover, a commitment ought to be made to using the best educational techniques to teach ethics to all psychiatrists-in-training. Future research might delineate what kinds of teaching will effect attitudinal and behavioral change and produce ethical psychiatrists. Clearly, these are challenges just waiting to be met.

The authors acknowledge the cooperation of Dr. Jack F. Wilder and Dr. Pedro Ruiz in facilitating the response from the chief residents.


References

Use of a Matrix in Designing Training Experiences

Experience in a Rural Child and Adolescent Training Program

Robert J. Racusin, M.D.
Henry Cretella, M.D.

Rural child and adolescent psychiatry residency programs offer unique training opportunities with a distinct and underserved population. These programs also face the challenge of organizing teaching resources with maximum efficiency to compensate for low population density, geographical isolation, and a scarcity of available faculty. Using a case example, the authors describe the advantages of combining the use of a resource matrix with a set of program-specific priorities to design training opportunities for residents that simultaneously meet multiple program objectives. Potential results of this application may include expanded clinical services, new research opportunities, and easier recruitment of faculty.

There are many pressures on child and adolescent psychiatry training programs. Most are faced with the prospect of diminishing financial resources available for research, teaching, and clinical services (1-3). While the financial base for academic programs becomes less stable, the clinical and didactic requirements are becoming more stringent. Minimum program size has been established along with more clearly defined didactic and clinical expectations and more thorough documentation of their completion (4).

In addition to the formal ACGME requirements (4), there are certain aspects of child and adolescent psychiatry training unique to rural areas and rural populations. The significance of these differences is reflected by the high priority recently assigned by the National Institute of Mental Health to clinical and service systems research in rural child mental health (5). Epidemiologic surveys suggest that children in rural areas may be at greater risk for a variety of mental health problems (e.g., child abuse and depression) yet have less access to care than their urban and suburban counterparts (5,6).

Child and adolescent psychiatry practice in rural areas also has requirements for specialized training, including dealing with professional isolation and geographic obstacles to health care access, working within specific rural subcultures (e.g., Native American, Appalachian), and handling the complex problems of confidentiality and professional boundaries in settings in which anonymity and personal privacy are difficult to maintain (6).
For rural child and adolescent psychiatry training programs, the challenge of providing adequate teaching across a wide spectrum of clinical settings, treatment modalities, and patient types can be particularly vexing. By definition, rural communities are characterized by low population density, resulting in limited numbers of geographically accessible children who fall into the various clinical and treatment categories important for training residents. Also, the delivery of mental health care to rural children is adversely effected by fragmented systems of care (7), acute manpower shortages (1), a maldistribution of child psychiatrists toward more urban settings (8), and increasing pressure to "manage" mental health benefits (9). Not surprisingly, therefore, rural areas tend to have a limited number of available teachers of child psychiatry residents. For example, compared with urban centers, rural training programs have access to fewer adjunct or affiliate faculty from a surrounding population of private practitioners, agency-based professionals, and academicians (6).

In the face of so many diverse demands and diminishing resources, a training director in a rural area needs to be aware of all the resources available and should have a system of selecting training sites and organizing training experiences that will realize several objectives simultaneously. A matrix approach concisely organizes these factors.

**MATRIX APPROACH**

Training child and adolescent psychiatry residents involves the complex organization of different learning experiences to develop a wide range of knowledge, skills, and attitudes. A two-dimensional matrix can be used to display how training opportunities in a particular content area (e.g., infant psychiatry) are distributed across different sites and how they can be coordinated to efficiently achieve training program objectives. Areas of importance can be categorized in the matrix in any way that is helpful to the training director (e.g., infant psychiatry, consultation-liaison psychiatry, research training). Each content area of importance can be displayed as a separate matrix, the horizontal axis of which lists the potential training sites that relate to that area (e.g., infants at risk for neglect). The vertical axis of a theoretically complete matrix, shown in Table 1, lists all the critical elements related to clinical services, teaching, service delivery, research, and support.

Using the completed matrix to compare the relative value of different potential training sites can be made easier by listing elements on each axis by priority or by eliminating them. Such a priority list, of course, will be influenced by a wide range of factors; some of the most common considerations are listed in Table 2.

With the selected priorities in mind, the number of possible training sites (horizontal axis) and the number of critical elements to be considered (vertical axis) can both be reduced.

**EXAMPLE**

A residency program director decided that a high priority should be placed on training child and adolescent psychiatry residents in working with teenage mothers and their infants. This priority was determined because the training program needed to expand its teaching in infant psychiatry. In meeting this

---

**TABLE 1. Elements of the vertical axis of the “complete matrix”**

<table>
<thead>
<tr>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric services presently offered</td>
</tr>
<tr>
<td>Current or potential training activities for child psychiatry residents</td>
</tr>
<tr>
<td>Faculty/supervision currently associated with each service and available for teaching</td>
</tr>
<tr>
<td>Additional supervision needed</td>
</tr>
<tr>
<td>Financial and other resources available to support the clinical training (e.g., contracts, grants, barter arrangements)</td>
</tr>
<tr>
<td>Relevant didactic offerings</td>
</tr>
<tr>
<td>Research opportunities</td>
</tr>
</tbody>
</table>
need, it was important to develop clinical training at a site where teaching resources were available at no additional direct cost. Secondary priorities were to provide more group therapy training and to heighten the visibility of the training program’s outpatient services to respond to the competitive pressure of an influx of nonmedical, private practitioners. Research opportunities were not expected to result from the training. With these priorities in mind, the training director developed a matrix to evaluate training opportunities in infant psychiatry (see Table 3) that helped compare four possible sites: a local high school, the local office of Planned Parenthood, a community health center, and a residential group home for teenage mothers.

An affiliation between the training program and the group home would allow for the most efficient coordination of priorities because it would provide residents with exposure to two at-risk groups (i.e., teenage mothers and their infants) in at least two intervention settings (i.e., support group and day care) that were already in place.

<table>
<thead>
<tr>
<th>TABLE 2. Common considerations in establishing training program priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Importance of a particular type of psychiatric treatment to the comprehensiveness of the training program (e.g., teaching residents group psychotherapy skills)</td>
</tr>
<tr>
<td>Importance of providing clinical services to a particular group</td>
</tr>
<tr>
<td>“Investment potential” of developing a training opportunity (i.e., the willingness of a community agency to help support a faculty child psychiatrist if residents are available to provide clinical services)</td>
</tr>
<tr>
<td>Political and public relations significance of a training affiliation</td>
</tr>
<tr>
<td>Value of potential research opportunities</td>
</tr>
<tr>
<td>Impact of a training affiliation on other departmental/sectional programs, priorities, and resource allocations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TABLE 3. Comparison of training opportunities at four sites for teenage mothers and their infants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training Sites</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Service</td>
</tr>
<tr>
<td>Sex education classes</td>
</tr>
<tr>
<td>Human behavior classes</td>
</tr>
<tr>
<td>(infants and mothers in class)</td>
</tr>
<tr>
<td>Training opportunities</td>
</tr>
<tr>
<td>Observe class</td>
</tr>
<tr>
<td>Consult to teacher</td>
</tr>
<tr>
<td>Supervision currently available</td>
</tr>
<tr>
<td>None</td>
</tr>
<tr>
<td>Potential supervision</td>
</tr>
<tr>
<td>School psychologist</td>
</tr>
<tr>
<td>Nurse practitioner</td>
</tr>
<tr>
<td>Support/resources available</td>
</tr>
<tr>
<td>Exchange consultation for teaching time</td>
</tr>
<tr>
<td>Didactics/training area</td>
</tr>
<tr>
<td>Infant development</td>
</tr>
<tr>
<td>Community consultation</td>
</tr>
<tr>
<td>Adolescent consultation</td>
</tr>
<tr>
<td>Group therapy</td>
</tr>
<tr>
<td>Research</td>
</tr>
<tr>
<td>None</td>
</tr>
</tbody>
</table>

| Planned Parenthood                          |
| Sex education classes                        |
| Human behavior classes                       |
| (infants and mothers in class)               |
| Observe class                                |
| Consult to teacher                           |
| Exchange consultation for teaching time      |
| Infant development                           |
| Community consultation                       |
| Adolescent consultation                      |
| Group therapy                                |
| None                                         |

| Community Health Center                     |
| Prenatal care                               |
| Well-child visits                           |
| Observation                                 |
| Co-lead groups                              |
| Observe normal and developmentally delayed children |
| None                                         |

| Group Home                                  |
| Child care education group                   |
| Infant/mother support group                  |
| Infant/toddler daycare                      |
| Exchange inservice training for teaching time |
| Infant development                           |
| Adolescent development                       |
| Early childhood development                  |
| Vulnerability and resilience                 |
| Group therapy                                |
| Community consultation                       |
| None                                         |
Further, supervision could be provided by on-site staff (psychiatric nurse) without additional direct cost to the program. Finally, as a United Way agency heavily dependent upon volunteers and donated goods and services, the group home was a location where the child psychiatry residents’ presence would be visible (or at least known) to a significant number of people in the community.

The curriculum for this training experience consisted of four elements. First, one of the core didactic offerings (a year-long, weekly seminar on child development, psychopathology, and treatment) was modified to include more readings in the area of attachment theory, infant development, and direct observation of mother/infant dyads. Selections included works by Ainsworth (10), Bowlby (11–14), and Brazelton (15). A session on community consultation was also moved to earlier in the year as a way of helping prepare residents for their rotation at the group home. Second, a faculty child psychiatrist (also trained in pediatrics) “debriefed” the residents after their day care observations to help the residents relate experiential and didactic learning. Third, the on-site psychiatric nurse acted as group co-leader and supervisor in the infant/mother support group. Fourth, residents were encouraged to bring their clinical experience from the group intervention to a group therapy seminar. This seminar was part of residents’ ongoing training in group therapy and consisted of a weekly meeting of residents at various levels of training who were leading inpatient and outpatient groups in various settings. This seminar was led by a senior member of the group therapy faculty in the department.

RESULTS

Written evaluations by the two cohorts of residents (N = 4, 1989–1991) who have completed the group home rotations have shown a high level of satisfaction. Three of the residents specifically had favorable comments about the training site because it combined observations of infants, group treatment of adolescents, and working in a community setting. The fact that these are some of the specific elements coordinated through the matrix approach suggests that this approach was of value.

The faculty child psychiatrist who directly supervised this training experience for all four residents felt that the residents received excellent on-site support and was impressed with their ability to relate what they observed at the infant day care program with what had been presented in didactic sessions. The on-site psychiatric nurse was similarly pleased with the effectiveness of the group intervention and with the enthusiasm and developmental perspective of the child psychiatry residents. As a concrete expression of the group home’s satisfaction with the services provided, the executive director of the home has requested that residents continue to be assigned on a regular basis.

DISCUSSION

The example cited in this article is not unique to rural areas, and the potential benefits and problems associated with using a matrix system to organize training could easily be extrapolated to an urban environment. Because the authors’ experiences with this method were obtained in rural settings, however, certain advantages that are particularly relevant to these settings will be emphasized.

The primary value of using a matrix is that it permits the training director to have a comprehensive and concrete overview of what is already available and what is possible. This overview can be put to use in ways that go beyond simply filling perceived gaps in training. The matrix allows visualization of the need for new clinical services, the potential for developing new funding sources for faculty and residents, and the
development of research opportunities. As these additional factors come into focus, choices become available that will serve a program's multiple priorities. This approach could also be applied to tasks other than organizing clinical training; for example, it could be used to coordinate the research agenda of a child and adolescent psychiatry division such that residents could be efficiently included in multiple research projects conducted by various faculty at different sites.

In addition to the efficiency of programming that can arise from this organizational approach, several other benefits may accrue to the training program. For one, since training opportunities are being selected with careful attention to meeting as many objectives as possible, there is an incentive for training directors to engage in long-term affiliations and long-term planning for developing new services. A positive feedback cycle may then evolve in which the training program's involvement results in the development of additional clinical services that then further enhance the training opportunities available. Other potential spinoffs of this process might include increased possibilities for research and an increased likelihood of community/state/federal support for new and innovative programs. The incentive for long-range planning also enhances the possibility for training programs to develop more highly specialized interventions that can be custom tailored to a particular population and to the program or agency serving it.

The example described in this article was implemented too recently to be used to gauge effects on recruitment and retention of faculty. It is likely, however, that the expansion of clinical training and clinical services will have a positive impact on enlarging the pool of potential teachers.

Further, additional teaching can also be found in community agencies in which adjunct faculty may be recruited at little or no cost. For example, many professionals in rural areas are willing to provide teaching in exchange for continuing medical education, consultation, or other services available from the academic center. The relationship between long-term affiliations, expansion of programs, and recruitment is particularly important in rural areas in which opportunities for recent graduates to maintain an ongoing affiliation with the training program have been shown to provide an incentive to keep the graduate within that geographical region (6).

Other benefits may be realized as the training director, by virtue of amassing data about clinical services in the community, becomes a clearinghouse for information of value to the local social services network. Depending on the sophistication of this network, the training director may be in a position to facilitate service coordination and planning in the community. In this role, the training director both provides and increases the visibility and understanding of child and adolescent psychiatry in the community. The liaison with community-based service programs is of increasing importance for residency training as health care resources are shifted away from inpatient treatment and into a continuum of outpatient, partial hospital, and residential services. As mental health services for children and adolescents become more diffusely located in the community, a matrix system may be part of a useful strategy for training directors to organize and administer clinical rotations within the social and mental health service network.

There would appear to be few, if any, disadvantages to using a matrix system to organize training experiences for residents. As with any organizational tool, its value is limited by the extent to which it makes the organization more able to achieve agreed-upon goals in a more cost-effective way. Thus, for programs with well-integrated clinical and research training already in place, the time and effort necessary to create a complete series of matrices may not be
justified. Even a well-organized and smoothly running program should find it useful, however, to identify alternative training experiences that could be developed if personnel, budgetary, or other changes threaten the stability of a current training site.

To fulfill their educational obligation to teach residents about working with unique groups of at-risk children, training programs are under considerable pressure to become innovative and maximally efficient when organizing their didactic curricula and clinical rotations. Conceptualizing a training/service/recruitment matrix is one way for training directors to maintain efficiency while meeting multiple priorities as they attempt to “make do with less” rather than “do less with less.”

References

In her introduction to *Trauma and Recovery*, Dr. Judith Herman writes that her book will be "controversial...because it is written from a feminist perspective," challenges "established diagnostic concepts," and, "most importantly," because she writes about things "no one really wants to hear about."

A feminist perspective is one committed to political, economic, and social equality for both women and men and to the equalization of power between the sexes. A feminist perspective gives Dr. Herman the wide-angle lens needed to see the connections between the private worlds of domestic violence and the public world of political violence. To do this, Dr. Herman dedicates herself to "telling the truth" in a "language that preserves connections." Using this framework, she models the therapeutic techniques outlined so clearly in the latter part of the book.

She describes the fundamental stages of recovery as being the establishment of "safety, reconstructing the trauma story, and restoring the connection between survivors and the community." This last element is essential to understanding Dr. Herman's point that, from a feminist perspective, "the personal is political" (1). To better understand the effects of terror, we must be able to appreciate that the horrors perpetrated in abusive households are the same as those perpetrated in prisoner-of-war camps; the object of the torturer is always the same: annihilation of the self and complete disempowerment of the individual.

Dr. Herman argues that the study of psychological trauma is "periodically forgotten and...reclaimed" depending on whether a "political movement" exists to support such study. She cites the example of Sigmund Freud and Anna O. When Freud presented his theory on child abuse and etiology of hysteria, he was ostracized by the professional community. Anna O., on the other hand, strove to tell the truth about her life and was able to do this because she was supported by a feminist movement. Such movements provide a community for protection and safety, necessary elements for the recovering, traumatized individual.

Further, Dr. Herman makes the connection between the posttraumatic symptoms of denial and isolation in the individual as being mirrored by society's frequent silence in the face of atrocity. She points out that denial and isolation are tools the perpetrators use to torture victims and protect themselves, and that as bystanders, society plays right into their hands by its practice of see no evil, hear no evil.

Dr. Herman challenges existing diagnostic criteria, such as major depression, posttraumatic stress disorder, dissociative disorders, anxiety disorders, and borderline personality disorder as being too limited to describe the effects long-term captivity and torture have on the individual (i.e., to break down the already formed personality of an adult and to deform the developing personality of a child). She argues that trying to fit such patients into existing diagnostic categories results in a partial understanding of the problem and a fragmented approach to treatment. Dr. Herman instead endorses a diagnosis of "complex posttraumatic stress disorder," which is being considered for DSM-IV.
In describing treatment, Dr. Herman emphasizes that the “empowerment” of survivors means that they must be in charge of their own recovery. By embracing a new concept of diagnosis, she suggests that therapists empower the patients by using a more accurate model that they can use to understand their disorder.

If there is one weakness in the book, it is Dr. Herman’s minimal discussion of biological interventions that are available to aid an individual’s recovery. She does, however, do an adequate job in reminding us of the neurophysiological changes that occur in a terrorized individual. Although Dr. Herman does not describe this in depth, more of this description may be useful to psychiatrists and therapists, whereas non-physician therapists may find her descriptions sufficient to appreciate the “biological” effects of trauma.

Dr. Herman is successful in her integration of the psychosocial understanding of violence and what it creates in the individual relative to his or her community. She articulates what survivors know, what many clinicians understand, and what all of society needs to realize: that “torture is torture,” regardless of the setting (Garcia-Peltoniemi R., personal communication, 1992). She reminds us we cannot always give a dispassionate discussion of our traumatized symptoms without addressing the cause—which affects all of us and could happen to any of us. Our willingness to publicly condemn acts of terror becomes as important as our ability to privately “sit with” the horrors our patients describe.

In summary, Dr. Herman helps us to “make the connections” between public and private violence as a means of prevention as much as contributing to the healing of our outpatients. She quotes a holocaust survivor, Levi, who said, “We have learnt that our personality is fragile, that it is [in] much more danger than our life. . . . If from inside, a message could have seeped out to free men . . . it would have been this: take care not to suffer in your own homes what is inflicted on us here.”

Reference

Dr. Witterholt is staff psychiatrist, Ramsey Hospital, St. Paul, MN, and Center for Victims of Torture, Minneapolis, MN.

Incest-Related Syndromes of Adult Psychopathology
Edited by Richard Kluft
ISBN 0-88048-160-9, $32.00

Reviewed by Norma Safransky, M.D.

It is always difficult to ascribe cause and effect in psychiatry. The medical journals are filled with research articles attempting to do just that, but more often than not the studies are inconclusive or raise more questions than answers. This is particularly true when it comes to ascribing a past life event as a cause for a present symptom. The effect of incest as a childhood event is again at the forefront of discussion in psychotherapeutic circles. It is interesting that incest, as a cause of adult psychopathology, was Freud’s first conclusion regarding the origin of hysteria-spectrum symptoms. Incest-Related Syndromes of Adult Psychopathology is editor Richard Kluft’s attempt to bring together a series of comprehensive reviews on this topic.

This book is remarkable for its breadth and detail, but what distinguishes it from other series of review articles is its revealing and moving chapters by Drs. Richard Kluft and Judith Herman.

In the opening essay, “On the Apparent Invisibility of Incest” (Chapter 2), Dr. Kluft candidly reveals his efforts to discover his own exposure to incest. He describes several encounters with girls or women who had
In describing treatment, Dr. Herman emphasizes that the “empowerment” of survivors means that they must be in charge of their own recovery. By embracing a new concept of diagnosis, she suggests that therapists empower the patients by using a more accurate model that they can use to understand their disorder.

If there is one weakness in the book, it is Dr. Herman’s minimal discussion of biological interventions that are available to aid an individual’s recovery. She does, however, do an adequate job in reminding us of the neurophysiological changes that occur in a terrorized individual. Although Dr. Herman does not describe this in depth, more of this description may be useful to psychiatrists and therapists, whereas nonphysician therapists may find her descriptions sufficient to appreciate the “biological” effects of trauma.

Dr. Herman is successful in her integration of the psychosocial understanding of violence and what it creates in the individual relative to his or her community. She articulates what survivors know, what many clinicians understand, and what all of society needs to realize: that “torture is torture,” regardless of the setting (Garcia-Peltoniemi R., personal communication, 1992). She reminds us we cannot always give a dispassionate discussion of our traumatized symptoms without addressing the cause—which affects all of us and could happen to any of us. Our willingness to publicly condemn acts of terror becomes as important as our ability to privately “sit with” the horrors our patients describe.

In summary, Dr. Herman helps us to “make the connections” between public and private violence as a means of prevention as much as contributing to the healing of our outpatients. She quotes a holocaust survivor, Levi, who said, ““We have learnt that our personality is fragile, that it is [in] much more danger than our life... If from inside, a message could have seeped out to free men... it would have been this: take care not to suffer in your own homes what is inflicted on us here.””

Reference

Dr. Witterholt is staff psychiatrist, Ramsey Hospital, St. Paul, MN, and Center for Victims of Torture, Minneapolis, MN.

Incest-Related Syndromes of Adult Psychopathology
Edited by Richard Kluft
ISBN 0-88048-160-9, $32.00

Reviewed by Norma Safransky, M.D.

It is always difficult to ascribe cause and effect in psychiatry. The medical journals are filled with research articles attempting to do just that, but more often than not the studies are inconclusive or raise more questions than answers. This is particularly true when it comes to ascribing a past life event as a cause for a present symptom. The effect of incest as a childhood event is again at the forefront of discussion in psychotherapeutic circles. It is interesting that incest, as a cause of adult psychopathology, was Freud’s first conclusion regarding the origin of hysterspectrum symptoms. Incest-Related Syndromes of Adult Psychopathology is editor Richard Kluft’s attempt to bring together a series of comprehensive reviews on this topic.

This book is remarkable for its breadth and detail, but what distinguishes it from other series of review articles is its revealing and moving chapters by Drs. Richard Kluft and Judith Herman.

In the opening essay, “On the Apparent Invisibility of Incest” (Chapter 2), Dr. Kluft candidly reveals his efforts to discover his own exposure to incest. He describes several encounters with girls or women who had
been incestuously abused. In doing so, he confronts the repression and denial we, as professionals and as a society, use to keep incest out of view. His exploration is so without the cloak of dispassionate professionalism that it is painful at times to read. Especially poignant is his description of his dilemma when encouraged as a young adult to participate in a "male bonding ritual of intercourse with a prostitute" (p. 293). Dr. Kluft's book mirrors the courage survivors need to proceed through their own rediscovery.

In the concluding chapter, Dr. Herman recounts the connection between incest and psychopathology in a way that braids together all the strands of evidence presented in the intervening pages. One can sense that the depth of her conviction is based on both the objectivity of research studies and the experience of her work with real individuals. When this truth is recognized, she states, "victims can begin their recovery in a relatively uncomplicated fashion." Dr. Herman also repeatedly confronts the countertransferential aspect of incest as professionals and as a society. One is sobered by her description of the ease in which therapists can find themselves reenacting the dilemmas a patient is experiencing regarding telling and knowing.

In the remaining chapters, experienced clinicians explore the behavioral, affective, sensory, and knowledge (cognitive) effects (BASK pneumonic, p. 165) of incest. Despite a certain repetitiveness common to books of collected reviews, this book is readable and complete. Particularly interesting is Chapter 8 on the cognitive sequelae, by Dr. Catherine Fine. As a profound disruption on development, incest allows for a close examination of the components of cognitive development. As Dr. Herman eloquently describes it, incest serves the same function as a linear accelerator and explodes the central core of one's sense of self into its most minute particles.

Even after reading the objective and subjective evidence presented in this book, a dilemma remains. How can it be known without doubt that incest is truly the root cause of these symptom complexes? Not surprisingly, this is one of the same dilemmas that faces the incest survivor: Did this really happen? Is this really true? And, as with the incest survivor, one must begin by trusting the mounting evidence.

_Dr. Safransky is a psychiatrist in private practice in Chapel Hill, NC._

**Concise Guide to Consultation Psychiatry**

By Michael G. Wise, M.D., and James R. Rundell, M.D.


ISBN 0-88048-123-4, $18.50

Reviewed by Susan Williamson, M.D.

_A s series editor Robert E. Hales, M.D., promises, this compact volume delivers high-density information in an accessible format. Scanning the table of contents on the way to see a patient, one can briskly locate the topic-at-hand and be reassured by a wealth of pertinent material. This little “pocket coach” offers many readable charts, an excellent chapter on the mental status examination for the budding bedside neuropsychiatrist, and a list of further readings and references at the end of each chapter should more in-depth information be required for a particularly challenging case or an attending physician._
been incestuously abused. In doing so, he confronts the repression and denial we, as professionals and as a society, use to keep incest out of view. His exploration is so without the cloak of dispassionate professionalism that it is painful at times to read. Especially poignant is his description of his dilemma when encouraged as a young adult to participate in a “male bonding ritual of intercourse with a prostitute” (p. 293). Dr. Kluft’s book mirrors the courage survivors need to proceed through their own rediscovery.

In the concluding chapter, Dr. Herman recounts the connection between incest and psychopathology in a way that braids together all the strands of evidence presented in the intervening pages. One can sense that the depth of her conviction is based on both the objectivity of research studies and the experience of her work with real individuals. When this truth is recognized, she states, “victims can begin their recovery in a relatively uncomplicated fashion.” Dr. Herman also repeatedly confronts the countertransferential aspect of incest as professionals and as a society. One is sobered by her description of the ease in which therapists can find themselves reenacting the dilemmas a patient is experiencing regarding telling and knowing.

In the remaining chapters, experienced clinicians explore the behavioral, affective sensory, and knowledge (cognitive) effects (BASK pneumonic, p. 165) of incest. Despite a certain repetitiveness common to books of collected reviews, this book is readable and complete. Particularly interesting is Chapter 8 on the cognitive sequelae, by Dr. Catherine Fine. As a profound disruption on development, incest allows for a close examination of the components of cognitive development. As Dr. Herman eloquently describes it, incest serves the same function as a linear accelerator and explodes the central core of one’s sense of self into its most minute particles.

Even after reading the objective and subjective evidence presented in this book, a dilemma remains. How can it be known without doubt that incest is truly the root cause of these symptom complexes? Not surprisingly, this is one of the same dilemmas that faces the incest survivor: Did this really happen? Is this really true? And, as with the incest survivor, one must begin by trusting the mounting evidence.

Dr. Safransky is a psychiatrist in private practice in Chapel Hill, NC.

Concise Guide to Consultation Psychiatry
By Michael G. Wise, M.D., and James R. Rundell, M.D.
ISBN 0-88048-123-4, $18.50
Reviewed by Susan Williamson, M.D.

As series editor Robert E. Hales, M.D., promises, this compact volume delivers high-density information in an accessible format. Scanning the table of contents on the way to see a patient, one can briskly locate the topic-at-hand and be reassured by a wealth of pertinent material. This little “peripheral brain” assists in organizing one’s thoughts regarding the most frequently asked questions of a consulting psychiatrist, including suicidality, dementia, depression, substance abuse, and legal issues. The book also includes coverage of special topics such as burns, HIV infection, transplantation, and impotence. In fact, the only area not readily found in this book is that of pregnancy and substance abuse. Outstanding in its genre, this “pocket coach” offers many readable charts, an excellent chapter on the mental status examination for the budding bedside neuropsychiatrist, and a list of further readings and references at the end of each chapter should more in-depth information be required for a particularly challenging case or an attending physician.
Dr. Williamson is a third-year resident, Department of Psychiatry, University of North Carolina, Chapel Hill, NC.

Psychiatry for Medical Students, 2nd Edition
By Robert J. Waldinger, M.D.
ISBN 0-88048-276-1, $49.95

Reviewed by Robert A. Bashford, M.D.

I evaluate this book as a teacher introducing second-year medical students to psychiatric concepts. I found the book to be a good review of the basics of our field. The author states in the preface that his aim is to provide fundamentals and an introduction to the major relevant topics of psychiatry. He has done that from schizophrenia to DSM-III-R, neurotransmitters, ECT, psychotherapy, and development. The text is divided into five logical segments: assessment skills, basic psychopathology, special populations, special problems, and treatment. The language is clear, plain, and almost conversational in style. The print is large and easy to read. The index is comprehensive, and the references are just enough in number and breadth for the beginning student. The four appendixes are brief but particularly helpful in outlining frequently abused drugs and common psychotropic medications with trade names. However, the appendixes outline only one clinical evaluation; I think the book would be well served by several additional clinical evaluations.

After using this text for 1 year, I have decided to let it speak for itself and use less extensive didactic lecturing on basic material, which frees me to supplement with more clinical material. I can also spend time elaborating on the basic material and introducing some early divergent viewpoints that are not covered in the text. Lack of even fundamental contemporary controversies is a limitation of this book and most beginning texts.

The intent of this text to serve as an introduction to psychiatry for beginners is obvious. It is not adequate for the more sophisticated reader, but therein probably lies its success. The author has stuck to introducing the basics and not tried to do too much. I think he has done an admirable job of coralling the exploding psychiatric literature, combining biologic/dynamic approaches, and even paying attention to the countertransference issues of young doctors confronting severe emotional distress for the first time.

I polled 10 second-year medical students from my class and each found the text readable, understandable, and even enjoyable. All felt it could be used with lectures and free even more time for supplementary work during class time. Most suggested an increase in patient interview examples to illustrate the text.

The most engaging aspect of the book was the manner in which the author addressed the personal issues involving the student of psychiatry. Attention is paid to what suicide, violence, personality disorder, and just psychiatric interviewing evokes in all of us. This material is encountered throughout the book and prepares the student to consider issues that may arise for a psychiatrist. The best-written "how to" chapter was on consultation-liaison psychiatry. One good reading will enable a competent third-year medical student to do a passable consultation. This chapter does an excellent job of clarifying the consultation question and directing answers to that question.

One other particularly well-written section was on treatment. In less than 100 pages, the beginning student can gain an excellent understanding of the rudiments of different psychotherapies, somatic therapies, and ECT. It is "cookbook" enough that one could understand at least the large concepts of the correct treatment and potential benefits and hazards of most psychiatric disorders.

This text is important to all trainees as an
Dr. Williamson is a third-year resident, Department of Psychiatry, University of North Carolina, Chapel Hill, NC.

Psychiatry for Medical Students, 2nd Edition
By Robert J. Waldinger, M.D.
ISBN 0-88048-276-1, $49.95
Reviewed by Robert A. Bashford, M.D.

I evaluate this book as a teacher introducing second-year medical students to psychiatric concepts. I found the book to be a good review of the basics of our field. The author states in the preface that his aim is to provide fundamentals and an introduction to the major relevant topics of psychiatry. He has done that from schizophrenia to DSM-III-R, neurotransmitters, ECT, psychotherapy, and development. The text is divided into five logical segments: assessment skills, basic psychopathology, special populations, special problems, and treatment. The language is clear, plain, and almost conversational in style. The print is large and easy to read. The index is comprehensive, and the references are just enough in number and breadth for the beginning student. The four appendixes are brief but particularly helpful in outlining frequently abused drugs and common psychotropic medications with trade names. However, the appendixes outline only one clinical evaluation; I think the book would be well served by several additional clinical evaluations.

After using this text for 1 year, I have decided to let it speak for itself and use less extensive didactic lecturing on basic material, which frees me to supplement with more clinical material. I can also spend time elaborating on the basic material and introducing some early divergent viewpoints that are not covered in the text. Lack of even fundamental contemporary controversies is a limitation of this book and most beginning texts.

The intent of this text to serve as an introduction to psychiatry for beginners is obvious. It is not adequate for the more sophisticated reader, but therein probably lies its success. The author has stuck to introducing the basics and not tried to do too much. I think he has done an admirable job of coralling the exploding psychiatric literature, combining biologic/dynamic approaches, and even paying attention to the countertransference issues of young doctors confronting severe emotional distress for the first time.

I polled 10 second-year medical students from my class and each found the text readable, understandable, and even enjoyable. All felt it could be used with lectures and free even more time for supplementary work during class time. Most suggested an increase in patient interview examples to illustrate the text.

The most engaging aspect of the book was the manner in which the author addressed the personal issues involving the student of psychiatry. Attention is paid to what suicide, violence, personality disorder, and just psychiatric interviewing evokes in all of us. This material is encountered throughout the book and prepares the student to consider issues that may arise for a psychiatrist. The best-written “how to” chapter was on consultation-liaison psychiatry. One good reading will enable a competent third-year medical student to do a passable consultation. This chapter does an excellent job of clarifying the consultation question and directing answers to that question.

One other particularly well-written section was on treatment. In less than 100 pages, the beginning student can gain an excellent understanding of the rudiments of different psychotherapies, somatic therapies, and ECT. It is “cookbook” enough that one could understand at least the large concepts of the correct treatment and potential benefits and hazards of most psychiatric disorders.

This text is important to all trainees as an
outline for how to treat what. From a teacher's standpoint, the more striking contribution lies in informing students how psychiatry is both different from and similar to other medical specialties. This is the most challenging task I have encountered in teaching beginners.

This book serves nonpsychiatric medicine and psychiatry well. I highly recommend it.

Dr. Bashford is clinical assistant professor, Department of Psychiatry, Clinical and Adolescent Division, University of North Carolina, Chapel Hill, NC.
Do house officers learn from their mistakes? Journal of the American Medical Association 1991; 265:2089–2094

Wu et al. mailed a questionnaire to 254 house officers in three internal medicine residency programs that asked them to describe their most significant medical mistake in the last year, their response to it, and the events that followed. A mistake was defined as an act of commission or omission with serious or potentially serious consequences for the patient.

Forty-five percent (114) responded, and their descriptions were analyzed by type, frequency, outcomes, and causes of mistakes; house officers’ and institutional responses to mistakes; and changes in practice.

The most common mistakes were errors in diagnosis (33%), followed by errors in prescribing and dosing (29%), errors in evaluation and treatment (21%), procedural complications (11%), and faulty communication (5%). In 90% of the cases, the patients had significant adverse outcomes, including physical and emotional discomfort, additional therapy or procedures, prolonged hospital stays, and death.

Examples of errors from each category that resulted in death were failure to diagnose eclampsia, prescription of lorazepam to patient with respiratory muscle weakness, induction of renal failure and congestive heart failure during work up of a hypoglycemic seizure, laceration of liver during liver biopsy, and acceptance of misinformation that a patient was not to be resuscitated.

The house officers were usually willing to accept responsibility for the incident and generally attributed the error to multiple causes that included lack of information and being too busy. Fatigue was cited as a factor in 41% of the cases. The house officers often experienced emotional distress, and a few reported that these negative feelings persisted.

Although most of the house officers discussed the mistake with someone, only 54% brought it to the attention of the supervising attending physician. Almost all residents reported some change in practice as a result of their mistake. Changes most frequently cited were paying more attention to detail, confirming clinical data personally, and seeking advice. Twenty-six percent said they were ordering more tests.

The authors suggest that supervisors can help residents learn from their mistakes by encouraging their trainees to report their errors and to accept responsibility for them while providing appropriate emotional support. They also suggest that there should be more active supervision and that issues of work load should be addressed to try to minimize mistakes.

A review of studies concerning effects of sleep deprivation and fatigue on residents’ performance.


Samkoff and Jacques reviewed the literature from 1970 to the present on the effects of sleep deprivation and fatigue on residents’ performances, moods, attitudes, and interactions with patients. They identified about 30 studies and also summarize the large sleep deprivation literature for non-physician populations. That body of work suggests that sleep deprivation clearly affects brain function with behavioral and psy-
Psychological performance declining after one night's sleep loss and declining further as sleep loss persists. Tasks that are prolonged, dull, or repetitive are particularly affected by fatigue.

The authors point out that the studies done on physician groups have often relied on measures that may not be sensitive enough nor is it clear how performance on these tasks is related to clinical work. The effects of acute sleep deprivation have been studied more than those of a chronic reduction in sleep.

The most obvious finding was changes in mood states. Residents were more angry and hostile after a sleepless night and at mid-year compared with the beginning of training, and symptoms of depression were also common. The effects on performance were less conclusive but suggest that performance of short tasks appears to suffer less than performance of tasks requiring sustained vigilance and concentration. Samkoff and Jacques state:

In the world of the hospitals in which they work, acutely sleep-deprived house officers may remain effective, if somewhat less efficient, in crises and other novel situations. Residents may be more prone to errors in routine, repetitive tasks that constitute much of their work (p. 692).

They conclude that the unfavorable effects of sleep deprivation on residents' moods, affects, and attitudes are clear and that more research needs to be done to establish definitively the effects on clinical care.


In 1985, the American Board of Internal Medicine (ABIM) issued a guide for evaluating humanistic qualities in internists, and this study reports on an effort to assess the validity and reliability of an instrument to be used by nurses to assess these qualities. The form contained 17 items that were subdivided into professional relationships (e.g., "The house officer respects your role in patient care.") and patient/family relationships (e.g., "The house officer respects the rights and choices of patients regarding their care"). There was also a general item that asked about the residents' overall ability to act with integrity, respect, and compassion.

A total of 116 internal medicine residents at three levels of training (PGY-1, -2, -3) from three diverse training sites were rated by 493 nurses on three occasions during the academic year. Nurses who volunteered to participate in the study had to have at least 2 years of postgraduate experience and regular contact with residents. Corresponding data were also collected from the attending physicians and house staff evaluation committee at each site. Residents received summaries of the first round of ratings from the nurses before the second round of ratings was obtained.

The nurses rated the majority of residents as having satisfactory to excellent interpersonal skills and humanistic behaviors, and the overwhelming majority (92%) of the nurses felt they could rate this dimension of resident behavior. The majority of residents described themselves as caring and compassionate, but only 19% thought nurses could adequately assess their humanistic behavior. There were no significant changes in the nurses' ratings over time, nor were there any differences due to training year, site, gender, or method of feedback.

Several generalizability (reliability) coefficients were calculated and 86% were between 0.61 and 0.98, indicating stable, reliable ratings.

The nurses' ratings were positively and significantly correlated with the attendings' ratings (0.38) and with the evaluation committees' ratings (0.49). The correlations between the two sets of physician ratings

In 1985, the American Board of Internal Medicine (ABIM) issued a guide for evaluating humanistic qualities in internists, and this study reports on an effort to assess the validity and reliability of an instrument to be used by nurses to assess these qualities. The form contained 17 items that were subdivided into professional relationships (e.g., "The house officer respects your role in patient care.") and patient/family relationships (e.g., "The house officer respects the rights and choices of patients regarding their care"). There was also a general item that asked about the residents' overall ability to act with integrity, respect, and compassion.

A total of 116 internal medicine residents at three levels of training (PGY-1, -2, -3) from three diverse training sites were rated by 493 nurses on three occasions during the academic year. Nurses who volunteered to participate in the study had to have at least 2 years of postgraduate experience and regular contact with residents. Corresponding data were also collected from the attending physicians and house staff evaluation committee at each site. Residents received summaries of the first round of ratings from the nurses before the second round of ratings was obtained.

The nurses rated the majority of residents as having satisfactory to excellent interpersonal skills and humanistic behaviors, and the overwhelming majority (92%) of the nurses felt they could rate this dimension of resident behavior. The majority of residents described themselves as caring and compassionate, but only 19% thought nurses could adequately assess their humanistic behavior. There were no significant changes in the nurses' ratings over time, nor were there any differences due to training year, site, gender, or method of feedback.

Several generalizability (reliability) coefficients were calculated and 86% were between 0.61 and 0.98, indicating stable, reliable ratings.

The nurses' ratings were positively and significantly correlated with the attendings' ratings (0.38) and with the evaluation committees' ratings (0.49). The correlations between the two sets of physician ratings
was 0.63. However, the attendings' ratings were significantly higher than the nurses' and the evaluators' ratings, which suggests that they were using different standards to assess the residents.

The authors conclude that the form was assessing the qualities of respect, integrity, and compassion that are of interest to the ABIM and internal medicine training program directors and that nurses were consistent, reliable raters. They suggest that the form could be easily used at other institutions with ratings from five to six nurses needed for reliability. Obtaining data from nurses provides a somewhat different perspective on residents' humanistic behaviors than that of medical faculty.


Peters and Schimpfhauser compared student self-evaluations with faculty evaluations for each of five third-year clinical rotations (medicine, obstetrics/gynecology, pediatrics, psychiatry, and surgery). Both groups used the same 16-item checklist that was subsequently collapsed into three factors on the basis of factor analyses and expert opinion. These factors were knowledge and clinical judgment, initiative and interpersonal skills, and clinical management skills. Students were given the faculty ratings after each rotation and asked to compare them with their own ratings. Faculty did not receive the students' self-evaluations. Complete data were available for 114 students, who also completed a brief summary questionnaire at the end of the year.

The students rated themselves higher on initiative and interpersonal skills than on the other two skills for all the rotations. These ratings did not change over time, whereas their ratings of knowledge and clinical judgment and clinical management skills increased over the year. Correlations among the ratings for the first four clerkships were all in the moderate range (0.43–0.52) for all three skills, whereas those between the first and fifth clerkships were lower (0.33–0.36).

The mean faculty ratings tended to increase over time but not as much as the self-ratings did, and the faculty also rated the students higher on the initiative and interpersonal skills factor than on the other two. The mean student ratings were higher than the mean faculty ratings for all three skills across all rotations; these differences tended to increase over time. The correlation between the faculty and student ratings was higher for the knowledge and clinical judgment factor (0.45) than for the clinical management skills (0.33) and initiative and interpersonal skills (0.30).

At the end of the year, almost all of the students indicated that they felt there was little difference between their self-ratings and those from faculty and, perhaps as a result, they also said that comparing the ratings did not help them alter their performance in subsequent rotations. A majority of the students (67%) felt that they had no difficulty rating their own performance.

The researchers had expected the student ratings to become more similar to the faculty ratings over time; instead, there was a pattern of divergence that was especially significant for clinical management skills. The students' perception was that the ratings were in fact similar. The authors suggest that "after a certain amount of clinical experience, students' personal standards replace external standards" (p. 487) and call for further investigation of the relationship between feedback and performance.
**Letter**

**The Well-Read Psychiatrist**

SIR: Resident physicians are inundated with information and frequently lack time, direction, and, alas, motivation for professional reading and introspection. The myriad schools of thought and the vast territory from molecules to the mind make it difficult for psychiatry trainees to know where to begin. However, reading from a variety of sources can be a solace from the strains of intense patient interactions.

Psychiatric study is best undertaken as a shared adventure of teacher and student. One joy of growth and development as a psychiatry resident has been the discovery that faculty share similar literary places of refuge. An even greater discovery has been that golden moments may occur between resident and supervisory faculty members not only during discussions of nonpsychiatric writings (for their own merits or in reference to a specific psychotherapeutic scenario) but also while sharing favorite, particularly meaningful passages from the masters of our craft—passages that speak to each in a special way and spark a certain resonance during the supervisory moment, making it a collegial one. Shared readings between resident and supervisor may become “the foundation of a solid and enduring friendship” (1). This study was undertaken to foster the well-read, well-rounded psychiatrist tradition by surveying a distinguished, diverse medical faculty of psychiatry for a core of indispensable reading. This approach has a historical basis (2).

**Methods**

During the winter of 1990, we sent 128 questionnaires to physician-faculty members of the Department of Psychiatry at the University of Texas Southwestern Medical Center at Dallas. We followed up with a second round of questionnaires to nonrespondents. Volunteer and consulting faculty and full-time faculty were surveyed. Faculty members were asked to survey their private bookcases and/or reprint files to make their best recommendations in four equally important categories that reflected various unquantifiable aspects of the faculty members’ personal opinions about these books. The categories were 1) “would rescue in a fire,” 2) “would never loan,” 3) “wished you had read before the boards,” and 4) “would read if you had the time.” Faculty could list four or more articles/books in each of these four categories. No restrictions were placed upon the nature of the recommendations; psychiatric, medical, and nonmedical literature were all fair game.

**Results**

Forty surveys from the first mailing and 13 surveys from the second mailing were returned. Of these, 50 surveys were completed and comprise the data for this study.

Over 190 individual book titles were mentioned. Table 1 lists by category the books cited at least twice by the faculty. The work cited most often in any category was *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (3). Seven faculty members reported that they would never loan this reference; four responded that the *Standard Edition* would be the one work that they would retrieve in a fire. The faculty members held the same regard for various editions of *The Comprehensive Textbook of Psychiatry*; five faculty said they would retrieve “The CTP” in a fire, and another six said they wished they had read it before the boards.

Most of the volumes cited with any frequency by the faculty were well-established works in the field. The DSM-III-R and the American Psychiatric Association’s *Annual Reviews* were included by several faculty members in at least one of the four categories. Many respondents also listed the general or collected works of Johann Wolfgang von Goethe, Sidney Tarachow, Frieda Fromm-Reichmann, Philip Dick (science fiction), Jacques Lacan, and Roy Shafer. Of par-
ticular note was the great frequency of mention of the new classic on manic-depressive illness by Goodwin and Janison (4).

Only two journal articles were mentioned: "Countertransference Hate in the Treatment of Suicidal Patients" and "Sociopathy as a Human Process: A Viewpoint," both published in the Archives of General Psychiatry (5,6).

A second list (available from the authors upon request) of over 100 books currently in print was also compiled. These books received single mentions as "personal favorites" that were read over the years by faculty members. The readings in this group ran the gamut from general psychiatry, substance abuse, schizophrenia, depression, and psychoanalytic therapy to classical literature,

### TABLE 1. Number of times books were listed by faculty as "would rescue in fire," "would never loan," "wished you had read before the boards," and "would read if you had the time"

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>Author</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>American Psychiatric Association</td>
<td>DSM-III-R</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td>Talbott, Hales, and Yudofsky</td>
<td>Textbook of Psychiatry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>American Psychiatric Association</td>
<td>Treatments of Psychiatric Disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>American Psychiatric Association</td>
<td>Annual Review Series</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Beck et al.</td>
<td>Cognitive Therapy of Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Bettelheim</td>
<td>The Uses of Enchantment: The Meaning and Importance of Fairy Tales</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Brenner</td>
<td>An Elementary Textbook of Psychoanalysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Edelman</td>
<td>The Remembered Present: A Biological Theory of Consciousness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Ellenberger</td>
<td>The Discovery of the Unconscious: The History and Evolution of Dynamic Psychiatry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Fenichel</td>
<td>The Psychoanalytic Theory of Neurosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Fraiberg</td>
<td>The Magic Years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Frances et al.</td>
<td>Differential Therapeutics in Psychiatry: The Art and Science of Treatment Selection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Freud, Anna</td>
<td>Ego and the Mechanisms of Defense</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Goodman and Gilman</td>
<td>Pharmacological Basis of Therapeutics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Goodwin and Guze</td>
<td>Psychiatric Diagnosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Goodwin and Jamison</td>
<td>Manic Depressive Illness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Greenberg and Mitchell</td>
<td>Object Relations in Psychoanalytic Theory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Greenzon</td>
<td>Technique and Practice of Psychoanalysis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>7</td>
<td>Strachey</td>
<td>The Standard Edition of the Complete Psychological Works of Sigmund Freud</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Hales and Yudofsky</td>
<td>American Psychiatric Press Textbook of Neuropsychiatry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Havens</td>
<td>Approaches to the Mind</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>Kaplan and Sadock</td>
<td>Comprehensive Textbook of Psychiatry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Kaufman</td>
<td>Clinical Neurology for Psychiatrists</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Lishman</td>
<td>Organic Psychiatry: The Psychological Consequences of Cerebral Disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>MacKinnon and Yudofsky</td>
<td>Psychiatric Evaluation in Clinical Practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Mahler</td>
<td>Psychological Birth of the Human Infant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Morrison and Munoz</td>
<td>Boarding Time: A Psychiatry Candidate's Guide to Part I of the ABPN Examination</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Yalom</td>
<td>Theory and Practice of Group Psychotherapy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: A = rescue in fire; B = never loan; C = boards review; D = read if had time.
All of these sources were mentioned by at least two different faculty members.
the individual works of Shakespeare, and the Decline and Fall of the Roman Empire.

Discussion

The authors recognize that this study is limited to a single faculty and has a small rate of questionnaire return. As such, our findings cannot be generalized to other institutions. This limited pilot study warrants expansion to evaluate the influence of age and theoretical philosophy on the recommendations of the respondents.

Psychiatry is in great flux. During “the decade of the brain,” huge strides have been made in the molecular understanding of its function. Many fear that the original object of this information explosion—humanity—has been forgotten (7). Opposing tugs of the new biological studies of the brain and classic psychoanalytic teachings about the structure and function of the mind have been felt in lively debates at national psychiatric meetings and are displayed in the plethora of biologically and psychodynamically oriented journals and newsletters. A few exciting articles have begun to bridge the gap between biological and psychological realms; studies of the biology of the mind and self have given rise to thought-provoking articles, such as one on the biology of empathy (8).

The psychiatrist-in-training yearns for those who can help synthesize these different views of mankind. Beginning students of the mind seek a solid core of knowledge on which they can fit new ideas. Supervisors are sought who are skillful in testing these new ideas empirically and methodically to reject them or weave them into a new integrated understanding. To confront the divergent biological and psychodynamic models of man without strong guidance and framework is perhaps an impossible task.

We report here the professional literary preferences of a single faculty. Members internationally known for their biologically based research frequently cited psychodynamically based readings as those they felt most important. Not everyone who listed Freud’s Standard Edition as volumes of importance was a psychoanalyst. Apparently, in this institution, many psychiatrists with strong interest in the biologic basis of brain function keep a sturdy two-wheeled book trolley by the front door to wheel out these precious volumes in case of emergency!

Though classic psychoanalytic thought was well-represented, this faculty also emphasized the latest research in self- and egopsychology theory. The schism between mind and brain was seemingly bridged by this faculty in that neuroanatomical, neurochemical, and clinical neurological references were also strongly represented.

Psychiatry’s breadth was reflected by the wide range of recommendations in subspecialty topics, while its technical aspects were emphasized in areas as diverse as ECT and psychoanalysis. The close relationships between history, philosophy, and the human mind; the close ties of psychiatry with religion in the quest for the true human nature; and human reflection in one’s own written word were emphasized in the personal favorites (not published here). Finally, that psychiatry is a branch of medicine, the art, craft, and study of the essence of mankind, was evidenced by the inclusion of Osler’s seminal work, Aequanimitas.

Claudia L. Greene, M.D.
Deborah A. Miller, Ph.D.
Department of Psychiatry
Dallas Veterans Affairs Medical Center, and
University of Texas Southwestern Medical Center, Dallas, TX

References

Academic Psychiatry

Editor
JONATHAN F. BORUS, M.D.
Boston, Mass.

Deputy Editor
WILLIAM H. SLEDGE, M.D.
New Haven, Conn.

Book Forum Editor
SEYMOUR L. HALLECK, M.D.
Chapel Hill, N.C.

Abstracts Editor
DORTHEA JUUL, Ph.D.
Deerfield, Ill.

Editorial Board Members
ARNOLD M. COOPER, M.D.
New York, N.Y.
MINA K. DULCAN, M.D.
Atlanta, Ga.
ROBERT E. HALES, M.D.
San Francisco, Calif.
JERALD KAY, M.D.
Dayton, Ohio
JAMES LOMAX II, M.D.
Houston, Tex.
CAROLYN B. ROBINOWITZ, M.D.
Washington, D.C.
STEPHEN C. SCHEIBER, M.D.
Chicago, Ill.

STEFAN STEIN, M.D.
New York, N.Y.
ALAN STOUDEMIRE, M.D.
Atlanta, Ga.
GORDON STRAUSS, M.D.
Los Angeles, Calif.
ZEBULON TAINTOR, M.D.
New York, N.Y.
GARY J. TUCKER, M.D.
Seattle, Wash.
SHERWYN M. WOODS, M.D.
Los Angeles, Calif.
JOEL YAGER, M.D.
Los Angeles, Calif.

Corresponding Member Organizations
American Association of Chairmen of Departments of Psychiatry
Association for the Study of Medical Education (United Kingdom)
Association of Directors of Medical Student Education in Psychiatry
Association of University Professors of Psychiatry (United Kingdom)
Coordinators of Psychiatric Education (Canada)
Coordinators of Undergraduate Psychiatric Education (Canada)
Society of Professors of Child Psychiatry

Academic Psychiatry (formerly the Journal of Psychiatric Education) publishes material describing educational efforts for and by psychiatrists as well as articles addressing other issues relevant to the academic missions of departments of psychiatry. The journal provides a forum for work which furthers knowledge in psychiatric education and stimulates improvements in academic psychiatry.
Journal Policy
Advisory Committee
CAROL C. NADELSON, M.D.
Editor-in-Chief
JONATHAN F. BORUS, M.D.
Editor
Academic Psychiatry
GENE D. COHEN, M.D.
Editor
The American Journal of Geriatric Psychiatry
SHERVERT H. FRAZIER, M.D.
JERALD KAY, M.D.
Editor
The Journal of Psychotherapy Practice and Research
SHELTON J. MILLER, M.D.
Editor
The American Journal on Addictions
ROBERT O. PASNAU, M.D.
THOMAS N. WISE, M.D.
Editor-in-Chief
Psychosomatics
STUART C. YUDOPSKY, M.D.
Editor
The Journal of Neuropsychiatry and Clinical Neurosciences
Board of Directors
MELVIN SARBIN, M.D.
President and
Chairman of the Board
ELISSA P. BENEDEK, M.D.
DOYLE I. CARSON, M.D.
LAWRENCE HARTMANN, M.D.
RALPH A. O'CONNELL, M.D.
ROBERT O. PASNAU, M.D.
JOHN A. TALBOTT, M.D.
Ex Officio
CAROL C. NADELSON, M.D.
Editor-in-Chief
RONALD E. Mc MILLEN
General Manager
SHERVERT H. FRAZIER, M.D.
Founder Consultant

American Psychiatric Press, Inc.
Journals Division
JOHN McDUFFIE
Managing Editor
MARTIN LYNDS
ROXANNE RHODES
Assistant Editors
SOL ELENA MORALES
Editorial Assistant
CLAIRE REINBURG
Editorial Director
JANE HOOVER DAVENPORT
Electronic Prepress Director
JOANIE LEFKOWITZ
Electronic Prepress Manager
RICHARD BARDES
Business Manager
BETH PRESTER
Circulation Manager
JACQUELINE COLEMAN YOUNG
Fulfillment Manager
JON O. JENSEN
Director of Marketing
MARK BLOOM
Advertising and Marketing Manager


Subscriptions are $85 a year (4 issues) individuals; $135 institutions; $42.50 residents. Foreign subscriptions are $100 a year individuals; $150 institutions. Single issues are U.S. $35; foreign $40. All single issue orders must include prepayment. For information on subscriptions, single issues, address changes, and adjustments, telephone (202) 682-6240 or write to Academic Psychiatry, American Psychiatric Press, Inc., 1400 K Street, N.W., Washington, DC 20005.

Members of the following organizations receive Academic Psychiatry as a perquisite of membership: the American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry. Members of the Corresponding Member Organizations (see list on previous page) are entitled to a 20% discount on subscriptions through membership in their organization.

Advertising inquiries may be sent to Mark Bloom, Academic Psychiatry, American Psychiatric Press, Inc., 1400 K Street, N.W., Washington, DC 20005, (202) 682-6213. American Psychiatric Press, Inc., the American Association of Directors of Psychiatric Residency Training, the Association for Academic Psychiatry, and the Corresponding Member Organizations do not hold themselves responsible for statements made in this publication by contributors or advertisers. Unless stated, material in Academic Psychiatry does not reflect the endorsement, official attitude, or position of the American Psychiatric Press, Inc., the American Association of Directors of Psychiatric Residency Training, the Association for Academic Psychiatry, or the Corresponding Member Organizations.

Academic Psychiatry is abstracted and indexed in Psychological Abstracts, Excerpta Medica, Chicago Psychonomic Literature, Social Sciences Citation Index, Current Contents/Social and Behavioral Sciences, Automatic Subject Citation Index, Abstracts Research Pastoral Care, Current Opinion in Psychiatry, and Information Updates.
The American Association of Directors of Psychiatric Residency Training

Salutes the Selection of the

1993 GEORGE GINSBERG-AADPRT/CHARTER FELLOWS

Eileen Ahearn, M.D., Ph.D.
Duke University

Angela Hale, M.D.
Mount Sinai School of Medicine

Kathleen A. Kovner-Kline, M.D.
University of Connecticut

John Martyniuk, M.D., Ph.D.
Temple University

Paul Reardon, M.D.
University of California - Irvine

Michael E. Scott, M.D.
University of Arizona

Arthur L. Smith III, M.D.
St. Louis University

We look forward to their active participation in the AADPRT 1993 Mid-Winter Meeting and their ongoing commitment to the pursuit of excellence in psychiatric education and their future involvement in AADPRT.
# Author Index

**A**


**C**

- Carter RE: Criteria for the academic promotion of medical school-based psychiatrists. Fall 147–152
- Cavey C: See Ruedrich SL
- Chiang E, Bayer TL, Coverdale JH, Lomax JW: Evaluating the evaluations of psychiatry residents. Fall 153–159
- Coverdale JH: See Chiang E
- Coverdale JH, Bayer T, Isbell P, Moffic S: Are we teaching psychiatrists to be ethical? Winter 199–205
- Cretella H: See Racusin RJ

**D**

- Davis KL: See Swiller HI
- Drell MJ: See Josephson AM

**F**

- Fabrega H, Robles N, Benjamin L, Ulrich R: Medical students' evaluation of live psychiatric interviews. Spring 1–9
- Fairbanks L: See Ungerleider JT
- Faulkner LR: See Frierson RL
- Fine MA: See Mulderig J

**G**

- Gabbard GO: The big chill: the transition from residency to managed care nightmare. Fall 119–126
- Grush L: See Ruedrich SL

**H**

- Howard KI: See Jones SH

**I**

- Isbell P: See Coverdale JH

**J**

- Jones SH, Krasner RF, Howard KI: Components of supervisors' ratings of therapists' skillfulness. Spring 29–36
- Josephson AM, Drell MJ: Didactic modules for curricular development in child and adolescent psy-
K

Katz K: See Ruedrich SL
Kay J, Bienefeld D: The role of residency training director in psychiatric recruitment (commentary). Fall 127–133
Klein H: Therapist-initiated patient transfer in the residency training setting. Spring 37–43
Krasner RF: See Jones SH

L

Lomax JW: See Chiang E

M

MacDonald DM: Trends in the teaching of analytically oriented psychiatry and psychotherapy. Summer 83–89
Mann LS: See Steg JA
Markert RJ: See Rodenhauser P
Mega LT, Rand EH, Ritter KE: Textbooks and software used to teach behavioral science and clinical psychiatry to medical students. Spring 14–23
Miller D: See Mohl PC
Miller DA: See Greene CL
Moffic S: See Coverdale JH
Mohl PC, Miller D, Sadler JZ: Psychiatry residency accreditation and measuring educational outcomes. Winter 192–198
Mulderig J, Sansone RA, Fine MA: Psychiatry residents’ attitudes toward personal involvement in research. Summer 96–102

P

Pechnick RN: See Ungerleider JT
Porterfield PB: See Yank GR

R

Rand EH: See Mega LT
Ritchie EC, White R: Cognitive therapy training in U.S. psychiatry residency programs. Summer 90–95
Ritter KE: See Mega LT
Robles N: See Fabrega H
Rodenhauser P, Smith CJ, Markert RJ: Gender influence on specialists’ ratings of residency program candidates. Fall 134–140
Rowan JJ: The Founders of Humanistic Psychology, by Jose de Carvalho R (book review). Fall 170
Ruedrich SL, Cavey C, Katz K, Grush L: Recognition of teaching excellence through the use of teaching awards: a faculty perspective. Spring 10–13

S

Sadler JZ: See Mohl PC
Sansone RA: See Mulderig J
Schwartz RH: See Steg JA
Siegel N: See Ungerleider JT
Smith CJ: See Rodenhauser P
Sparr LF: Recruitment of academic psychiatrists: applicants’ decision factors. Fall 141–146
Spradlin WW: See Yank GR
Steg JA, Mann LS, Schwartz RH, Wise TN, Bailey GW: Comparison of child psychiatry residents’ and training directors’ perceptions of training for alcohol and substance abuse treat-
ment. Summer 103–108
Summit P: See Burt VK
Susman VL: See Braun D
Swiller HI, Davis KL: Continuing education in psychotherapy as a method
to attract and involve voluntary faculty in an academic department of
psychiatry. Winter 186–191

T

Thorbeck J: The development of the psycho-
dynamic psychotherapist in supervision. Summer 72–82

U

Ulrich R: See Fabrega H
Ungerleider JT, Pechnick RN, Wallbom AS, Siegel

V

Verhulst J: The sexuality curriculum in residency training (letter). Summer
115–117

W

Wallbom AS: See Ungerleider JT
White R: See Ritchie EC
Williamson S: Concise Guide to Consultation Psychiatry, by Wise MG,
Rundell JR (book review). Winter 214

Wise TN: See Steg JA
Witterholt S: Trauma and Recovery: The Aftermath of Violence From Domestic to
Political Terror, by Herman JL (book review). Winter 212–213

Y

Yager J: See Burt VK
Yank GR, Spradlin WW, Porterfield PB: General systems approaches in mental health administration: developing state-
university collaboration programs. Summer 59–71

Z

Ziedonis DM: See Ungerleider JT

Subject Index

A

Academic Promotion
Criteria for the academic promotion of medical school-based psychiatrists. Carter RE. Fall 147–152

Academic Trends
Trends in the teaching of analytically oriented psychiatry and psychotherapy. MacDonald DM. Summer 83–89

Accreditation
Psychiatry residency accreditation and measuring educational outcomes. Mohl PC, Miller D, Sadler JZ. Winter 192–198

Alcohol Abuse
Comparison of child psychiatry residents' and training directors' perceptions of training for alcohol and substance abuse treatment. Steg JA, Mann LS, Schwartz RH, Wise TN, Bailey GW. Summer 103–108

Attitudes
Comparison of child psychiatry residents' and training directors' perceptions of training for alcohol and substance abuse treatment. Steg JA, Mann LS, Schwartz RH, Wise TN, Bailey GW. Summer 103–108

Pregnancy during psychiatry residency: a study of attitudes. Braun D, Sus-
Ongoing

Handbook of the Evaluation of Equilibration, Concise Adult Books, and Textbooks of Behavioral Recognition. Awards

Assessment of teaching excellence through the use of teaching awards: a faculty perspective. Ruedrich SL, Cavey C, Katz K, Grush L. Spring 10–13

Behavioral Science

Textbooks and software used to teach behavioral science and clinical psychiatry to medical students. Mega LT, Rand EH, Ritter KE. Spring 14–23

Books Reviewed

Adult Children of Divorce, by Beal EW, Hochman G. Summer 111

Concise Guide to Consultation Psychiatry, by Wise MG, Rundell JR. Winter 214

Equilibration, Mind, and Brain: Toward an Integrated Psychology, by Parkins EJ. Summer 111

Evaluation of the Psychiatric Patient: A Primer, by Halleck SL. Spring 52–53

The Founders of Humanistic Psychology, by Jose de Carvalho R. Fall 170

Handbook of Family Therapy, Volume 2, edited by Gurman AS, Kniskern DP. Fall 171

Hidden Conversations: An Introduction to Communicative Psychoanalysis, by Smith DL. Summer 109–110

How to Win as a Step Family, by Visher EB, Visher JS. Summer 111

Incest-Related Syndromes of Adult Psychopathology, edited by Kluft R. Winter 213–214


Psychotropic Drugs: Fast Facts, by Maxmen JS. Fall 170

Putting On The Brakes, by Quinn PO, Stern JM. Summer 111

Scapegoating in Families: Intergenerational Patterns of Physical and Emotional Abuse, by Pillari V. Fall 170–171

Solving Problems in Couples and Family Therapy: Techniques and Tactics, by Sherman R, Oresky P, Rountree Y. Fall 171

Trauma and Recovery: The Aftermath of Violence From Domestic to Political Terror, by Herman JL. Winter 212–213

Child/Adolescent Psychiatry

Comparison of child psychiatry residents’ and training directors’ perceptions of training for alcohol and substance abuse treatment. Steg JA, Mann LS, Schwartz RH, Wise TN, Bailey GW. Summer 103–108

Didactic modules for curricular development in child and adolescent psychiatry education (new idea). Josephson AM, Drell MJ. Spring 44–51

Use of a matrix in designing training experiences: experience in a rural child and adolescent training program. Racusin RJ, Cretella H. Winter 206–211

Clinical Psychiatry

Textbooks and software used to teach behavioral science and clinical psychiatry to medical students. Mega LT, Rand EH, Ritter KE. Spring 14–23

Cognitive Therapy

Cognitive therapy training in U.S. psychiatry residency programs. Ritchie EC, White R. Summer 90–95

Commentaries

The role of residency training director in psychiatric recruitment. Kay J, Bienfenfeld D. Fall 127–133

Continuing Education

Continuing education in psychotherapy as a method to attract and involve voluntary faculty in an academic department of psychiatry. Swiller HI, Davis KL. Winter 186–191
Curriculum Content
Didactic modules for curricular development in child and adolescent psychiatry education (new idea). Josephson AM, Drell MJ. Spring 44–51
The sexuality curriculum in residency training (letter). Verhulst J. Summer 115–117

D

Depression
Cognitive therapy training in U.S. psychiatry residency programs. Ritchie BC, White R. Summer 90–95

E

Educational Literature
Abstracted
Butterfield PS, Mazzaferri EL: A new rating form for use by nurses in assessing residents' humanistic behavior. Winter 218–219
Case SM, Downing SM: Performance of various multiple-choice item types on medical specialty examinations: types A, B, C, K, and X. Spring 55–56
Dawson-Saunders B, Nungester RJ, Downing SM: A comparison of single best answer multiple-choice items (A-type) and complex multiple-choice items (K-type). Spring 55–56
Edwards JC, Kissling GE, Plauche WC, Marier RL: Evaluation of a teaching skills improvement program for residents. Fall 173–174
Edwards JC, Kissling GE, Brannan JR, Plauche WC, Marier RL: Study of teaching residents how to teach. Fall 173–174
Helms LB, Helms CM: Forty years of litigation involving medical students and their education: I. general educational issues. Summer 112–114
Helms LB, Helms CM: Forty years of litigation involving residents and their education: II. malpractice issues. Summer 112–114
Samkoff JS, Jacques CHM: A review of studies concerning effects of sleep deprivation and fatigue on residents' performance. Winter 217–218
Stritter FT, Bland CJ, Youngblood PL: Determining essential faculty competencies. Fall 174
Veloski JJ, Hojat M, Gonnella JS: A validity study of Part III of the National Board Examination. Spring 54
Wu AW, Folkman S, McPhee SJ, Lo B: Do house officers learn from their mistakes? Winter 217
Evaluations
Components of supervisors' ratings of therapists' skillfulness. Jones SH, Krasner RF,
Howard Kl. Spring 29–36
Evaluating the evaluations of psychiatry residents. Chiang E, Bayer TL, Coverdale JH, Lomax JW. Fall 153–159
Gender influence on specialists’ ratings of residency program candidates. Rodenhauser P, Smith CJ, Markert RJ. Fall 134–140
Medical students’ evaluation of live psychiatric interviews. Fabrega H, Robles N, Benjamin L, Ulrich R. Spring 1–9
Psychiatry residency accreditation and measuring educational outcomes. Mohl PC, Miller D, Sadler JZ. Winter 192–198

F

Faculty
Continuing education in psychotherapy as a method to attract and involve voluntary faculty in an academic department of psychiatry. Swiller HI, Davis KL. Winter 186–191
Criteria for the academic promotion of medical school-based psychiatrists. Carter RE. Fall 147–152
Recognition of teaching excellence through the use of teaching awards: a faculty perspective. Ruedrich SL, Cavey C, Katz K, Grush L. Spring 10–13
Recruitment of academic psychiatrists: applicants’ decision factors. Sparr LF. Fall 141–146

G

Gender
Gender influence on specialists’ ratings of residency program candidates. Rodenhauser P, Smith CJ, Markert RJ. Fall 134–140
Letters
The sexuality curriculum in residency training. Verhulst J. Summer 115–117
The well-read psychiatrist. Greene CL, Miller DA. Winter 220–223

M

Managed Care
The big chill: the transition from residency to managed care nightmare. Gabbard GO. Fall 119–126
Medical Ethics
Are we teaching psychiatrists to be ethical? Coverdale JH, Bayer T, Isbell P, Moffic S. Winter 199–205
Medical Literature
The well-read psychiatrist (letter). Greene CL, Miller DA. Winter 220–223
Medical Students
Medical students’ evaluation of live psychiatric interviews. Fabrega H, Robles N, Benjamin L, Ulrich R. Spring 1–9
Textbooks and software used to teach behavioral science and clinical psychiatry to medical students. Mega LT, Rand EH, Ritter KE. Spring 14–23

Mental Health Administration
General systems approaches in mental health administration: developing state-university collaboration programs. Yank GR, Spradlin WW, Porterfield PB. Summer 59–71

N

New Ideas
Didactic modules for curricular development in child and adolescent psychiatry education. Josephson AM, Drell MJ. Spring 44–51

O

Outpatient Management
Outpatient management teams: integrating educational and administrative tasks. Burt VK, Summit P, Yager J. Spring 24–28

P

Patient Transfer
Therapist-initiated patient
transfer in the residency training setting. Klein H. Spring 37–43

Pregnancy

Psychiatric Interviews
Medical students’ evaluation of live psychiatric interviews. Fabrega H, Robles N, Benjamin L, Ulrich R. Spring 1–9

Psychototherapy
Cognitive therapy training in U.S. psychiatry residency programs. Ritchie EC, White R. Summer 90–95

Components of supervisors’ ratings of therapists’ skillfulness. Jones SH, Krasner RF, Howard KL. Spring 29–36

Continuing education in psychotherapy as a method to attract and involve voluntary faculty in an academic department of psychiatry. Swiller HI, Davis KL. Winter 186–191

The development of the psychodynamic psychotherapist in supervision. Thorbeck J. Summer 72–82

Therapist-initiated patient transfer in the residency training setting. Klein H. Spring 37–43

Trends in the teaching of analytically oriented psychiatry and psychotherapy. MacDonald DM. Summer 83–89

R

Recruitment
Recruitment of academic psychiatrists: applicants’ decision factors. Sper LF. Fall 141–146

The role of residency training director in psychiatric recruitment (commentary). Kay J, Bienenfeld D. Fall 127–133

Residency Selection
Gender influence on specialists’ ratings of residency program candidates. Rodenhauser P, Smith CJ, Markert RJ. Fall 134–140

Residency Training, Child/Adolescent Psychiatry
Use of a matrix in designing training experiences: experience in a rural child and adolescent training program. Racusin RJ, Cretella H. Winter 206–211

Residency Training, Cognitive Therapy
Cognitive therapy training in U.S. psychiatry residency programs. Ritchie EC, White R. Summer 90–95

Residency Training, Evaluations
Evaluating the evaluations of psychiatry residents. Chiang E, Bayer TL, Coverdale JH, Lomax JW. Fall 153–159

Residency Training, Managed Care
The big chill: the transition from residency to managed care nightmare. Gabbard GO. Fall 119–126

Outpatient management teams: integrating educational and administrative tasks. Burt VK, Summit P, Yager J. Spring 24–28

Residency Training, Patient Transfer
Therapist-initiated patient transfer in the residency training setting. Klein H. Spring 37–43

Residency Training, Psychotherapy
The development of the psychodynamic psychotherapist in supervision. Thorbeck J. Summer 72–82

Residency Training, Recruitment
The role of residency training director in psychiatric recruitment (commentary). Kay J, Bienenfeld D. Fall 127–133

Residency Training, Research
Psychiatry residents’ attitudes toward personal involvement in research. Mulderig J, Sansone RA, Fine MA. Summer 96–102
Residency Training, Sexuality
The sexuality curriculum in residency training (letter): Verhulst J. Summer 119-117

Residency Training, Substance Abuse
Comparison of child psychiatry residents' and training directors' perceptions of training for alcohol and substance abuse treatment. Steg JA, Mann LS, Schwartz RH, Wise TN, Bailey GW. Summer 103-108


Supervision
Components of supervisors' ratings of therapists' skillfulness. Jones SH, Krasner RF, Howard KI. Spring 29-36

The development of the psychodynamic psychotherapist in supervision. Thorbeck J. Summer 72-82

Software
Textbooks and software used to teach behavioral science and clinical psychiatry to medical students. Mega LT, Rand EH, Ritter KE. Spring 14-23

State-University Collaboration
General systems approaches in mental health administration: developing state-university collaboration programs. Yank GR, Spradlin WW, Porterfield PB. Summer 59-71

Substance Abuse
Comparison of child psychiatry residents' and training directors' perceptions of training for alcohol and substance abuse treatment. Steg JA, Mann LS, Schwartz RH, Wise TN, Bailey GW. Summer 103-108

Outpatient management teams: integrating educational and administrative tasks. Burt VK, Summit P, Yager J. Spring 24-28

Recognition of teaching excellence through the use of teaching awards: a faculty perspective. Ruedrich SL, Cavey C, Katz K, Grush L. Spring 10-13

Trends in the teaching of analytically oriented psychiatry and psychotherapy. MacDonald DM. Summer 83-89

Use of a matrix in designing training experiences: experience in a rural child and adolescent training program. Racusin RJ, Cretella H. Winter 206-211

Textbooks
Textbooks and software used to teach behavioral science and clinical psychiatry to medical students. Mega LT, Rand EH, Ritter KE. Spring 14-23

Teaching Methods
Didactic modules for curricular development in child and adolescent psychiatry education (new idea). Josephson AM, Drell MJ. Spring 44-51


Worksite Choices
Recruitment of academic psychiatrists: applicants' decision factors. Sparr LF. Fall 141-146
Statement of Ownership, Management and Circulation  
(Required by 39 U.S.C. 3685)

1A. Title of Publication  
Academic Psychiatry

1B. PUBLICATION NO.  
1 0 4 2 9 6 7 0

2. Date of Filing  
10/31/92

5. Frequency of Issue  
Quarterly

5A. No. of Issues Published Annually  
4 (four)

5B. Annual Subscription Price  
$85.00

4. Complete Mailing Address of Known Offices of Publication (Street, City, County, State and ZIP +4 Code) (See preview)  
American Psychiatric Press, Inc.  
1400 K Street N.W., Washington DC 20005

5. Complete Mailing Address of the Headquarters of General Business Offices of the Publisher (If preview)  
American Psychiatric Press, Inc.  
1400 K Street N.W., Washington DC 20005

8. Full Names and Complete Mailing Address of Publisher, Editor, and Managing Editor (This line MUST NOT be Masked)  
Publisher (Name and Complete Mailing Address)  
American Psychiatric Press, Inc.  
1400 K Street N.W., Washington DC 20005

Managing Editor (Name and Complete Mailing Address)  
Jonathan F. Borus, M.D., above address

John Muddie, above address

7. Owner (If owned by a corporation, its name and address must be stated also immediately thereunder the names and addresses of stockholders owning or holding 1 percent or more of total amount of stock. If not owned by a corporation, the names and addresses of the individual owners must be given. If owned by a partnership or other unincorporated firm, its name and address, as well as that of each individual must be given. If the publication is published by a nonprofit organization, its name and address must be stated.)

Full Name  
Complete Mailing Address  
American Association of Directors of  
Psychiatric Residency Training  
400 Washington Street  
Hartford, CT 06106

Association for Academic Psychiatry  
Mt. Auburn Hospital  
Cambridge, MA 02138

8. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages or Other Securities (If there are none, so state)

Full Name  
Complete Mailing Address

NONE

9. For Completion by Nonprofit Organizations Authorized To Mail at Special Rates (39 U.S.C. Sections 436a-2) only

The purpose, function, and nonprofit status of this organization and the exempt status for Federal Income tax purposes (Check one)

(1) Has Not Changed During Previous 12 Months

(2) Has Changed During Previous 12 Months

If changed, publisher must submit explanation of change with this statement.

10. Extent and Nature of Circulation  
(See instructions on reverse side)

Average No. Copies Each Issue During Proceeding 12 Months  
Actual No. Copies of Single Issue Published Nearest to Filing Date

A. Total No. Copies (Net Press Run)  
1,700  
1,702

B. Paid and/or Requested Circulation  
1. Sales through dealers and carriers, street vendors and counter sales  
-0-  
-0-

2. Mail Subscription (Paid and/or requested)  
1,068  
1,076

C. Total Paid and/or Requested Circulation  
1,068  
1,076

D. Free Distribution by Mail, Carrier or Other Means  
Samples, Complimentary, and Other Free Copies  
35  
50

E. Total Distribution (Sum of C and D)  
1,103  
1,126

F. Copies Not Distributed  
1. Office use, left over, unaccounted, spoiled after printing  
597  
576

2. Return from News Agents  
-0-  
-0-

G. TOTAL (Sum of E, F1 and 2—should equal net press run shown in A)  
1,700  
1,702

11. I certify that the statements made by me above are correct and complete  
Signature and Title of Editor, Publisher, Business Manager, or Owner  
Beth Prester, Circulation Director

PE Form 3528, January 1991 (See instructions on reverse side)
Information for Contributors

Peer Review: All submissions are reviewed by at least two experts to determine the originality, validity, and importance to the field of their content and conclusions. Reviewers of a manuscript will be blind to the authors’ identity, and authors will be sent reviewer comments that are judged to be useful to them. *Academic Psychiatry* has initiated a rapid review procedure, and authors can expect to receive notification of the Editor’s decision regarding their submission within three months of receipt of the submission by the journal office. To foster rapid publication, any required revisions are expected to be accomplished by the authors within an additional two-month period.

Manuscript Specifications: Manuscripts must be prepared according to the manuscript specifications of *The American Journal of Psychiatry*. All manuscripts will be edited for clarity, conciseness, and conformity to journal style.

Original Articles: Original reports of empirical research or critical analyses of important topics in psychiatric education or academic psychiatry may be submitted in one of the following formats. Special Articles are overview articles that bring together important information on a topic of general interest to academic psychiatrists. Authors who wish to write a Special Article are advised to check with the Editor to ensure that a similar work has not already been submitted or invited. Special Articles may not exceed 6,250 words (25 double-spaced pages), including tables, figures, an abstract of no more than 100 words, and no more than 100 references. Regular Articles may not exceed 3,750 words (15 double-spaced pages), including references, tables, figures, and an abstract of no more than 100 words. For all articles, a table or figure that fills one-half of a vertical manuscript page equals 100 words of text; one that fills one-half of a horizontal page equals 150 words of text.

New Ideas: This section includes descriptions of innovative programs, curriculums, teaching strategies, techniques, and technologies worthy of broad dissemination to the field. Generally, the programs being described should have been implemented, and some form of evaluation should be reported. Submissions for the New Ideas section are limited to 3,750 words (15 double-spaced pages).

Commentary: Submissions for the Commentary section should be tightly reasoned opinion pieces not exceeding 3,750 words (15 double-spaced pages) that address an important issue in psychiatric education or academic psychiatry.

Other Communications: Brief letters will be considered if they include the notation “for publication.” Editorial notices and pertinent notices and official actions of the sponsoring organizations will also be published.

Submission Procedure: The original typescript, three copies, and a cover letter specifying the section of the journal for which the submission is intended should be submitted to Jonathan F. Borus, M.D., Editor, at the address at left. Upon acceptance of an article, the author(s) will be required to assign copyright ownership in writing to *Academic Psychiatry*. All inquiries should be directed by mail to the address at left.

Submit the original typescript and three copies to:
Jonathan F. Borus, M.D.
Editor
*Academic Psychiatry*
American Psychiatric Press, Inc.
1400 K Street, N.W.
Washington, DC 20005