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A Curriculum for Learning About American Indians and Alaska Natives in Psychiatry Residency Training
James W. Thompson, M.D., M.P.H.

Psychiatric Education at a Veterans Affairs Medical Center
Michael Tedford Lambert, M.D.
Donald Robert Fowler, M.D.

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Special Article

A Curriculum for Learning About American Indians and Alaska Natives in Psychiatry Residency Training

James W. Thompson, M.D., M.P.H.

EDITOR'S NOTE: This article is the third of six residency training curricula written for psychiatric educators by members of the American Psychiatric Association's (APA) minority and underrepresented component committees. The first curriculum (on homosexuality) appeared in the Summer 1994 issue of Academic Psychiatry, the second curriculum (on gender and women's issues) in the Winter 1995 issue. Commissioned by the APA Assembly, these curricula are intended to represent collectively a state-of-the-art description of psychiatric residency training regarding the needs of individuals from minority and traditionally underrepresented populations within the United States. They may be seen as a companion work to the growing body of clinically oriented volumes on the subject of the interaction of culture, ethnicity, and psychiatry. They are valuable resources and serve as guideposts for psychiatric educators. The remaining three curricula will appear in upcoming issues.

A curriculum is proposed for teaching psychiatric residents about the diagnosis and treatment of American Indians and Alaska Natives. The historical context, contemporary myths, and the rationale for the inclusion of curriculum materials on Indians in residency training are presented. The curriculum for the 4 years of residency training is then briefly described, and the knowledge, skills, and attitudes needed by residents are outlined. In postgraduate year (PGY)-1 and PGY-2, the curriculum includes a basic history and description of Indian people, information on myths about the group, and psychiatric epidemiology and psychopathology. In PGY-3, information is included on clinical care, as well as on related areas such as service utilization and illness prevention. In PGY-4, a seminar is proposed in which psychotherapy and other clinical cases are discussed. (Academic Psychiatry 1996; 20:5–14)

This curriculum is designed to provide basic information about the native peoples of North America and about the diagnosis and treatment of mental disorders in these groups. It is intended for use in courses on culture and psychiatry given as a component of psychiatry residency training programs. A more complete discussion of this material can be found in an earlier publication (1) and in the readings listed in the Appendix at the end of this article.

The term "Indian" is used to refer to all

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American Indian and Alaska Native peoples, although these groups are enormously diverse. It should be noted that although Native Hawaiians are also Native Americans, there is little if any scientific literature on their psychiatric status, and they are not covered in this curriculum. Similarly, there is little information available on Mexican Indians. Canadian Indians are included only in some references. If a residency program is near Hawaii, Mexico, or Canada, persons with knowledge and expertise about and familiarity with these indigenous peoples should assist in developing, augmenting, and implementing this curriculum.

RATIONALE FOR INCLUSION OF CURRICULUM MATERIAL ON INDIANS

Inclusion of material on culture and psychiatry in residency training is required by the Accreditation Council for Graduate Medical Education (ACGME) (2): “Residents must be taught to conceptualize an illness in terms of biological, psychological, and sociocultural factors that determine normal and disordered behavior.” Also, ACGME guidelines prescribe that supervised clinical experience must be provided with patients “from a variety of ethnic, racial, social and economic backgrounds” (2). Inclusion of material specifically on Indians is important because there are few areas in the United States where psychiatrists will not have some contact with and exposure to Indian people. Also, a wide variety of misconceptions exists about Indians, which can greatly distort the psychiatric assessment and treatment process.

HISTORY AND CONTEMPORARY MYTHS

Knowledge of the historical context and cultural background of American Indians is important to help the curriculum planner understand the need for a psychiatric residency curriculum on this group. In addition, many misunderstandings still remain today about Indian people that, unless corrected, will tend to color the implementation of the curriculum. The following brief historical overview of Indian people will assist the curriculum planner to achieve a more informed development and sensitive application of the curriculum.

Present-day American Indians and Alaska Natives are descendants of the pre-Columbian inhabitants of North America. “Pre-Columbian” and “precontact” refer to the time before Europeans landed on the North American continent, usually dated as 1492 (3,4). According to 1990 U.S. Census data, there were about 2 million American Indian, Eskimo, and Aleut people in the United States, with most states having substantial Indian communities; 56% of Indians lived in urban areas (5).

It is believed that Indian people crossed onto this continent from Asia in perhaps three separate migrations (6). The time of the first migration is usually accepted as between 20,000 and 27,000 years ago (4,7). Approximately 300 distinct cultural groups, who spoke many languages, existed in what is now the United States (7–9). However, the modern notion of a “tribe” as a homogenous geopolitical unit is a European misconception (10). Some of the cultural differences between groups have today become blurred, but the wide diversity among Indians has continued (11,12). One cannot assume that either the cultures or the psychopathologies of Indian people are universal and/or similar.

Although some of the early contacts between Indians and Europeans were positive (13), these were, by far, the exception (14). From 1500 to 1900, known as the holocaust period for Indians, several factors led to their near extermination. The most prominent factor was infectious diseases (15,16). Another factor was a federal policy to move and relocate Indians from areas desired by European settlers, a policy that resulted in many Indian deaths (10,17–19). Alcohol was also a contributing factor in the Indian holocaust (9), one that led to increased disability and mortality.
Christian religion was an important contributor to the near annihilation of Indian cultures (7,18). Most European settlers and their governments were intolerant of Indian religions and customs and believed it to be their duty to Christianize the "heathen" Indians. Indian people were often forced to ignore their traditional cultures and adopt European history, religion, and customs as their own. In addition, many children were lost in the name of European education, as they were taken from their families and placed into residential boarding schools, with the intention to "teach" these children how to be "white" and Christian (20, p. 492; 21–24).

The last 100 years have been referred to as the "Assimilation Era" (7), as federal policy changed to one of absorbing Indian people into mainstream society. Under this policy, much of the remaining Indian land found its way into Caucasian hands, often by fraud (10,17,25). On reservations, where the remnants of many tribes were relocated, disease and starvation were common (26). Even today, poverty and unemployment plague many reservations.

The history just outlined is very much a part of the lives of contemporary Indian people and has helped to shape their world view. However, present-day non-Indians know little of this history. Vogel (16) has recounted the ways in which American history textbooks have created or perpetuated inaccuracies about Indian people and their history.

It is also important to understand the many contemporary myths that exist about Indians. False impressions abound, often perpetuated by the media, as Indians are portrayed as savages, drunkards, or idealized romantics (10). Other misconceptions are that all Indian cultures are "dead" (when in fact many are alive and well), that Indians are "disappearing" (when in fact their numbers are growing), and that "all Indians are alike" (when in fact they are quite diverse).

Finally, there is the belief that although many individuals in the United States have Indian ancestors, "real" Indians no longer exist. This "nonperson" status has a profound effect on the Indian person's self-concept. Whether the psychiatrist treats the Indian patient in psychotherapy, with medication and other somatic therapies, or in the psychosocial rehabilitation setting, an understanding of Indian history and world view is a critical component to a positive therapeutic outcome and therefore must provide the context for the development of a culturally sensitive curriculum.

**OVERVIEW OF THE CURRICULUM**

This curriculum assumes the point of view that it is impossible in a residency program to teach all of the necessary facts about the large number of cultures that exist in the United States (27). Even if a full year of lectures were to be presented on only one of the major ethnic minority groups (i.e., Indians, Asians, Hispanics, African Americans), only a few of the many subgroups within that ethnic group could be covered in detail. Therefore, training in culture and clinical care must out of necessity be aimed toward the more general goal of helping the trainee assess and treat people who are culturally different from himself or herself. The task of the clinician is to let each patient educate him or her about the patient's culture.

Courses on culture and psychiatry should contain basic information on a few groups that the trainee is likely to encounter. Open discussion of such cultural material in the training program is absolutely necessary to overcome xenophobia and stereotyping. Familiarity helps to counter the sense of "the other," and frank discussions can combat negative or overly romantic notions about certain cultural groups. While didactic materials are the focus of this article, clinical (and in some situations, research) experiences are also important components of training in culture and psychiatry. Clinical experiences with patients from various cultures, accom-
panied by culturally sensitive supervision, can provide an important bridge between the knowledge, skills, and attitudes learned in the classroom and the clinical practice of psychiatry.

The educational objectives that follow, along with the material referenced, are intended to provide basic information on American Indians and Alaska Natives. The recommended ideal usage of this material is to distribute it during the 4-year curriculum as 3 courses. It is proposed that a history and description of American Indians, myths about them, and their basic psychiatric epidemiology and psychopathology be taught in postgraduate year (PGY)-1 or PGY-2. In PGY-3, more information should be provided on the clinical care of Indians, service utilization, and illness prevention. In PGY-4, a seminar is suggested in which clinical material (psychotherapy and other clinical cases) involving various ethnic groups is discussed from a culturally sensitive point of view. For programs unable to institute the entire curriculum, items for a shorter basic curriculum are marked with an asterisk (*).

**PGY-1 to PGY-2**

By the end of PGY-2, residents should have acquired the following:

- Knowledge of

1. * basic history of Indian people, as outlined earlier, including the precontact and postcontact periods, and the effects of that historical experience on contemporary Indian people (1,7,8,10,14);  

2. basic demographic information on Indians in the United States (1,5,6,11,12);  

3. * myths about the group, how these myths arose, and why they are destructive (1,7,8,10,28,29);  

4. psychiatric epidemiology of Indians, including differences in rates between tribes and other Indian subgroups; differences between services utilization data and community prevalence data; and methodologic problems in collecting and interpreting data on Indians (30–39);  

5. * descriptive psychopathology in Indians, that is, affective disorders (32,40,41), alcoholism (42–47), other substance abuse (45,48–51), disorders usually first evident in childhood or prominent in childhood or adolescence (52–54), the psychoses (1,55,56), and other mental disorders (36,56), stressing similarities and differences with the majority culture, and differences between Indian groups; and  

6. "culture-bound" syndromes and their meaning (or nonmeaning) for Indians (57).  

- Skills to

1. * make a culturally sensitive diagnosis of an Indian patient;  

2. * make a culturally sensitive dynamic formulation of an Indian patient; and  


- Attitudes that

1. * go beyond the myths about Indians perpetuated in our society and understand Indian people as having a long history and an active present;  

2. * consider Indian cultures as containing valid ways of thinking about the self, others, and society; and  

3. * appreciate the need of Indian people to live in both traditional Indian culture and the majority culture.

**PGY-3**

In this year, the clinical care of the group is stressed, as well as an understanding of service utilization and illness prevention. By the end of PGY-3, the resident should have acquired the following:

- Knowledge of

1. Indian medicine and traditional healers in the treatment of Indian people, including practices such as ceremonials, the use of herbs and other plants to...
affect thinking and feeling, “sweats,” and feasts (7,18,20,58);
2.* Indian medicine and traditional healers as serving a wide variety of functions (59–61);
3.* western treatments for mental disorder in Indians (1);
4. psychiatric services available to Indians (1);
5. multiple systems involved in the psychiatric treatment of Indian people (1);
6.* the Indian Health Service in the psychiatric treatment of Indians in the United States (1);
7. psychiatric treatment of urban Indian people (1); and
8. illness prevention and its difficulties (62,63).
   • Skills to
1. work in cooperation with traditional healers;
2.* formulate a culturally sensitive treatment plan for Indian patients, and carry out that plan (e.g., ref. 64);
3.* use biological, psychological, and social interventions with Indian people (34,36,65,66);
4. use the multiple systems involved in the psychiatric care of Indian people;
5.* work with an individual Indian patient to understand more about that patient’s culture as it interfaces with the therapeutic process; and
6. work with Indian communities to develop effective health care systems for Indian people.
   • Attitudes that
1.* see Indian medicine and healers as useful and effective, rather than as worthless or based in magic or witchcraft (61,67–70);
2.* see western medicine as useful and effective in the psychiatric treatment of Indians; and
3.* do not allow his/her own negative or romantic attitudes about Indians to govern therapeutic interactions.

PGY-4

In PGY-4, attention should turn to honing the knowledge, skills, and attitudes discussed above through a seminar focusing on clinical cases involving patients representing various cultural groups. The discussions should stress a culturally sensitive point of view. The residents should have acquired the following:
   • Knowledge of
1.* psychodynamics across cultural boundaries, as applied to psychotherapy and all therapeutic interactions with patients; and
2. how to educate others to use a culturally sensitive approach to clinical care.
   • Skills to
1.* do psychotherapy across cultural boundaries; and
2. use dynamic understandings in applying biologic and psychosocial interventions across cultural boundaries.
   • Attitudes that
1.* consider a culturally sensitive approach as not only possible, but also exciting and effective; and
2.* appreciate that Indians and other underrepresented groups have strong and vibrant cultures, which can be a source of strength for the individual patient.

As mentioned before, an annotated bibliography of basic readings for curriculum planners is included in the Appendix.

CONCLUSION

To the curriculum planner who is inundated with new topics that should be included in the residency training program, the inclusion of culture-specific didactic and clinical material may seem a daunting task. Because there are a large number of cultural groups in the United States, and many variations within each group, the entire didactic program in a residency program could be filled with nothing but culture-specific material.
Because this is not practical, formal courses on culture will of necessity be limited. However, there are some key priorities for such courses, whatever their length.

First, a desensitization process should take place, so residents think of understanding an individual patient's culture as an acceptable part of their psychiatric education and treatment process.

Second, residents should be taught the basics of relating to people from other cultures.

Third, some factual material on the primary U.S. minority groups should be presented. This need not be extensive, but it should be geared toward what will be clinically useful to psychiatrists, rather than toward the esoteric.

Fourth, courses on culture should start in PGY-1 or PGY-2 and continue into later years, moving from basic information to clinical application.

Finally, all material on culture and psychiatry need not and should not be presented in formal courses. All material taught in residency programs—be it on psychodynamics, neurotransmitters, or psychosocial rehabilitation—has an important cultural component. For example, in lectures on psychodynamic concepts, the influences of culture can be included along with other material, and culture can also be dealt with in psychotherapy supervision. In pharmacology lectures and clinics, biologic differences in medication effects between cultures can be discussed, as well as the cultural context as it influences such issues as compliance. Culturally sensitive supervision and teaching should be emphasized throughout residency training, rather than simply be sequestered into formal courses on "culture and psychiatry." Such a comprehensive approach is the key to producing culturally knowledgeable and sensitive psychiatrists.

The author thanks R. Dale Walker, M.D., and Patricia Silk-Walker, Ph.D., for their assistance.

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Appendix

Readings for Curriculum Planners

The following basic readings are suggested for persons introducing this curriculum.

Year of Implementation: PGY 1–4


  This chapter provides an overview of all material in the curriculum and an extensive bibliography. The book includes chapters on a wide variety of cultures.


  Debo’s nondistorted history of Indian people is a classic. A complete reading is not necessary, but portions may be used in the curriculum.


  This is one of the better books on myths about Indians. It traces many myths from their beginnings and demonstrates that they still exist.


  Manson et al. have written one of the few articles that provides a comprehensive approach to psychiatric assessment and treatment of Indian patients.

Year of Implementation: PGY 3–4

- Walker RD, LaDue R: An integrative approach to American Indian mental health, in Ethnic Psychiatry, edited by Wilkinson CB. New York, Plenum Medical, 1986

  This chapter provides a history, before and after contact, and also sets forth important principles in the delivery of psychiatric care to Indians.


  In spite of the use of the term “witch-doctors,” which is not the usual term used for Indian healers in the United States, Jelik and Todd demonstrate the value of traditional Indian medicine.


  Depression, a common disorder in

  (continued)
Appendix.  Readings for Curriculum Planners (continued)

Indians, is presented from a culturally sensitive point of view.


  This article addresses another common disorder associated with Indians, alcoholism, and shows both the seriousness of the problem and the myths associated with the condition.


  Sue and Zane provide one of the few discussions of a specific treatment modality (psychotherapy) as used for Indian patients.
Regular Articles

A Survey of Child and Adolescent Psychiatry Residents

Demographic Characteristics, Program Selection Factors, Training Satisfaction, and Career Choice

Christopher K. Varley, M.D., Rose Calderon, Ph.D.
Jennifer G. Vincent, M.D., Lisa Hacker, M.D.

This study attempted to discover how child and adolescent psychiatry residents chose their training programs, what they intended to do with their careers, and how they perceived their educational experiences. The survey was distributed to all psychiatry residents in the United States through their training directors in 1990. The authors received 310 responses. Significant differences were noted between male and female residents. Most residents expressed an intention to go into private practice after training. There were significant differences in residents interested in private practice vs. academic careers. The residents had applied to comparatively few programs and made training decisions early. The study generated objective information that may yield more specific recruitment strategies for child and adolescent psychiatry. (Academic Psychiatry 1996; 20:15–25)

In 1980, the Graduate Medical Education National Advisory Committee (GMENAC) considered whether there were adequate numbers of child and adolescent psychiatrists in the United States. The committee concluded that by the year 1990 the number would need to increase from 3,000 to 9,000 (1). The accuracy and precision of the GMENAC report has been questioned about its conclusions about determination of need. For example, the GMENAC projection assumed that child psychiatrists worked 36 hours per week with children and adolescents, considerably more than past surveys indicate is the usual practice (2). More recent projections suggest that the needs for care would require many more child psychiatrists. Although Yager and Borus (3) have argued that given changes in reimbursement and competition with other mental health professionals, there may be too many general psychiatrists being trained, and there is a general consensus that there are not enough child and adolescent psychiatrists in the United States, a position supported by Beresin and Borus (4).

Over the past decade, the number of residency positions in child and adolescent psychiatry in the United States has remained at approximately 700. The exact number of child psychiatry residents in training at the time of this survey was uncertain. An American Medical Association survey based on program directors' reports found that 712 resident positions were offered in child and adolescent psychiatry training in the United States in 1990. This was the expected number to meet the number needed by the GMENAC report (1). The 1990 survey was distributed to all psychiatry residency programs in the United States by the American Psychiatric Association. The authors received 310 responses, for a response rate of 5.1 percent. Over 70 percent of the respondents were female. The residents were asked to estimate how many hours they worked with children and adolescents. The results suggest that many residents work less than the 36 hours per week projected by GMENAC, and that the number of hours worked per week is significantly correlated with a number of demographic factors.
adolescent psychiatry in 1989, compared with 713 in 1988 and 684 in 1987 (5). The 1989 figures were based on responses from 112 of the 122 accredited programs in 1989.

The number of child and adolescent psychiatrists in the United States is steadily, but slowly increasing (6): 817 in 1965, 2,090 in 1970, 3,271 in 1980, and 4,223 in 1989. Many more, 3,273, are under age 55 than over, 950 (6). This finding suggests that if the current trends continue (350 graduating from child and adolescent psychiatry residencies per year), the number of child psychiatrists will rise. However, the figure of 9,000 projected as needed in the GMENAC report will not be reached any time soon.

Nearly all child and adolescent psychiatry residents come out of the pool of general psychiatry residents. There was a gradual increase in the 1980s in the percentage of graduates from medical school entering into psychiatry residencies, but the numbers entering child and adolescent psychiatry have not kept pace (6,7). Since 1989, there has been a decline in the number of U.S. medical graduates training in general psychiatry. In 1992, there was a significant drop in the number of graduates from medical school entering a general psychiatry residency, with 71% of programs not filling the initial match. There was a similar occurrence in 1993. It is unclear whether this is a transient deviation from a steadily increasing trend, or a reflection of a fundamental shift.

Several factors may affect the number of residents entering child and adolescent psychiatric training. A rising phenomenon in psychiatric training in the United States has been the increased emphasis on subspecialization (8). The increase of physicians in training entering into subspecialty areas such as geriatric psychiatry and addiction psychiatry may decrease the numbers of residents entering child and adolescent psychiatry.

Forces such as increasing medical student debt may also have a profound effect on the direction in which students elect to train, perhaps pressuring students toward selecting more lucrative specialties. As well, the issue of AIDS may have an influence on the decision to enter medicine. Managed health care, physician income, and the current administration’s plans for major health care reform, particularly its emphasis on primary care and reduction in specialization, may influence the number of students entering medical school, the number entering psychiatry, and more specifically, the number entering child and adolescent psychiatry.

Little is known about the decision-making process or about the general characteristics of physicians who elect to train in child and adolescent psychiatry. Based on studies done in 1982 and 1984, Weissman and Bashook (9,10) have reported that 30% of residents entering a general psychiatry residency express interest in child psychiatry, but only about 18% actually will do a residency. Weissman and Bashook (9,10) also report that those students in medical school who have an interest in child and adolescent psychiatry tend to be women, come from medical schools with relatively little emphasis in research, and had a previous interest in pediatrics.

Recruitment is viewed as a common and important problem by training directors in child and adolescent psychiatry (4). A conference on recruitment was held in San Diego in 1989 in conjunction with the annual midwinter meeting of the American Association of Directors of Psychiatric Residency Training (2,11). Although many recruitment suggestions have been made, comparatively little is systematically known about child and adolescent psychiatry residents, especially as to what factors went into their decision to train at one institution or another, what they identify as career plans, what they see as important elements in their training, and how satisfied they are with their experience. Further information needs to be gathered if recruitment efforts are to be more successful.

The present investigation surveyed child and adolescent psychiatry residents in training in the United States. The survey
inquired about demographic features of this population, salient elements of their backgrounds, factors in their selection of training programs, current satisfaction with training, and career plans. This information generated a database to better understand the group who enters child and adolescent psychiatry. An objective was to identify strategies for increasing the numbers who train in this area.

METHODS

The survey questionnaire was distributed to all of the program directors of accredited programs in child and adolescent psychiatry in the United States in the spring of 1990. All 122 programs accredited at that time were contacted. A letter was sent to the program directors asking them to distribute the questionnaire to all their child and adolescent psychiatry residents, along with a stamped, self-addressed return envelope. The number of questionnaires sent was equal to the maximum number listed for each program in the current directory of graduate medical education. Child and adolescent residents were asked to indicate whether they wanted the survey's results returned to them. Survey anonymity was preserved by providing a form separate from the questionnaire to request results.

The questionnaire survey was divided into four sections: 1) a demographic section, 2) a series of questions asking how a resident chose a program, 3) questions on degree of satisfaction in the current residency training program, and 4) questions about career choice. The survey took less than 10 minutes to complete. A repeat mailing was not sent.

RESULTS

Three-hundred ten responses were received. This was approximately 45% of the total number of residents in training. Forty-seven percent were women. The modal age of residents was 31, with a mean age of 34 (range: 27–67 years). Sixty-eight percent were married; 18% were never married; 6.5% were living with a partner; 5.2% were divorced; and 2% were separated. Forty-nine percent had no children, 20% had 1 child, and 31% had 2 or more children.


Assuming the figure of the maximum number of available positions in each program, the following regional response rates were obtained: Northeast—37%, 107 out of 298; South and Southwest—45%, 85 out of 191; Midwest—43%, 64 out of 155; West—48%, 52 out of 108. Results of a chi-square analysis indicated no significant differences existed in the percentage of responses from each U.S. region ($\chi^2 = 6.66, df = 3, P < 0.05$). One or more responses were obtained from at least 109 of the 122 programs. Although all of the respondents completed the question in the survey as to which region they trained in, some did not include specific program identification, so it is possible that we got responses from more than 109 programs.

Regarding regional distribution, 35% of the respondents were in training in the Northeastern section of the United States, 27% in the South and Southwest, 21% in the Midwest, and 17% in the Western United States. Twenty-three percent ($n = 71$) reported that they had postgraduate training and specialties other than psychiatry. Thirty
of the 71 (42%) had 1 year of postgraduate training in another specialty. Twenty-one of the 71 (34%) training in other specialties indicated that they were board-eligible in another specialty. The remainder had more than 1 year of postgraduate training but did not complete training in another specialty.

Residents were asked to rank order their top three most likely career choices. The choices were selected as mutually exclusive. As seen in Table 1, the most common first choice was a combination of child, adolescent, and adult psychiatry in a private practice setting (36.5%). The second most common choice (18%) was in the private practice of child and adolescent psychiatry alone. Twelve percent expressed an interest in academic child and adolescent psychiatry, and 10% selected community or public sector psychiatry as a first career choice.

As shown in Table 2, 60% reported that they were doing their child and adolescent psychiatry training at the same institution where they did their general psychiatry training. In addition, 2% indicated that they had not yet completed their general training, suggesting that they had entered out of the normal sequence. Fifty-three percent indicated that they had applied to only 1 child and adolescent residency program; 12% to 2; 12% to 3; 7% to 4; 7% to 5; and 10% to 6 or more. Fifty-six percent indicated that they had interviewed at 1 program; 13% at 2; 10% at 3; 6% at 4; 5% at 5; and 8% at 6 or more.

The residents were asked how they determined their final choice of program. They were asked to rank on a scale from 1 (not important) to 10 (very important) a number of factors that influenced their final program choice. Table 3 summarizes the responses listed in order of the factor rated most impor-

| TABLE 1. Career plans for child and adolescent psychiatry residents |
|--------------------------|----------------|------------------|
|                          | Frequency (%)  |                  |
|                          | 1st Choice     | 2nd Choice       | 3rd Choice       |
| Child and adult private practice | 113 (36.5)     | 57 (18.4)        | 33 (10.6)        |
| Child psychiatry private practice | 55 (17.7)     | 59 (19.0)        | 30 (9.7)         |
| Full-time academic        | 37 (11.9)      | 17 (5.5)         | 25 (8.1)         |
| Community or public psychiatry | 31 (10.0)     | 34 (11.0)        | 38 (12.3)        |
| Clinical faculty          | 30 (9.7)       | 63 (20.3)        | 60 (19.4)        |
| Other career position     | 24 (7.7)       | 19 (6.1)         | 32 (10.3)        |
| Undecided                 | 14 (4.5)       | 1 (0.3)          | 7 (2.3)          |
| Missing                   | 6 (1.9)        | 60 (19.4)        | 85 (27.4)        |
| Total                     | 310 (100.0)    | 310 (100.0)      | 310 (100.0)      |

| TABLE 2. Relationship of site of current training institution to prior training |
|-----------------------------------|----------------|----------------|
| Previous Training Experience      | Yes | No | Missing |
| Same medical school               | 13.5 | 85.8 | 0.6 |
| Same region as medical school     | 38.7 | 58.7 | 2.6 |
| Same site as where elective was taken in medical school | 15.2 | 81.6 | 3.2 |
| Same general psychiatry residency | 60.3 | 37.7 | 0   |
| Same region as general psychiatry residency | 71.9 | 23.5 | 4.5 |
### TABLE 3. Factors in selection of training program

<table>
<thead>
<tr>
<th>Factor</th>
<th>Not Important</th>
<th>Somewhat Important</th>
<th>Very Important</th>
<th>Missing Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program location</td>
<td>3.5</td>
<td>1.0</td>
<td>1.0</td>
<td>17.1</td>
</tr>
<tr>
<td>Family or “significant other” considerations</td>
<td>13.2</td>
<td>0.6</td>
<td>2.3</td>
<td>9.7</td>
</tr>
<tr>
<td>Clinical opportunities (rotations, specifics, populations)</td>
<td>0</td>
<td>0.6</td>
<td>2.9</td>
<td>25.5</td>
</tr>
<tr>
<td>Overall program reputation</td>
<td>0.3</td>
<td>1.0</td>
<td>2.9</td>
<td>21.6</td>
</tr>
<tr>
<td>Theoretical program orientation</td>
<td>0.3</td>
<td>0.3</td>
<td>1.3</td>
<td>23.5</td>
</tr>
<tr>
<td>Quality of program residents</td>
<td>1.9</td>
<td>0</td>
<td>2.6</td>
<td>23.5</td>
</tr>
<tr>
<td>Attraction of specific faculty</td>
<td>3.5</td>
<td>1.0</td>
<td>6.1</td>
<td>18.7</td>
</tr>
<tr>
<td>Advice of preceptors or influential others</td>
<td>5.2</td>
<td>3.9</td>
<td>6.8</td>
<td>19.0</td>
</tr>
<tr>
<td>Interview experience</td>
<td>11.3</td>
<td>4.5</td>
<td>4.5</td>
<td>16.1</td>
</tr>
<tr>
<td>Frequency of night call</td>
<td>10.6</td>
<td>4.5</td>
<td>4.5</td>
<td>15.5</td>
</tr>
<tr>
<td>Program size</td>
<td>13.5</td>
<td>3.2</td>
<td>9.7</td>
<td>11.3</td>
</tr>
<tr>
<td>Salary and benefits</td>
<td>18.7</td>
<td>5.2</td>
<td>10.6</td>
<td>9.7</td>
</tr>
<tr>
<td>Availability of practice opportunities in this area</td>
<td>26.5</td>
<td>5.5</td>
<td>6.5</td>
<td>10.6</td>
</tr>
<tr>
<td>Availability of research training</td>
<td>12.6</td>
<td>9.0</td>
<td>10.6</td>
<td>7.7</td>
</tr>
<tr>
<td>Reluctance to change programs after general residency</td>
<td>38.4</td>
<td>2.6</td>
<td>1.9</td>
<td>8.4</td>
</tr>
<tr>
<td>Availability of academic positions</td>
<td>30.0</td>
<td>7.4</td>
<td>7.4</td>
<td>6.1</td>
</tr>
<tr>
<td>Availability of moonlighting opportunities</td>
<td>38.7</td>
<td>5.5</td>
<td>7.4</td>
<td>7.4</td>
</tr>
<tr>
<td>Limitation of where you were offered a position</td>
<td>53.2</td>
<td>5.8</td>
<td>3.5</td>
<td>4.8</td>
</tr>
<tr>
<td>Availability of part-time status</td>
<td>59.7</td>
<td>5.5</td>
<td>8.1</td>
<td>3.9</td>
</tr>
</tbody>
</table>

*Factors are listed in order of importance as rated by the respondents.*
tant by the respondents to the factor rated least important.

Particularly noted as important factors were the overall reputation of the program, theoretical orientation of the program, clinical opportunities, quality of the residents in the program, and program location. Especially noteworthy were the comments about part-time status availability. Sixty percent listed part-time status availability as not important at all, whereas 7% listed it as the most important consideration. Also of interest was the distribution of considerations of family or significant others: 13% listed this as not at all important, and 51% listed it as very important.

Male and female differences are also noteworthy. Table 4 includes the program selection factors reported in Table 3 that were significantly different, that is, only the factors in which the results of t-test or chi-square comparisons indicated a significant difference between the men and women. Family factors were more important in program selection for women. Part-time status availability and consideration of family and significant other were rated significantly higher by female residents in their selection

<table>
<thead>
<tr>
<th>TABLE 4. Gender differences in program choice and career plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program Selection Factor Ratings, mean ± SD</strong></td>
</tr>
<tr>
<td>Males (N = 159)</td>
</tr>
<tr>
<td>Part-time status available</td>
</tr>
<tr>
<td>Consideration of family or significant other</td>
</tr>
<tr>
<td>Career Plans, N (%)b</td>
</tr>
<tr>
<td>Other career position</td>
</tr>
<tr>
<td>All alternate careersd</td>
</tr>
</tbody>
</table>

*aSee Table 3 for specific categories.
*bFemale N = 145.
*cValue based on x².
*dSee Table 1 for specific categories.

<table>
<thead>
<tr>
<th>TABLE 5. Satisfaction with current program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Value</strong></td>
</tr>
<tr>
<td>Quite satisfied (would definitely choose it again)</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>Satisfied</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>9</td>
</tr>
<tr>
<td>Very dissatisfied (would definitely not choose it again)</td>
</tr>
<tr>
<td>10</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

*N = 310; number of respondents missing: 2, or 0.6% of sample.*
of a training program. Other areas that suggested possible familial considerations included women rating program location as more important and more often considering alternate career options. The mean comparison findings demonstrated a trend for men to rate financial issues as more important than women. For example, the availability of moonlighting opportunities was somewhat more important to men.

Three questions were asked about child psychiatry residency satisfaction. In the first question, the residents were asked how satisfied they were with their current program on a scale from 1, quite satisfied (would definitely choose it again), to 10, very dissatisfied (would not choose it again.) As shown in Table 5, the residents expressed a reasonable degree of program satisfaction when asked how satisfied they were with their current program. In the second question as to how closely the program matched their expectations, 60% felt that the program closely matched their expectations, whereas 32% felt their program met some of their expectations, and 7% felt their program was very different from expectations. The third question asked how well their program had prepared them for career plans and goals. Forty-three percent believed that they were well prepared for their career goals; 50% believed there was some inadequate preparation, and 6% believed that there was a great deal of inadequate preparation.

Those interested in academic careers differed from those who expressed a first career choice in all other areas combined, as illustrated in Table 6. Results from t-test comparisons indicated that residents interested in full-time academic careers rated as significantly more important research training availability and as significantly less important private practice opportunities. Difference trends (i.e., mean differences that were close to but did not achieve statistical significance to $P < 0.05$) were noted for factors of program reputation, specific faculty attraction, and availability of academic positions.

These program selection factors tended to be rated as more important by academic career-minded residents, whereas moonlighting opportunity was rated lower. There was no difference in terms of program satisfaction with one expressed career choice vs. another. Difference trends were also noted for those interested in private practice combining work with children, adolescents, and adults. They rated a reluctance to change programs after general residency and moonlighting availability as higher in importance. Academic position availability was rated as less important to them.

Those interested in the private practice of child and adolescent psychiatry, compared with all other career options combined, rated research training availability significantly lower in importance, also illustrated in Table 6. Difference trends existed between those residents interested in child and adolescent private practice and all other residents: the residents interested in private practice rated as less important specific faculty availability and quality of residents in current program, and rated as more important practice opportunities in the area.

Efforts were made to identify different responses from the residents based on regional characteristics. There was no difference in program satisfaction across regions. As shown in Table 7, results of one-way ANOVAs indicated that applicants in the Northeastern United States applied to significantly more programs than all three other regions and that they rated the importance of program reputation as significantly higher than the residents from the South or Midwest. Chi-square results indicated that residents in the Midwest region were significantly more interested in the private practice of child and adolescent psychiatry than residents from the other three regions. The residents in the Northeastern region demonstrated a trend for more interest in academic child psychiatry and less interest in the private practice of child psychiatry. In addition, the Midwest residents tended to indicate
higher reluctance to change programs following general residency than did the Northeastern residents.

The residents who initially trained outside of psychiatry (N = 71) and those who initially chose psychiatry (N = 239) differed in two ways when compared across demographics, program selection factors, career choices, program expectancies, and program satisfaction using t-tests and chi-square analyses. The first is a significant difference in age between the groups (t = 2.72, df = 308, P = 0.007), with the residents who later entered psychiatry being older. This finding is understandable given the added years spent in another specialty area. The second and more interesting difference is that those who later came to psychiatry indicated a first choice career preference for a full-time academic career vs. all other career choices combined (χ² = 3.71, df = 1, P = 0.054) over those who chose psychiatry as their initial specialty area. Furthermore, this finding was not confounded by regional training area,

### TABLE 6. Career choice by program selection factor ratings

<table>
<thead>
<tr>
<th>Program selection factors, mean ± SD</th>
<th>Full-Time Academic (N = 37)</th>
<th>Other Career Options Combined (N = 263)</th>
<th>t</th>
<th>df</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research training availability</td>
<td>7.38 ± 2.03</td>
<td>4.33 ± 2.44</td>
<td>7.25</td>
<td>298</td>
<td>0.000</td>
</tr>
<tr>
<td>Private practice</td>
<td>3.16 ± 2.52</td>
<td>4.95 ± 3.02</td>
<td>3.43</td>
<td>299</td>
<td>&lt; 0.001</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program selection factors, mean ± SD</th>
<th>Private Practice Adult and Child Psychiatry (N = 113)</th>
<th>Other Career Options Combined (N = 187)</th>
<th>t</th>
<th>df</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research training availability</td>
<td>4.03 ± 2.18</td>
<td>5.12 ± 2.73</td>
<td>-3.58</td>
<td>298</td>
<td>0.000</td>
</tr>
</tbody>
</table>

### TABLE 7. Training region differences

<table>
<thead>
<tr>
<th>Number of programs applied to, mean ± SD</th>
<th>Northeast (N = 109)</th>
<th>South-Southwest (N = 83)</th>
<th>Midwest (N = 63)</th>
<th>West (N = 52)</th>
<th>F-ratio</th>
<th>df</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program selection factor ratings a</td>
<td>3.28 ± 2.58</td>
<td>2.17 ± 2.10</td>
<td>1.65 ± 1.49</td>
<td>2.37 ± 1.79</td>
<td>8.84</td>
<td>306</td>
<td>0.000</td>
</tr>
<tr>
<td>Program reputation, mean ± SD</td>
<td>8.33 ± 1.72</td>
<td>7.35 ± 1.66</td>
<td>7.54 ± 1.96</td>
<td>7.94 ± 2.02</td>
<td>5.29</td>
<td>305</td>
<td>0.002</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Career plans b</th>
<th>Number (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child psychiatry private practice</td>
<td>7 (6.4) 19 (23.5) 22 (35.5) 7 (13.5) 24.99 3 0.000</td>
</tr>
<tr>
<td>All alternative careers</td>
<td>102 (93.62) 62 (76.5) 40 (64.5) 45 (86.5)</td>
</tr>
</tbody>
</table>

aSee Table 3.  
bSee Table 1.
that is, those residents who later switched to psychiatry were not predominantly from the Northeast region. There was no difference in the distribution of these residents across training regions as indicated using chi-square analysis. This suggests that despite a preponderance of Northeastern residents choosing full-time academic careers, another factor such as change in specialty area is also a corollary of those who indicate a strong interest in pursuing full-time academic careers.

DISCUSSION

Although this survey's response rate of approximately 45% compares favorably with the only other published survey of child and adolescent residents by Dech et al. (12) regarding perceptions of an ideal training program, our results should be interpreted with caution. The 310 responses represent less than half of the residents in training at the time of this survey. The generally comparable rates of response between regions and the securing of at least one response from the vast majority of programs suggest that these data are representative, but the absence of a second mailing to the respondents limits the extent to which conclusions can be drawn. The data may be skewed by the larger number of respondents from the Northeast. There is not a high response rate, but the survey is breaking new ground.

There was a general agreement with the findings of Dech et al. (12) in terms of an overall degree of moderate satisfaction with training. Their findings of residents' preference for a stronger emphasis on clinical training rather than research in an ideal training program matches the comparatively low level of interest in research as a career emphasis in our study. In Dech et al.'s survey, the residents wanted child development and diagnostic and outpatient experiences to be enhanced. This desire also coincides with the expressed interest in clinical child and adolescent psychiatry in this survey. As well, the relatively low interest in community psychiatry matches the prior survey's findings.

The emphasis in clinical training as a primary interest agrees with the responses to a survey by program directors rating the importance of required residency experiences (13). In that study, the program directors indicated that the most indispensable elements included clinical experiences with older children and adolescents, outpatient therapy, and psychopharmacology. The program directors rated research and consultation with the courts among the least essential experiences.

Noteworthy elements from our survey include the striking predilection of the training group to have an interest in the private practice of child and adolescent psychiatry. Despite the numerous available academic positions and the pronounced need for community psychiatric care, the overwhelming majority of the residents intended a career in the private practice of child and adolescent or child and adolescent and adult psychiatry. Smaller groups did endorse an interest in academic careers and in community psychiatry. It is not known how residents in general psychiatry would respond to these questions.

This study did not explain the drift away from child psychiatry as an area of potential interest for first-year residents in general psychiatry or identify those who actually do a residency in child and adolescent psychiatry (9,10). It did suggest, however, that there was a remarkable tendency on the part of child and adolescent residents to stay where they trained in general psychiatry. A surprising finding was the comparatively small number of programs that the vast majority of residents considered for training. The tendencies to stay within an area were striking as well. This indicates that a critical decision as to where an individual resident will train is made at the point of entry into a general psychiatry residency. Attrition may occur from there, but most residents will stay where they began training.
There was a noteworthy distribution of the importance of significant others on decision making. This was a critical variable for a significant percentage of resident applicants, especially women, a finding that is particularly relevant given the large number of women in child and adolescent psychiatry. To the extent that many women are married to physicians in specialties other than psychiatry, large medical schools with multiple residency and fellowship programs are likely to have an advantage in recruitment. Part-time status may also be, as suggested by this survey, an important variable for a subset of residents.

Examination of the mean values in Table 4 does not accurately reflect the difference in meaningfulness for women vs. men for the program factors “part-time work available” and “consideration of family and significant other.” When absolute frequencies of each rating (1–10; 1 = not important, 10 = very important) are calculated, the results indicate that 31.5% of women residents rate “part-time work available” as somewhat to very important compared with only 11.9% of the male residents. Similarly, although both groups rated “consideration of family or significant other” as somewhat important, 73.3% of the women residents rated this factor at 8 or higher in importance compared with 49.4% of the male residents. Despite limited differences between the male and female residents in the mean ratings of these two program factors, frequencies for each rating indicate that there are major differences in the importance men and women attach to them.

Highly influential factors that led to a decision to select a program included the overall program reputation, theoretical orientation of the program, ability to work with specific faculty, quality of the residents in the program, advice from preceptors, and interview experience. Program location was a particularly important factor and was rated as the very most important more frequently than any other variable.

Factors not seen as especially important included salary and benefits, practice opportunities in the area, availability of academic positions, frequency of night call, and availability of research opportunities. The failure to endorse financial concerns is somewhat surprising given the increasing levels of debt that medical students are accruing. This suggests that quality of life and programmatic training experiences still drive the primary decision-making processes for residents. Alternatively, it may be that there was little variability between programs in terms of salary; hence, it may not have been likely to be a discriminating factor.

There were interesting and potentially important differences among sub-groups of residents: men compared with women, those interested in academic psychiatry compared with those interested in private practice, and those in the Northeast compared with those in the Midwest. All were, in a sense, in predictable directions. These distinctions may be relevant as to how an individual institution develops recruitment strategies and considers working with the child psychiatry residents in their own programs.

We intend to repeat this survey. A second survey conducted with a repeat mailing should obtain a higher response rate and allow for more confidence in the results obtained. It would be of interest to learn whether there is any evidence of change of attitude in this period of change in the practice of medicine; whether financial issues, family matters, and interests in academics change; and whether pursuit of programs change in parallel.

It would be of interest to learn more about the subgroup of child psychiatry residents who trained in other medical specialties in a second survey. A recent report indicates that residents coming into child and adolescent psychiatry with a background in pediatrics compare favorably in performance with those who do not (14).

The results of this survey should be of
interest to training directors as they consider their academic programs, as well as to the field in general as it considers how to enhance the number of medical students entering this specialty. It certainly does corroborate suggestions to intervene early in the training experience. It also needs to be restated, as it often has, that most recruitment is a local experience. The national thrust to highlight these issues notwithstanding, each program, with its own characteristics, strengths, and weaknesses, must respond to the challenge individually.

This work was done in the Division of Child and Adolescent Psychiatry, Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, Washington.

References


Resident and Faculty Evaluations of a Psychiatry Night-Float System

Benjamin G. Druss, M.D., M.P.H., Gregory Pelton, M.D.
Lynn Lyons, M.S., William H. Sledge, M.D.

This study used self-report questionnaires to examine resident and faculty perceptions of a new night-float schedule for coverage of a psychiatric emergency room compared with a traditional night-call system. The residents reported improved well-being, educational experience, and performance of clinical duties under the night-float system compared with a traditional call schedule. The faculty had a generally favorable impression of the new system. Night-float systems may provide a means of improving psychiatric residents' emergency room and outpatient experiences without compromising patient care, although further studies are needed to measure fully the cost-benefit ratio of such programs. (Academic Psychiatry 1996; 20:26–34)

Medical educators are increasingly questioning whether the long working hours and frequent night call that have traditionally been a part of medical residency may be detrimental to resident morale, education, or patient care. New York has enacted statutory requirements reducing working hours for residents of all specialties, and the Accreditation Council for Graduate Medical Education has set limits on frequency of night call for most specialties (1). Residency programs are struggling with how to reduce resident work hours without sacrificing resident education or patient care.

Editorials and studies since the early 1970s have addressed the toll taken on resident physicians and patients by the demands of residency (2–5). More than any other factors, lack of sleep and long hours are cited as contributing to resident distress. For instance, Schwartz and colleagues (6) found that house officers listed lack of sufficient sleep and frequent overnight call as the two factors that detracted most from their sense of well-being during their residencies. Other studies have found high levels of depression, anxiety, and hostility among residents, symptoms that have been associated with sleep deprivation (7–10).

A number of studies have also examined the effects of sleep deprivation on residents' cognitive and motor performance. These effects are less well established than the subjective distress caused by call; for instance, one study (11) found that sleep deprivation had little effect on cognition, visual and auditory vigilance, or rapid eye-hand coordination. Earlier studies, however, found

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Dr. Druss is an instructor in the Department of Psychiatry and research fellow in the School of Epidemiology and Public Health; Dr. Pelton is an instructor in the Department of Psychiatry, Ms. Lyons is a research associate in the Department of Psychiatry, and Dr. Sledge is a professor in the Department of Psychiatry; all are at Yale University, New Haven, CT. Address reprint requests to Dr. Druss, Yale University, Psychiatry Service, 116A, Department of Veterans' Affairs VA Connecticut Health Care System, 950 Campbell Ave, West Haven, CT 06516.

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detrimental effects on such activities as reading ECGs (2), grammatical reasoning (12), and overall cognitive function (13).

One increasingly common solution to the problem of long resident hours has been the introduction of night-float schedules (4,5). These systems assign one resident to assume the night-shift duties for a block of several days to a month, freeing them of daytime responsibilities. The remaining residents are relieved of nighttime responsibilities, allowing them increased sleep.

Night-float systems have been gaining in popularity since the mid-1980s. A recent poll of internal medicine residency directors found that approximately 30% had experience with a night-float system (14). Four studies (14–17) have specifically investigated the effects of instituting a night-float system.

Trontell et al. (14) administered a questionnaire to all of the U.S. internal medicine residency program directors. Of those respondents who had experience with night-float systems, most strongly agreed that the systems improved housestaff morale; had a positive effect on recruitment; did not seriously compromise educational opportunities; and produced a standard of both nighttime and daytime care that was at least equivalent to that given under a traditional night-call system.

The problems identified with the system were decreased continuity of care, less teaching for the night-float team, and miscommunication between night-float and day staff. In a similar study, Seltzer et al. (17) interviewed residency directors of U.S. obstetrics and gynecology training programs. Again, the researchers found a generally favorable response, with the program directors perceiving the night-float system as benefiting resident satisfaction, resident education, and patient care. Neither of these studies involved any interviews with residents or with faculty who were directly supervising them.

Gottlieb et al. (15) looked at the effect of instituting a night-float system for internal medicine residents on a number of outcome variables relating to patient care. The researchers discovered that under the night-float system the patients had a shorter length of stay, fewer laboratory tests ordered, and fewer medication errors committed by housestaff when compared with patients cared for in a traditional “night-call” system. Again, this study did not explore the residents’ perception of the new system, although the authors report that as a whole the housestaff appeared to have “negative attitudes” toward the night-float system.

Lieu et al. (16) studied the effects of a partial night-float system, in which the system relieved pediatrics residents of routine admissions but not medically unstable ones. Although they found that the residents slept an extra 30–80 minutes under this system, they found no change in the residents’ perception of overall quality of call nights, or in patient care as measured by interviews with the patients’ parents.

In summary, there are a limited number of studies of night-float systems, and none that closely examines residents’ perceptions of such systems. Although the studies agree that such systems do not appear to be detrimental to patient care, they are inconclusive as to whether residents perceive such systems as beneficial, detrimental, or neutral.

Prior studies have interviewed program directors or studied parameters such as hours slept by residents, but no studies provide a detailed evaluation by residents of their night-float experience or an assessment by faculty who were in a position to observe residents’ performance in their work settings.

This study evaluated psychiatric residents’ perceptions of a night-float system compared with a traditional night-call system and examined the hypothesis that residents will report improvement in well-being under such a system without any decrease in the perceived quality of their educational experience or their ability to perform their clinical duties.
METHODS

Night-Float System

The Yale-New Haven Hospital Psychiatric Emergency Room (ER) is a locked, 6-bed unit located in the medical ER. Patients may remain there up to 72 hours for hospitalization or discharge assessment. Until 1993, a traditional night-call system was used for PGY-3 psychiatry residents working in the Yale-New Haven Hospital Psychiatric ER. Call was taken approximately every 11th night, and the residents usually worked a full work day on the day following their call nights. Each resident took call for a total of 6 months during the year.

Starting in July of 1993, a night-float system was initiated, in which night-call residents worked two 1-week blocks of nights from 6 P.M. until 8 A.M., as well as several weekend days (10-hour shifts), during a 6-month period. The residents were relieved of all daytime responsibilities during their night-float weeks. During the first month of each 6-month block (July and December), the residents used the traditional night-call system so they could compare it against their night-float experience.

Questionnaires

A self-rated questionnaire was given to the 21 PGY-3 psychiatry house officers who took call in Yale-New Haven's psychiatric ER. The survey (see Appendix 1), based on similar previous instruments (14), was divided into three segments.

The first segment asked 27 questions about residents' well-being, educational experience, and ability to perform clinical duties. (In Appendix 1, these questions are annotated as "W" for well-being, "E" for education, and "C" for clinical performance.) A 5-point Likert-type scale allowed the residents to indicate their level of agreement with each of the statements. There were an approximately equal number of positive and negative statements. A second segment of the questionnaire asked three questions about sleep, and a third segment asked open-ended questions about the best and worst aspects of the new system.

Each resident was asked to compare his or her time spent under the night-float system to the initial month spent under the traditional call system, so each resident served as his or her own control. In addition, each resident was asked to complete the questionnaire twice during the 6-month block, once immediately after the first week of night-float duty (Time 1) and then again after completing both weeks at the end of the 6-month block (Time 2). We asked the residents to complete the survey twice to examine the effects of recall bias and possible change in attitude with experience.

The questionnaires were sent to all faculty (N = 52), many who supervised the residents in their night-float emergency work (n = 45) and all who supervised their outpatient work (n = 52). Like the resident questionnaire, the faculty questionnaire contained 27 questions addressing resident morale, clinical performance, and educational opportunities, but the questionnaire was slightly modified to reflect the respondents' different role.

Questionnaire responses were combined within each category of question (i.e., well-being, education, and clinical performance) and added together, correcting negative questions by subtracting them from 6, so that 1 represented the most positive statement about the system and 5 represented the most negative for all responses. The questions were combined within each category, and then all were combined and averaged to produce a score representing overall satisfaction with the night-float system, for which 1 represented the most satisfied and 5 represented the least. Z-scores were calculated by comparing means to a null set composed of all "3s" (neutral response).

The residents' responses were compared
between Time 1 and Time 2, as well as between Time 2 and faculty responses by using paired t-tests and correlation coefficients. All statistics were performed using SYSTAT (18) and STATVIEW (19).

RESULTS

The residents had a response rate of 90% at Time 1 and 100% at Time 2. The faculty response rate was 60%, after 2 mailings and a follow-up letter. Of the 40% of the faculty who did not complete the questionnaires, 5 faculty (10%) returned the questionnaires without completing them, stating that they did not feel they had sufficient familiarity with the residents' experiences to respond.

The residents favored the night-float system compared with the traditional call system. After both weeks of the night-float system (Time 2), they gave the experience as a whole a mean rating of 1.92, which was significantly better (i.e., lower score) than a "neutral" score of 3 ($Z = -10.71, P < 0.0001$, see Table 1). They viewed the night-float system as improving well-being (mean rating = 2.1, $Z = -4.78, P = 0.001$), education (mean rating = 1.71, $Z = -9.79, P = 0.0002$), and performance of clinical duties (mean rating = 1.86, $Z = -7.07, P < 0.0001$). Although there was a statistically significant difference between the residents' overall ratings after their first week of the night-float system and after both weeks at the end of their rotation, (paired t-value = 2.76, $P = 0.01$), there was a high covariance between these two scores ($r^2 = 0.87$). Within each subset of questions, there was also a high covariance between the two rating periods ($r^2 = 0.93$ for well-being, 0.70 for education, and 0.88 for clinical performance).

The residents reported sleeping an average of 2.1 hours on duty while on night float, which was almost identical to the 2.0 hours they reported sleeping while under the traditional night-call system. However, under the night-float system, they reported sleeping 4.9 hours per day while off duty, for a total of 6.9 hours total per 24-hour period. They reported needing 2 days to convert from a day to a night schedule. Fifty-two percent reported that converting to the schedule was easy for them.

The faculty had a generally favorable impression of the new system compared with the old one, though their ratings were less positive (overall mean ± SD = 2.49 ± 0.14, $Z = -7.11, P < 0.0001$). This was also the

<table>
<thead>
<tr>
<th>Variable</th>
<th>Resident Time 1 Mean ±SD</th>
<th>Resident Time 2 Mean ±SD</th>
<th>Faculty Mean ±SD</th>
<th>t-test Time 1 vs. Time 2</th>
<th>t-test Time 2 vs. Faculty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall satisfaction</td>
<td>2.02 ± 0.47***</td>
<td>1.92 ± 0.53***</td>
<td>2.49 ± 0.32***</td>
<td>2.76*</td>
<td>-6.15***</td>
</tr>
<tr>
<td>Well-being</td>
<td>2.28 ± 0.48***</td>
<td>2.10 ± 0.60***</td>
<td>2.80 ± 0.23</td>
<td>3.01*</td>
<td>-2.15</td>
</tr>
<tr>
<td>Education</td>
<td>1.74 ± 0.28***</td>
<td>1.71 ± 0.32***</td>
<td>2.37 ± 0.20***</td>
<td>0.42</td>
<td>-5.31**</td>
</tr>
<tr>
<td>Clinical duties</td>
<td>1.93 ± 0.45***</td>
<td>1.86 ± 0.53***</td>
<td>2.43 ± 0.32***</td>
<td>1.19</td>
<td>-3.91**</td>
</tr>
<tr>
<td>Average Hours Slept</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Night float on duty</td>
<td>2.3 ± 1.4</td>
<td>2.1 ± 0.9</td>
<td></td>
<td>1.06</td>
<td></td>
</tr>
<tr>
<td>Off duty</td>
<td>5.1 ± 1.0</td>
<td>4.9 ± 1.0</td>
<td></td>
<td>1.05</td>
<td></td>
</tr>
<tr>
<td>Long call on duty</td>
<td>2.3 ± 1.0</td>
<td>2.0 ± 2.0</td>
<td></td>
<td>0.81</td>
<td></td>
</tr>
<tr>
<td>Days to convert</td>
<td>2.6 ± 2.0</td>
<td>2.0 ± 1.0</td>
<td></td>
<td>1.32</td>
<td></td>
</tr>
<tr>
<td>East to convert?</td>
<td>10 Yes 6 No</td>
<td>11 Yes 10 No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*P < 0.05; **P < 0.01; ***P < 0.001.
case for questions in subgroups relating to education (mean = 2.37, Z = -7.58, P = 0.0006) and clinical performance (mean = 2.43, Z = -5.87, P = 0.0002). There was no significant difference from the null set for faculty ratings of resident well-being (mean = 2.80, Z = -1.96, P = 0.12). Their ratings were significantly different from residents' ratings at Time 2 (t = -6.15, P < 0.0001), and correlation between faculty and residents' responses was low ($r^2$ for overall rating = 0.32, $r^2$ values for subgroups = 0.52 for well-being, 0.16 for education, 0.22 for clinical performance). In summary, faculty had a favorable rating of the night-float system, although their ratings were more neutral than the residents', particularly on the issue of resident well-being.

On the open-ended questions, the residents cited the following advantages to the night-float system: improved continuity of care for ER patients (53%); not needing to treat outpatients in a sleep-deprived state (48%); improvement in quality of life during the weeks without call (43%); and improved relationship with ER staff (24%). The disadvantages most commonly reported were the cumulative fatigue during the night-float call week (38%) and excessive hours per shift (19%). Among faculty responses to open-ended questions, 35% reported improved continuity of care in the ER, 23% reported improved resident morale, and 19% reported that they were better able to develop an ongoing relationship with residents (attending physicians are on call for 1-week blocks). Faculty criticisms of the system included the loss of residents on daytime duties (19%) and the residents' reports of fatigue during the week (11%).

**DISCUSSION**

This study found that the residents preferred a night-float coverage system to a traditional night-call system and that they reported improvement not only in their well-being, but also in their educational experience and their ability to perform their ER and outpatient clinical duties. These views remained consistent following the first week of night-float rotation and after both weeks were completed at the end of the 6-month ER rotation. The residents reported sleeping almost 7 hours per 24-hour period under the night-float system. They reported adjusting their sleep patterns to a night schedule within 2 days, although many acknowledged that this switch was not easy.

Why did the residents prefer a night-float system over the traditional call schedule? The factor that the residents cited most commonly was improved continuity of care for ER patients. Patients are frequently held in the ER for a 48- to 72-hour evaluation, making continuity of care an important issue. This increased clinical continuity coupled with the fact that the same attending physician works all week with the on-call resident may account for the residents' reports of an improved ER educational experience under this system.

The second most common reason that the residents offered for preferring the night-float system to a traditional call system was that the night-float schedule permitted them to avoid treating patients in a sleep-deprived state. Although call duty had previously been only every 11th night, earlier groups of residents had been concerned about their ability to care for their patients endured on their days following night-call. Paradoxically, the night-float system may have shifted some of that fatigue to the ER rotation, where the residents complained of long shifts and cumulative fatigue.

The residents reported that the night-float system improved their quality of life in the weeks without call. They did not specifically mention whether part of this improved quality of life meant more opportunity to moonlight. Although increased moonlighting might be popular with residents, it would defeat the purpose of ensuring a well-
rested group of residents in the outpatient clinics.

A Hawthorne effect, in which implementing a new program or study itself produces a positive or beneficial response in the subjects, may also explain the residents' positive reports about the night-float system. However, the residents' overall impressions of the night-float experience actually improved between the first measurement period (after 1 week of night float) and the second (after the 6-month block). A Hawthorne effect would have been more likely to fade with time.

The faculty generally approved of the night-float system and did not report a decline in the residents' clinical performance under this schedule. Their responses tended to be more neutral than those of the residents, which may represent that they felt less personally invested in the structure of call than did residents and that neutral answers may have been given for questions they did not feel qualified to answer (for instance, questions related to the residents' sense of well-being). This explanation is supported by faculty responses on the open-ended questions and because 10% of the faculty stated they could not complete the questionnaire at all because they had not had sufficient contact with the residents. The differences between resident and faculty responses suggest that previous studies, which used only faculty or administrators' impressions of such systems, may not have adequately captured residents' experiences (15,16,18).

The study had several limitations. The sample size was small, and the study was only conducted at a single site, which may limit its generalizability. The self-report design makes it more difficult to assess the validity of reports of outcome variables such as quality of patient care and hours slept. We did not look at the effect of individual factors such as moonlighting status, gender, or marital status on the rating of night-float systems. Finally, the study did not include patient-level outcome data, which would be useful to gather in future reports.

In the face of a rapidly changing health care system, academic program directors are rethinking the structure of residency training. They are attempting to balance factors such as housestaff quality of life with service demands and a finite resident pool. This study found that a night-float system of coverage for a psychiatric emergency rotation was feasible to institute, preferred by residents, and that neither housestaff nor faculty reported detrimental effects in the residents' clinical performance or educational experience. However, further research is needed to fully assess whether, or in what cases, the benefits of such programs outweigh the costs.

The authors thank the Yale faculty who were crucial both in the implementation and evaluation of this program.

References

Appendix

Resident Questionnaire

The questions asked below are to compare your “night-float” week in the emergency room (ER) to the “long call” system used during your first month of the ER 6-month rotation. For example, Question 1 would read, “Night float has improved my general sense of well-being and/or morale when compared to regular ‘long call’ in the ER.” Then choose a number 1 through 5 that corresponds with your feelings toward the question, with 1 meaning you strongly agree and 5 meaning you strongly disagree.

<table>
<thead>
<tr>
<th>Questions</th>
<th>Strongly Agree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. improved my general sense of well-being and/or morale. (W)</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2. improved my attitude toward my residency experience. (W)</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. reduced my stress during call. (W)</td>
<td>5</td>
<td></td>
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<tr>
<td>4. reduced the quantity of professional articles I read. (E)</td>
<td></td>
<td></td>
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<tr>
<td>5. improved my effectiveness during daytime responsibilities. (C)</td>
<td></td>
<td></td>
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<tr>
<td>6. interfered with my daytime outpatient educational experiences when compared with long call. (E)</td>
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<tr>
<td>7. reduced my effectiveness as a psychotherapist due to lost sessions during the day. (C)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. impaired the quality of care I deliver to night ER patients. (C)</td>
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<td></td>
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<tr>
<td>9. decreased my general fatigue during daytime working hours. (while not doing night float). (W)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. increased my daytime workload in the outpatient department. (C)</td>
<td></td>
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</tr>
<tr>
<td>11. increased the burden of my coverage for other residents. (C)</td>
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<td></td>
</tr>
<tr>
<td>12. improved the continuity of night coverage for ER patients. (C)</td>
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<tr>
<td>13. allowed me more flexibility in scheduling during the time I was not in the ER. (W)</td>
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<tr>
<td>14. impaired my ER educational experience. (E)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. too many days in a row. (W)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. adversely affected my personal life. (W)</td>
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<td></td>
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<tr>
<td>17. interfered with my outpatient clinical supervision experiences because of missed sessions. (E)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. resulted in missed classes, which had a significant effect on my outpatient education. (E)</td>
<td></td>
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</tr>
<tr>
<td>19. improved my ability to manage acute psychiatric problems. (C)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. overall worsened my relationship with the ER support staff. (C)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. impaired my ability to learn about outpatient psychopharmacology. (E)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. improved my attitude toward outpatient psychiatry. (W)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. made the psychiatric ER more appealing as a potential career choice. (W)</td>
<td></td>
<td></td>
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<tr>
<td>24. reduced my overall stress in my outpatient work. (W)</td>
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(continued)
APPENDIX  Resident Questionnaire (continued)

25. precipitated increased symptomatology in my outpatients because of missed sessions.(C) 
26. improved my effectiveness as a psychiatrist because of elimination of "postcall" sessions.(C) 
27. worsened my decision-making abilities in the ER because of increased fatigue.(C) 

Sleep Questions:
1. How much sleep (approximate hours) did you get a day during your night-float week?
   Off duty ______
   On duty ______
2. How many days did it take you to convert from a day-night to night-day sleep schedule?
   ______
Did you find this process to be an easy one? Yes/No
3. How much sleep did you get during the "long call" system while on duty? 
   Open-Ended Questions:
   What were the best parts of the night-float system?
   What were the worst parts of the night-float system?
Medical Students' Attitudes on Specialist Physicians' Social and Sexual Contact With Patients

John Coverdale, M.B., Ch.B., Timothy Bayer, M.D.
Elizabeth Chiang, M.D., Constance Moore, M.D.
Mark Bangs, M.D.

To assess medical students' attitudes toward social and sexual contact with patients by physicians from three medical specialties (internal medicine, obstetrics-gynecology, and psychiatry), 326 students were surveyed at one medical school and 239 students responded (response rate = 73.3%). Most students perceived that arranging to date and/or dating and genital sexual contact were not appropriate either during a patient visit or concurrent with ongoing treatment. However, as many as 20% of the male students and 3.5% of the female students said that genital sexual contact with patients concurrent with treatment was (sometimes or usually) appropriate, depending on the specialty. Significant gender differences were found in attitudes about physician-patient sexual contact. Genital sexual contact was also significantly less likely to be perceived as appropriate for psychiatrists, as might be expected, than for obstetrician-gynecologists and internal medicine specialists. These results are discussed in relation to current codes of ethics. (Academic Psychiatry 1996; 20:35-42)

Physician-patient sexual contact has been shown to be damaging to patients (1–7). Negative reactions of involved patients are wide-ranging and include feelings of humiliation, guilt, anger, confusion and embarrassment, cognitive dysfunction, and an impaired ability to trust health care professionals (1–3). Surveys of physicians also provide evidence that patients are harmed (4–6). Factors that argue for prohibiting therapist-patient sexual contact also include the possibility of significant impairment in a patient's decision-making capacity, the presence of a coercive element in the relationship, and the possible exploitation of a fiduciary relationship (7).

Prohibition against sexual relations between physicians and patients goes back to the time of Hippocrates. However, because of the general disbelief that sex between physicians and their patients was other than an extremely rare event, it was not until surveys done in the 1970s and 1980s demonstrated the frequency of contact that medical organizations codified prohibitions again. A 1991...
American Medical Association (AMA) report and later opinions by the AMA's Council on Ethical and Judicial Affairs classify sexual contact as sexual misconduct when it occurs concurrent with the physician-patient relationship (3,8). The AMA also classifies sexual or romantic relationships with former patients as unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the prior professional relationship. The American Psychiatric Association (APA) recently classified all sexual activity with either current or former patients as unethical (9).

There are several reports on psychiatrists' attitudes and behaviors toward sexual contact with patients (4,10-12); the few reports of nonpsychiatric physicians' attitudes and behaviors about this issue suggest that they are similar to those of psychiatrists (5,13-15). In the only report we could find in the literature that examines medical students' attitudes about physician-patient sex, 4% of the students from the University of Virginia considered sexual relations with patients acceptable (16). This report did not, however, examine either students' attitudes by level of medical school seniority or their thoughts about the appropriateness of sexual contact with patients by physicians in different specialties.

With these unexplored issues in mind, we conducted a survey to determine 1) the attitudes of medical students toward social and sexual contact with patients; 2) whether these attitudes are influenced by the seniority of the medical student (first- vs. fourth-year students); 3) whether these attitudes are influenced by the gender of the medical student; 4) whether medical students make distinctions in their standards for the appropriateness of physician-patient sexual behavior in physicians of different specialties (psychiatry, internal medicine, obstetrics-gynecology); and 5) if such attitudes are influenced by whether the physician's sexual contact with a patient occurs during patient visits, concurrent with treatment but outside the patient visits, or after treatment termination with the patient.

METHODS

The first- and fourth-year medical school class at Baylor College of Medicine anonymously completed a questionnaire. All first-year Baylor medical students \( n = 172 \); 104 men, 68 women) were asked to complete this questionnaire in November 1990, while all fourth-year students \( n = 154; 104 \text{ men, 50 women} \) were requested to complete it later in the same academic year (April 1991). The questionnaire was given at different times for reasons of convenience to both students and researchers. At Baylor, an elective 4-year track is available for medical students wanting to develop expertise in medical ethics that includes courses on general medical ethics, ethics and health care policy, ethics and health care law, and theology and bioethics. Baylor also places emphasis on teaching medical ethics through case conferences run for medical students throughout their clinical rotations (17). The general medical ethics course was the only one that had begun before the first-year students received the questionnaires. No data were collected on whether the students surveyed had taken any of these electives. However, the students did not receive formal instruction on issues concerning doctor-patient sexual contact during either the courses on ethics or the ethics case conferences.

In the questionnaire the students were asked to indicate their attitudes about the appropriateness of doctors hugging, arranging to date or dating, and/or having genital sexual contact with their patients (whether usually appropriate, sometimes appropriate, never appropriate, or no opinion). These questions were answered for each of three different time frames: 1) during patient visits, 2) concurrent with treatment but outside of the patient visit, and 3) after termination of treatment with the patient.

These questions were essentially the
same as those previously used by Herman et al. to evaluate psychiatrists' attitudes toward sexual contact with patients (4). The medical students were also asked about each of three different specialty groups: 1) psychiatrists, 2) internal medicine specialists (internists), and 3) obstetrician-gynecologists (ob-gyns). In addition, we asked the students in the fourth-year class to explain their responses to questions concerning genital sexual contact between a specialist and patient during patient visits and concurrent with treatment. All students were also asked whether they had known of medical students engaged in each of these social or sexual activities with patients or of faculty who engaged in these activities with medical students.

They were also asked whether they thought these issues should be discussed during medical training and, if so, whether the teaching should be by planned discussion (such as in a formal component of a course, lecture, seminar series, or grand rounds) or by unplanned discussion. To maintain anonymity, demographic data collected from the respondents was limited to their year of medical school and gender. The effect of the respondents' medical school year and gender on their perspectives toward the appropriateness of the various behaviors (sometimes or usually appropriate vs. never appropriate) by physicians in each of the three specialties was assessed by a categorical data analysis of variance, the categorical counterpart of the usual parametric analysis of variance, using the program CATMOD (18).

RESULTS

The questionnaire was completed by 141 first-year and 98 fourth-year medical students, for a response rate of 82% for the first-year class and 63.6% for the fourth-year class. The number and percentage of respondents by gender are provided for each class and both classes together in Table 1. There was a response bias by gender for the fourth-
year class ($\chi^2 = 9.94$, df = 1, $P < 0.005$) and for both classes together ($\chi^2 = 6.2$, df = 1, $P < 0.05$), with the women being more likely to respond.

As can be seen from Table 2, the majority of both the male and female respondents felt that hugging might be (sometimes or usually) appropriate between internists, ob-gyns, or psychiatrists and their patients at any time. However, less than 20% of the respondents thought that arranging to date or dating was appropriate by any of the specialties either during patient visits or concurrent with treatment, and less than 14% thought that genital sexual contact was appropriate by any of the specialties either during patient visits or concurrent with treatment. The percentage of respondents who specified that genital sexual contact was usually appropriate (vs. sometimes or never appropriate) when concurrent with treatment and after termination of treatment, respectively, was as follows: internists 1.3% and 15.8%, ob-gyns 1.3% and 14.6%, and psychiatrists 0.8% and 11%. The women tended to be less likely than the men to rate each of the various categories of behavior as appropriate during each time frame, with some of these differences reaching significance (Table 2). Genital sexual contact was considered less appropriate for psychiatrists than for the other specialists in each time period. Genital sexual contact by physicians in any of the three specialties was perceived to be appropriate behavior by a majority of the respondents if it occurred after termination of treatment.

To determine whether there were differences in responses between the first- and fourth-year medical school classes regarding attitudes toward genital sexual contact, nine categorical analyses were conducted. These were conducted for the respondents' medical school year and gender with attitudes toward the appropriateness of genital sexual contact at the three time frames (during patient visits, concurrent with treatment but outside of the patient visit, and after termination of treatment) by physicians in each of the three specialties (internal medicine, obstetrics-gynecology, psychiatry). With the level of significance at the 0.05, no significant main effects were found for year; therefore, we combined the two medical school classes together for all subsequent analyses. Significant main effects were found for gender for questions on genital sexual contact with patients both during visits and concurrent with treatment, with the women being more likely to respond that this behavior was never appropriate ($\chi^2 = 7.62$, df = 1, $P < 0.01$ and $\chi^2 = 16.48$, df = 1, $P < 0.0001$, respectively). However, there was not a significant main effect for gender for the question on genital sexual contact after treatment.

A significant main effect was found for specialty for genital sexual contact concurrent with treatment ($\chi^2 = 6.97$, df = 2, $P < 0.03$) and for genital sexual contact after treatment ($\chi^2 = 32.76$, df = 2, $P < 0.0001$). The students felt that physician-patient sexual behavior concurrent with treatment was less appropriate for psychiatrists than internists ($\chi^2 = 6.92$, $P < 0.01$) or ob-gyns ($\chi^2 = 4.19$, $P < 0.05$). Such behavior was also considered to be least appropriate after the conclusion of treatment for psychiatrists when compared with each of the other two specialties and less likely to be appropriate after the conclusion of treatment for ob-gyns than for internists (internists vs. psychiatrists: $\chi^2 = 32.76$, $P < 0.0001$; ob-gyns vs. psychiatrists: $\chi^2 = 17.67$, $P < 0.0001$; and internists vs. ob-gyns: $\chi^2 = 7.62$, $P < 0.01$). There was no significant main effect for specialty for the condition of genital sexual contact during patient visits. There were also no significant interaction effects between the three specialties, and there were no significant interaction effects between specialty and gender.

Open-Ended Responses

Fourth-year students were also asked to explain their answers to questions about the
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<th>TABLE 2. The percentage of medical student respondents endorsing at “sometimes” or “usually appropriate” vs. “never appropriate” specific social and sexual behaviors between physicians of three specialties and patients (N = 239)</th>
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</thead>
<tbody>
<tr>
<td><strong>Internists</strong></td>
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<tr>
<td>Respondents</td>
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<tr>
<td><strong>Male</strong></td>
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<tr>
<td><strong>During patient visits</strong></td>
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<tr>
<td>Hugging</td>
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<tr>
<td>Arranging to date</td>
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<tr>
<td>Genital sexual contact</td>
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<tr>
<td><strong>Concurrent with treatment</strong></td>
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<tr>
<td>Hugging</td>
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<tr>
<td>Dating</td>
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<tr>
<td>Genital sexual contact</td>
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<tr>
<td><strong>After termination of treatment</strong></td>
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<tr>
<td>Hugging</td>
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<tr>
<td>Dating</td>
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<tr>
<td>Genital sexual contact</td>
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</tbody>
</table>

*The percentage of respondents who had no opinion for any question ranged from 0% to 5%.

bP-values calculated by Fisher’s Exact Test (two-tailed).

*P < 0.5; **P < 0.01; ***P < 0.005.
appropriateness of genital sexual contact between a specialist and patient. Of the 14 to report that such contact was sometimes or usually appropriate, either during patient visits or concurrent with treatment, the most frequent explanation simply was that “it is appropriate” \((n = 3)\). Singular student responses were that sexual behavior patients was appropriate if “there is no ethical conflict,” “it is concurrent with treatment such as medications,” “done between two adults who over the course of time have fallen in love with each other,” “a physician is not taking advantage of the situation,” “loving feelings are there,” or “the patient is not taken advantage of.” The most frequent explanations given by the 84 who responded that genital sexual contact was never appropriate included that “it is not professional” \((n = 13)\), that it disrupts or harms the doctor-patient relationship \((n = 12)\), and that there is an unequal power relationship between the patient and the doctor \((n = 12)\).

**Perceived Sexual Activity in Peers**

All medical students were asked about their personal knowledge about social and sexual contact between patients and medical students or physicians. Twenty-four percent of all respondents reported that they had known a medical student or doctor who had hugged a patient either during patient visits or concurrent with treatment, whereas only 2% had known of dating and 3% had known of genital sexual contact between doctors and their patients. After termination of treatment, these percentages were higher. Twenty-nine percent of the respondents reported that they had known a medical student or doctor who had hugged a patient, 13% had known of dating, and 10% had known of genital sexual contact with patients after termination of treatment. Six percent of the first-year students and 43% of the fourth-year students reported that they had known of sexual contact between medical students and faculty. Eighty-seven percent of the respondents said that doctor-patient sexual contacts should be discussed in training, with 82% of those who felt it should be discussed indicating that this should be done in a formal, planned way.

**DISCUSSION**

These data demonstrate that the vast majority of medical students endorse an absolute prohibition against dating and genital sexual contact with patients during patient visits and concurrent with ongoing treatment. In contrast, hugging was perceived as being appropriate by the majority of the students, although it is difficult to determine what this finding means because there are many different kinds of hugging. The percentage of the students who endorsed behaviors of dating and genital sexual contact with patients, however, is larger than the 4% of the Virginia medical students who thought that doctor-patient sex might be appropriate \((16)\). As many as 20% of the male and 3.5% of the female Baylor medical students who offered an opinion endorsed genital sexual contact concurrent with treatment as being sometimes or usually appropriate behavior with patients. There are no clear explanations for these attitudinal differences between the medical students at the two schools. While the relationship between attitudes and subsequent behavior is unknown, an important question raised by our data is whether the students who endorsed sexual behaviors with patients include those future physicians most likely to have sexual relationships with their patients when in practice.

Medical students were much more accepting of dating and genital sexual contact with patients after treatment had ended. Sixty-nine percent thought that genital sexual contact was appropriate for internists, 63% for ob-gyns, and 51% for psychiatrists. Although this finding suggests that medical students lack an understanding of the potential for exploitation of patients' emotions and trust, and of the undue influence that can be
derived from the previous professional relationship, it does not contradict the AMA’s position, which does not categorically prohibit all sexual or romantic relationships with former patients (8). The APA principles, however, do categorically prohibit any such activity (9), even though this is still a controversial area in psychiatry (7,19).

We were interested to find that medical students had different attitudes toward sexual behavior with patients by different types of specialists. Such behavior was considered as being least likely appropriate for psychiatrists during any of the three time frames and less appropriate for ob-gyns than internists after treatment had ended. This may reflect an understanding that psychiatric practice is colored by the essentially private, highly personal, and sometimes intensely emotional nature of the psychiatrist-patient relationship (9). Such intense treatment relationships may activate sexual fantasies on the part of both patient and psychiatrist. These feelings may include infantile sexual desires arising from the transference that impair the patient’s ability to provide informed consent to sexual involvement and weaken the objectivity necessary for control (7,20). Some patients such as those with severe personality disorders may be particularly vulnerable. Obstetrician-gynecologists may be held to a higher standard than internists because the former work exclusively with female patients and are primarily involved in treatment of problems involving the genital area, leading to a greater likelihood of confusion on the part of the patient about the physician’s professional and personal interests.

The female students were significantly more likely to respond that genital sexual contact with patients was inappropriate during a patient visit or at any time during the course of treatment. They may more readily identify with the potential vulnerability of female patients. Studies of psychiatrists’ sexual behavior with their patients have found that 88% of the sexual contacts were reported to have been between male psychiatrists and their female patients (10).

Very few medical students reported knowledge of sexual contact between other medical students or other doctors and their patients. However, 43% of the fourth-year student respondents reported knowledge of sexual contact between medical students and faculty (although such a finding does not tell us about the prevalence of these behaviors). One argument for prohibiting relationships between faculty and students is that this provides a model that may influence the likelihood of subsequent doctor-patient sexual contact. The importance of role modeling in learning ethical behavior is suggested by a study of psychologists where those who reported sexual contact with supervisors as a trainee were more likely to report sexual contact with patients after graduation (21).

Our results should be viewed in light of several limitations. First, behaviors such as hugging and arranging to date were not specifically defined, and we did not distinguish between homosexual and heterosexual contact. Second, we have self-report data, and the possibility of bias in the direction of socially desirable responses exists. Third, our data are drawn from a single medical school, so our findings are not necessarily generalizable to other medical students. Last, we did not ask about social and sexual contacts in unusual circumstances, such as when a single physician resides in a small town where the pool of nonpatient partners is relatively small or unavailable.

Despite these limitations, we have shown that many medical students’ attitudes may conflict with AMA standards and are contrary to APA standards about sexual contact with patients. While sexual behaviors with patients was generally perceived to be less appropriate for psychiatrists than for the other specialists, 12% of male students responded that psychiatrist-patient genital sexual contact was appropriate concurrent with treatment and 51% of both male and female students reported such contact was
appropriate after termination of treatment. The finding that attitudes were not significantly different in the first- and fourth-year classes suggests that attitudes do not change as a result of the process of professional socialization during medical school. Although various courses and case seminars on medical ethics were offered to medical students at Baylor (15), issues concerning doctor-patient sexual contact were not formally addressed. Therefore, there appears to be a need to address this issue directly during medical school, an idea strongly supported by the students we queried and recommended as a measure to prevent serious violations of professional boundaries (22). Future studies should evaluate the effectiveness of such educational interventions in changing medical students’ attitudes about social and sexual relations with patients, and longitudinal studies are needed to determine if such attitudes predict physician behaviors in practice.

The authors thank John Thornby, Ph.D., for his statistical advice.

References

Ethics Series

A Pilot Course for Residents on Sexual Feelings and Boundary Maintenance in Treatment

Gregg E. Gorton, M.D.
Steven E. Samuel, Ph.D.
Sandra M. Zebrowski, M.D.

Surveys indicate that between 6% and 10% of psychiatrists report sexual contact with patients. Surveys also indicate that only a small minority of psychiatrists feel that they have received adequate teaching about this unethical behavior. Educational efforts aimed at reducing sexual exploitation of patients would be of value to trainees, patients, academic programs, and the profession. The authors report their experience with a pilot 6-session course for residents, and a longer model course is outlined. Such education should be mandatory in U.S. residencies. Mandated instruction would be consistent with both the high priority training directors have reported placing on the subject of sexual misconduct in ethics teaching, and with the widespread calls for increased education on this important subject. (Academic Psychiatry 1996; 20:43–55)

Survey research data indicate that between 6% and 10% of psychiatrists have had sexual contact with their patients, despite ethical codes prohibiting such behavior (1). Surveys also indicate that only a minority of psychiatrists have received what they consider to be adequate education on the subject of boundary violations in therapy and sexual exploitation of patients (2–4). This is especially surprising given that 72% of residents surveyed acknowledged sexual attraction to one or more patients (2). Though nontrainee psychiatrists have not, to our knowledge, been polled on this issue, 87%–92% of practicing therapists in other fields report having had sexual feelings for patients, ranging from attraction to genital excitement (5–7). There is no reason to believe that practicing psychiatrists are at less risk than residents of having such feelings, nor that they would be any better equipped to deal with them appropriately, in the absence of training in the management of such feelings.

Many have called for increased education and training focusing on these critical clinical and ethical issues (2,5,8–21). Although a 1989 national survey of residency training directors and chief residents found that the ethical issue felt to be most important in a core ethics curriculum was precisely this issue of sexual involvement with pa-

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patients, the survey also found that only 20% of the 136 responding residency programs offered a formal course on this topic (22). Unlike residency training in Canada, where the Psychiatric Association Board of Directors recently approved guidelines for "essential" education on prevention of sexual exploitation of patients (4), no such guidelines for U.S. residency programs exist, apart from the general requirement for ethics teaching (23).

One might reasonably question the value of education for prevention of sexual exploitation of patients, since there is as yet no clear evidence that it leads to a lower incidence of this unethical behavior. We believe that there are at least four compelling reasons why such education would be important and potentially useful, even if it may have negligible or no effect on trainees with certain types of personality pathology that may make them more likely to exploit patients (1,10).

First, education would heighten awareness of trainees about the common occurrence of sexual feelings in the treatment setting and the need for an absolute boundary maintenance between such intrapsychic experiences and any unethical outward expression of them. As suggested by survey research (2,5), education may facilitate discussion of sexual feelings in both supervision and consultation settings. In addition, education may empower residents and faculty to speak openly about these issues without fear of stigmatization or recrimination.

Second, education would heighten awareness of the existence of therapist-patient sexual exploitation; its history and prevalence; and that it inevitably harms patients, psychiatrists, and our profession.

Third, educational efforts may foster a culture of awareness and of diminished tolerance of unethical behavior in training institutions and in the profession. Efforts would help signal within departments of psychiatry that sexual boundary violations—including between faculty and trainees—are unacceptable. For example, there is evidence that professionals who have received training on this topic are more likely to take appropriate action upon hearing about ongoing sexual exploitation of a patient by a colleague (24).

Fourth, institution of education about sexual exploitation may indirectly influence public awareness and engender greater trust in potential patients—trust that psychiatrists take this problem seriously and are addressing it. Institution of this education would help send a clear message that psychiatry condemns sexual boundary violations and has affirmed a strong commitment to prevention by ensuring that trainees are exposed to such education.

Relatively few publications address specific approaches to training and education on this subject, and these are found largely in the nonpsychiatric literature (4,5,13,16, 17,25-33). We know of no specific didactic course on this subject described in the psychiatric literature, though videotaped vignettes (34,35) depicting aspects of these issues have been produced by psychiatrists and to some extent disseminated for use in teaching.

We describe the administrative and didactic aspects of a pilot course that we taught in spring 1993 to postgraduate year (PGY)-4 residents at Thomas Jefferson University Hospital in Philadelphia, Pennsylvania. We will give pre- and postcourse knowledge and attitude data, as well as the residents' course evaluation data, and we also describe our experience teaching the course.

**COURSE DESCRIPTION**

**Administrative Framework**

A pilot course was taught to the entire class of 5 male and 4 female PGY-4 residents in the spring of 1993. The course met weekly for 6 50-minute sessions, which were mandatory, as are all classes in the core curriculum. The residents were asked to complete a questionnaire to assess their knowledge and atti-
tudes both before and after the course. They also completed two endpoint course evaluation questionnaires.

The authors served as faculty for the course. We met with the residency training director several weeks before the first session. A variety of clinical and administrative matters were discussed, including potential resistance to the course by the faculty or trainees, and confidentiality. We reflected on how to handle any sensitive clinical material presented by the residents that might raise the possible need for supervisory intervention, and we agreed that this would be dealt with by encouraging residents to consult a supervisor or the residency director. The faculty would neither provide specific clinical case guidance nor would we routinely identify to the director any residents having particular difficulty with sexual feelings or ethical issues in their clinical work.

Pennsylvania currently has no statute mandating reporting of alleged sexual misconduct. In states with such a law (e.g., Wisconsin, Minnesota, and California), this becomes a potentially thorny issue in the didactic setting. A logical approach would be to check the specific content and mandate of state law and then advise residents about it in the first session.

The following is a précis of the course content.

Session 1: Introduction. We first presented the purpose of the course, and we each described the evolution of our own interest in the subject matter. We provided working definitions of exploitation and countertransference, an historical perspective, and prevalence figures on both sexual misconduct by therapists and therapists' self-reported sexual feelings in treatment of patients. Exploitation was defined as the "act of utilizing or turning [a situation or person] to one's own use, or of making unethical use of [a situation or person] for one's own advantage or profit" (36). Countertransference was defined according to what has been called the totalistic view as "all of the therapist's conscious and unconscious responses to the patient," ranging from responses attributable to the therapists' own idiosyncrasies to responses that reflect the patient's personality and behavior (37). We acknowledged some degree of controversy in the profession about the "gray areas" in defining boundary violations (30,38–40). We emphasized the critical distinction between a therapist's experience of sexual feelings and a therapist's unethically acting on such feelings.

We introduced the concept of the fiduciary nature of the doctor-patient relationship (beneficence and nonmalfeasance) as the foundation for determining whether a given interpersonal behavior might violate boundaries and/or be exploitative (30,38,40). We also delineated some basic boundary guidelines that are widely accepted (30,38–40) as well as the fundamental ethical principles underlying these guidelines. These principles include the following: the rule of abstinence, the duty of neutrality, patient autonomy and self-determination, the fiduciary relationship, respect for human dignity, honesty, and confidentiality (30,38,40). We then provided a number of typologies of therapists who have exploited patients, and of patients who have been victimized (1,19,21). We emphasized that not all sexual exploitation of patients is necessarily related to improper management of countertransference. The residents were encouraged to use the Exploitation Index (41,42), "a self-assessment test designed to help therapists evaluate their management of boundary issues" (30). Finally, the residents were given a packet of reading material (2,5,8,9,37,39–46) and a list of recommended books (1,10,13).

Session 2: Ethical and Legal Issues. We discussed ethical guidelines (38,44), legal and professional strictures and sanctions (1,21,45), and procedural and reporting issues when dealing with a patient alleging prior exploitation by a health professional (44,46). An overview of types of boundary
violations and issues in boundary maintenance was offered (21,38,39,42,43). We stressed the concept of a "slippery slope" leading from subtle to overt boundary violations (26,30,39,43), as well as the power difference in mixed-gender and doctor-patient relationships. We detailed some of the many different types of potential boundary violations, both sexual and nonsexual (21,27,30,38,43). The residents were encouraged to begin presenting some of their own experiences establishing and maintaining treatment boundaries.

Session 3: Videotaped Material I. This session was the beginning of the experiential component of the course, considered vital to education on these subjects (13,17,20). The group viewed taped segments and vignettes (34, 35,47) that portray sexual feelings, boundary issues, and ethical dilemmas from both the patient's and the clinician's viewpoints. Discussion of countertransference issues, boundary management, and interaction techniques was initiated. We focused on framing the particular dilemma within a hypothetical treatment course, analyzing the ethical issues, and then therapeutically responding to minimize the risk of unethical behavior and maximize therapeutic efficacy.

Session 4: Videotaped Material II. This session continued with case vignettes and further discussion, plus boundary exercises (29). We encouraged the residents to discuss their thoughts and feelings, and then hypothetical interventions were entertained.

Session 5: Case Material. Three clinical cases from Gorkin (37) were discussed. Two residents presented some of their own case material. The focus of discussion was on noticing, containing, analyzing, monitoring, and therapeutically using the therapist's sexualized responses. Consistent with our approach throughout the course, the residents were cautioned against disclosure of their own sexual feelings to patients. Rather, the residents were encouraged to consider their own feelings as important data about themselves, their patients, and the therapeutic relationship (20,37)—data to be understood, not indiscriminately revealed. Appropriate use of consultation, referral, therapists' personal treatment, and possible termination was also emphasized.

Session 6: Conclusion. Factors predisposing a therapist to gratify his/her personal needs through a patient were highlighted, including personal life and professional practice isolation and a variety of life crises. We stressed the importance of having a satisfying personal life and suggested establishing a professional structure for potential consultation, referral, and personal psychotherapy. Administrative issues in group practice and institutional settings were discussed. The residents were asked to reflect on what the course had meant to them.

PROGRAM EVALUATION

Nine psychiatry residents attended an average of five sessions. Six residents reported using the Exploitation Index during the course. They had also been encouraged to keep a countertransference journal, to be cited at their discretion throughout the course or during their individual supervision. Only one actually kept such a journal, though all discussed some of their clinical experiences on at least one occasion.

Immediately before and after course participation, the residents anonymously completed a 3-section questionnaire. The first section contained a 22-item true/false questionnaire designed to assess general knowledge about boundary violations (a copy is available from the authors). All 11 PGY-4 psychiatry residents at the New Jersey School of Medicine and Dentistry, Cherry Hill, New Jersey, served as a control group that did not receive a formal course on this topic, but they completed pre- and post-course knowledge questionnaires during the
same time period as the Jefferson residents. Both groups had received a 1.5 hour overview grand rounds lecture on boundary violations from 2 of the authors approximately 3 months before completing the 22-item precourse questionnaire. Table 1 presents the two resident groups’ scores on the knowledge section of the questionnaire.

The Jefferson and New Jersey residents’ precourse knowledge questionnaire scores were not statistically significantly different from each other. Nor were the New Jersey residents’ pre- and postcourse scores statistically significantly different. However, the Jefferson residents’ pre- and postcourse scores revealed a significant improvement in knowledge.

The second section of the questionnaire (some of which was drawn from Steres’s work [ref. 16]) included 12 items that were designed to assess resident attitudes. The Jefferson residents were asked to rate their degree of comfort or discomfort with four countertransference situations. A rating scale anchored at one end with “1” (“very uncomfortable”) and at the other end with “10” (“very comfortable”) was used for this purpose. Table 2 presents the residents’ ratings.

No significant differences in levels of comfort with the four countertransference situations were apparent within the group before course completion. However, a nonsignificant shift in the direction of increased levels of comfort with three of the four countertransference situations was evident after the course.

The third section of the questionnaire also assessed attitudes (Table 3). The Jefferson residents were asked to “rate how comfortable you would be using [the listed] disclosure [statements] with appropriate preparation and thoughtful reflection regarding the patient and the therapeutic intent.” A rating scale anchored at one end with “1” (“very uncomfortable”) and at the other end with “10” (“very comfortable”) was used. Here, we wanted to assess whether the residents might, despite faculty’s cautionary teaching about disclosing sexual feelings to patients, become increasingly—and worryingly—comfortable doing this as a result of the course. Table 3 presents the residents’ ratings.

The residents indicated considerable discomfort with all five inappropriate disclosure statements before participating in the course. There was an increase in mean group comfort level for Statement 5 on disclosure after course completion. A separate data analysis indicated that male residents in particular demonstrated an increase in comfort level with disclosure Statement 5 (males: $t = 3.07, P < 0.05$; females: $t = 1.22, \text{NS}$).

We asked the residents several questions to get their evaluation of the course. Using a scale anchored at one end with “1” (“not at all important”) and at the other end with “5”

<table>
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<tr>
<th>TABLE 1. Results of 22-item knowledge section</th>
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<tr>
<td>Jefferson residents ($n = 9$)</td>
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<td>New Jersey residents ($n = 11$)</td>
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*$t = -2.17, P < 0.05$.

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<tr>
<th>TABLE 2. Results of attitude section: therapist’s situational comfort/discomfort</th>
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<tr>
<td>Strong Feelings of Sexual Attraction Toward:</td>
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<tr>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>A long-term patient</td>
</tr>
<tr>
<td>A patient of your nonpreferred sex</td>
</tr>
<tr>
<td>A patient who had previously been sexually abused</td>
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<td>A patient with a serious character disorder</td>
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("highest importance"), they found the teaching of subject matter such as that offered in the course to be of "high importance" (mean score = 4.1).

Using a scale having "1" ("no, definitely not") at one extreme and "4" ("yes, definitely") at the other extreme, the residents indicated they "generally" got what information they wanted by attending the course (mean score = 3.3). On a scale with "1" ("quite dissatisfied") at one extreme and "4" ("very satisfied") at the other extreme, the residents were "mostly satisfied" (mean score = 3.3) with the overall quality of the course. As a group, the female residents tended to give more positive responses to all the prior questions. As a group, the residents also indicated they would likely recommend the course to another resident and felt that the course had "helped somewhat" in their clinical work.

Table 4 indicates the Jefferson residents' group mean evaluations of specific topics covered in the course. Twelve of the 14 topics listed were considered by the residents to be either "quite important" or "extremely important" parts of the educational program, with none considered "not important."

<table>
<thead>
<tr>
<th>TABLE 3. Results of attitude section: therapist's comfort with self-disclosure of sexual feelings to patients*</th>
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<tr>
<td><strong>Question</strong></td>
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<td>1. As the response to a long-term patient who asks you directly if you are sexually attracted to him/her: &quot;There is no way that we are going to have a sexual relationship. For me it is just not ethically acceptable, but I want you to know that I find you very attractive.&quot;</td>
</tr>
<tr>
<td>2. As a comment to a patient who is acting very seductively in a session at a time when his or her life is in immediate crisis: &quot;I feel as though I'm being pulled seductively here at a time when your other problems are so pressing. What do you make of this?&quot;</td>
</tr>
<tr>
<td>3. To a long-term patient who has a family history of incest and secrecy regarding sexuality: &quot;You know, for some reason, I am finding myself sexually attracted to you today and I believe this would be useful for us to try and understand.&quot;</td>
</tr>
<tr>
<td>4. To a long-term patient who appears especially sexually vibrant after a period of depression: &quot;You seem especially sexy this morning. What do you make of this?&quot;</td>
</tr>
<tr>
<td>5. Comment to a long-term patient when you notice an intense build-up of sexual feelings between the two of you during the session: &quot;There is a lot of sexuality in the room right now. What do you make of this?&quot;</td>
</tr>
</tbody>
</table>

*Questionnaire items drawn, with permission, from Steres (1992)"
Finally, each resident was asked to participate anonymously in the routine course evaluation process conducted annually by the chief resident to provide feedback about the residency program to the training director. No negative remarks were made. Some of the residents’ verbatim comments sent to the residency director follow: “The instructors were prompt, clear, enthusiastic, and helpful.” “They enabled us to discuss some very affect-laden material in a safe, comfortable way.” “The material was valuable and helpful.” “We feel the course should be expanded and held earlier.” Finally, there was nearly unanimous support for continued use of mixed-gender faculty.

FACULTY EXPERIENCE
TEACHING THE COURSE

First Session

Following a brief history of the course, the faculty each provided personal examples about their interest in and experiences related to the topics. These examples included reactions to patients who had been exploited by previous therapists; reaction to a case presentation in which a presenter had apologized for mentioning aspects of his sexualized countertransference; an experience with an exploitative supervisor during training; erotic countertransference reactions to patients; the dilemma of whether to report a well-liked, well-respected colleague who had been sexually involved with a patient; and reactions to former teachers’ having been sued for alleged exploitation of patients. Our goal was to create a sense of familiarity and comfort—and at times discomfort—with our experiences in this area. We also hoped to provide a model of the variety of ways that we might reveal our feelings and thoughts about these situations.

Next, the residents were asked to comment on their own interest in the topics and on what they hoped to gain from the course. This semistructured technique was designed to draw the residents into a participatory and progressively revelatory mode, with the goal of minimizing the possibility that some would offer no comment at all, whereas others might dominate the discussion. The residents each contributed, with the male residents being more outspoken in the first session.

Middle Sessions

The second, third, fourth, and fifth sessions were notable for a certain amount of avoidance of open discussion on how to deal with sexual feelings, especially among the male residents. For example, only one male resident reported having the experience of being attracted to a female patient, and none admitted an attraction to a male patient. After viewing the videotapes, the residents, particularly the male residents, tended to ask the faculty for specific ways of responding to the dilemmas presented by the videotapes rather than expressing their own possible

<table>
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<th>TABLE 4. Results of course evaluation: ratings of specific course topics</th>
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<tr>
<td>“Extremely Important”</td>
</tr>
<tr>
<td>Managing eroticized transference</td>
</tr>
<tr>
<td>Noticing and analyzing eroticized countertransference</td>
</tr>
<tr>
<td>“Quite Important”</td>
</tr>
<tr>
<td>Historical survey of the issues</td>
</tr>
<tr>
<td>Current professional ethical guidelines</td>
</tr>
<tr>
<td>General legal issues</td>
</tr>
<tr>
<td>Current state laws</td>
</tr>
<tr>
<td>Current professional sanctions (e.g., licensure loss)</td>
</tr>
<tr>
<td>Case material presentation by residents</td>
</tr>
<tr>
<td>Case material presentation by faculty</td>
</tr>
<tr>
<td>Avoiding boundary violations</td>
</tr>
<tr>
<td>Seeking consultation</td>
</tr>
<tr>
<td>Seeking personal psychotherapy/psychoanalysis</td>
</tr>
<tr>
<td>“Somewhat Important”</td>
</tr>
<tr>
<td>Discussing case material from the literature</td>
</tr>
<tr>
<td>Epidemiologic data</td>
</tr>
<tr>
<td>“Not Important”</td>
</tr>
<tr>
<td>(None of the topics listed were considered “not important.”)</td>
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</table>
solutions. In some instances, the residents preferred to locate the potential source of boundary violations in patients, rather than acknowledge the possibility that they themselves might be vulnerable to even some unwitting blurring—not to mention violation—of boundaries. The female residents seemed particularly concerned about how setting limits on a sexually provocative male patient could negatively affect the transference and therapy processes.

Rather than immediately providing one or another “correct” response to specific questions, we elected initially to reflect many of these concerns back to the group to foster further discussion. After further group exploration of the possible responses and the risks and benefits of each, we then tried to provide a general framework for approaching each particular issue by talking about how we would approach the various situations. Differences in approach between the faculty members were acknowledged to highlight a range of possible human reactions as well as ethical and therapeutically useful interventions.

**Final Session**

In the final session, we continued to reflect with the trainees about optimal techniques for dealing with sexualized situations in therapy. They also raised questions about how best to handle administrative aspects of these issues in some of their new job settings, such as how to establish institutional ethics policies and how to screen and supervise clinic staff. We concluded with a discussion of how to develop a consultative relationship with a trusted colleague to whom one might turn for assistance in the future (31).

**DISCUSSION**

How might one conclude that the course we have described was successful? What are appropriate measures of its educational utility? We begin with relatively crude and subjective measures. The number of residents in the course was small; therefore, we can draw only tentative conclusions from both the questionnaire data and the more subjective data sources on this pilot experience. We hope to add data cumulatively in future years to strengthen and bolster our initial assessments and findings.

Attendance was excellent. All residents participated in the discussion, which progressively deepened, with an increased tendency by some, but not all of the residents, to further reveal their feelings and discuss sensitive clinical dilemmas. The residents showed an increased ease of processing relevant clinical and ethical decisions when discussing case material and video vignettes. We noted increased spontaneity of presentation by some residents of their own clinical case material. With others, however, we noticed a consistent reluctance to acknowledge their own vulnerability to sexual feelings. We cannot draw any firm conclusions about what the range of responses among the trainees to this education represents or what it may predict about the trainees’ future behavior. However, educators who teach mandatory courses on boundary issues should anticipate the similar possibility of diverse trainee responses, and should strive to create a learning environment in which increasing participation in the often anxiety-laden discussion of these issues is a reasonable expectation.

From the faculty’s perspective, this pilot course was successful in heightening the awareness in our institution and among trainees that therapist-patient exploitation, including sexual exploitation, exists in our field and may arise out of inappropriate management of boundaries, therapists’ personal needs, and sexualized countertransference.

From the comparative questionnaire data, we can tentatively conclude that the Jefferson residents increased their knowledge about boundary issues after the course, since they achieved significantly higher
scores on the postcourse questionnaire than did the control group. In addition to this short-term learning effect, the residents who took the course showed increased comfort in three out of four countertransference situations. Whether the apparent increase in knowledge and the possible increase in comfort with sexualized countertransference will persist in the long run is unknown, but this is an important area for future research.

What the apparent increase in comfort with self-disclosure of sexual feelings to patients may indicate is not clear. The residents may have felt as an implicit demand characteristic of the attitude section of the questionnaire that one answer should be found to have a higher comfort level than the other answers. Or, with the small number of subjects, this may not be a truly significant finding. To the extent that this represents a real finding suggesting that the residents might, after course completion, be more likely to inappropriately disclose sexual feelings, the cautionary messages from faculty throughout the course about the dangers of inappropriate disclosure would need to be strengthened. Despite some legitimate debate in our field about possible appropriate expressive uses of countertransference (16,20), we feel that as educators addressing the issue of sexual feelings toward patients, the best approach is to assist our trainees achieve greater comfort by acknowledging to themselves that they may have such feelings, but that they must then be contained and analyzed, not disclosed to patients (16, 30,31,37).

Although our course was by almost all the prior measures a success, this would not, of course, have been achieved had we been unable to institute the course in the first place. There may be a number of potential obstacles to instituting such education efforts at other academic centers. For example, teaching on these topics may fail to enter the formal curriculum because these efforts may be perceived of as being neither valuable nor important enough to institute. Alternatively, this subject matter may be taught, but not in a cohesive way, in a single course. It may be fragmented in a few parts of the curriculum, or only discussed superficially on one occasion. One such scenario might be a single hour of discussion of videotaped vignettes with the residency director. Or, a course that is actually instituted may fail because its content is devalued and its faculty denigrated in other parts of the training milieu.

A recent survey with excellent return rates (22) may perhaps serve as a proxy poll indicating broad consensus among directors and chief residents on the highest priority that should be accorded to education on psychiatrist-patient sexual contact in training programs. The fact that this issue was the second most frequently taught topic in ethics courses among the programs responding to this survey is another indicator of consensus, but the survey data showing a low prevalence of formal courses on this same topic are disturbing.

The trend toward statutory penalties for unethical conduct (now enacted in 15 states, with mandatory reporting of alleged sexual misconduct in 3 of them) may provide impetus for training directors to at least alert trainees that they are posing a grave risk to their careers if they behave unethically. If these legal sanctions are to do more than drive sexual misconduct even further underground, we believe that progressive expansion of training can facilitate the majority of trainees’ increased awareness of boundary issues and sexual feelings in therapy, with resultant enhancement of competence in conducting themselves in ethical, therapeutically beneficial ways. Even if there may always remain a small number of psychiatrists whose psychopathologic inability or refusal to adhere to professional ethics and community practice standards renders them beyond the reach of education (1,10), the consciousness of the profession will have been heightened, and a socioprofessional culture may develop that would serve as background to set “in relief” ongoing possi-
ble transgressions so that they may be dealt with more properly and effectively.

With these considerations in mind, we join with others (4,9,25) in calling for the type of mandatory education we have described. A national mandate would add the proper imprimatur signifying wholehearted approval of this kind of visible response to the tremendous concern raised by many about the potential for abuse by psychiatrists of their privilege and authority.

To the extent that residency programs may be instituting more education on sexual boundary issues, the possible shift in educational culture that this represents may wither in the future in the absence of state- or national-level mandate for its inclusion in accredited programs. One effect of mandatory education on this subject would be to guarantee its further institutionalization into the curriculum, that is, its survival and mainte-

nance as a vital and necessary part of the curriculum from year to year, irrespective of change in faculty, training director, or department chair.

We propose a model 12-hour course (Table 5) for consideration and discussion. We believe such a course could provide an even more comfortable milieu for most trainees to develop the degree of trust and emotional safety requisite for the in-depth didactic and experiential exploration (17,20) needed to consolidate learning about these issues.

Many experienced educators on this subject feel strongly that to make a meaningful impression on the maximum number of trainees, it is crucial to deploy diverse teaching modalities (G. Schoener, personal communication, 1994). Thus, the longer 12-session course would allow use of a didactic format for information transmission, videotaped trigger vignettes, group exer-

| TABLE 5. Proposed 12-session course model |
|-------------------------------|----------------------------------|
| **Session** | **Topics** | **Session** | **Topics** |
| 1 | Pre-course knowledge and attitude questionnaire  
Definitions, history, and prevalence of exploitation  
Common occurrence of sexual feelings in treatment  
Course outline, guidelines, and reading | 4, 5 | Videotaped vignettes, discussion, types of patients, and psychiatrists at risk of exploitation |
| 2 | Ethical codes and underlying principles  
Legal issues: fiduciary relationship  
State laws: criminalization, mandatory reporting  
Professional sanctions and liability | 6, 7 | Case material: from faculty and readings |
| 3 | Boundary maintenance and boundary violations  
Critical distinction between analyzing intrapsychic sexual experience and sexual acting-out  
"Slippery Slope" phenomenon: from subtle to overt boundary violations, risks of self-disclosure to patients  
Boundary exercises, use of Exploitation Index | 8 | Presentation by previously exploited patient, discussion (Alternative: videotaped or other case material) |
| | | 9 | Presentation by previously exploitative therapist, discussion (Alternative: videotaped or other case material) |
| 10, 11 | Residents’ case material: focus on management and therapeutic use of counter-, transference |
| 12 | Conclusion: emphasis on risk and preventive factors  
Importance of a satisfying personal life  
Postcourse knowledge and attitude questionnaire |
cises on boundaries (29), faculty case presentations, discussion of case material from the literature (17,20,28,32,48,49), resident case presentations, role playing, and presentations by a previously exploited patient and a previously exploitive therapist (preferably a psychiatrist). Given the expanding number of support groups and treatment programs for exploited patients and exploitative therapists, these latter sessions should be relatively feasible to arrange, though videotapes of such persons discussing their experiences are increasingly available and could be substituted if needed (50-53).

The faculty would ideally include persons well integrated into the training program and therefore already known to and trusted by the residents. Forensic psychiatric and ethics faculty might also be included, but care should be taken to avoid a “smorgasbord” approach that would dilute the educationally intimate environment we believe crucial for sensitive and substantive exploration of these issues. Maximal success with broader curricular integration of these topics may be best facilitated by a faculty supervisory seminar such as the one described by Berger et al. (54).

We are well aware of the risk of inundating training directors with burdensome requirements that may stifle flexibility and local control; and we are certainly aware of the current requirement for ethics training by the Accreditation Committee of Graduate Medical Education. We do not feel that it will be enough, however, merely to add the words “including sexual misconduct,” or the like, to the current general requirement for “a solid grounding in medical ethics” contained in the Essentials of Accredited Residencies (23), though this change would in itself be an important advance.

We believe strongly that the general issue of boundary maintenance should be integrated across all 4 years of training. It should be addressed when trainees are first oriented by the training director. Because boundary issues cut across aspects of ethics, forensics, sexuality, and psychotherapy, education on boundaries should be included in courses on all of these topics. These initial exposures should then be anchored in the fourth year with an in-depth formal course such as our 12-session model.

We hope that further provision of thorough, ongoing education on these topics throughout the professional life cycle (including continuing medical education requirements), further research on efficacy and long-term outcome with regard to trainees’ future practice behavior, and further discussion in the profession about all aspects of boundary issues and sexualized countertransference will result in routine consideration of these issues in everyday clinical practice by the vast majority of psychiatrists. This might well reduce the incidence of sexual exploitation of patients. In any case, it would represent the culmination of a professional cultural change that is, in our judgment, long needed and now attainable.

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New Idea

Psychiatric Education at a Veterans Affairs Medical Center

Michael Tedford Lambert, M.D.
Donald Robert Fowler, M.D.

The authors describe how a small and relatively low-functioning psychiatric teaching program at a Department of Veterans Affairs (VA) medical center was transformed over a 6-year period into an active and well-functioning program for both medical students and residents. Steps were taken to address trainees' negative perceptions about VA patients and faculty, recruit and support an education-oriented staff, and improve the "user-friendliness" of the system. Efforts were made to integrate education into the missions of a variety of clinical and research programs while emphasizing the convergence of trends in the field of psychiatry with the VA experience. Data are presented indicating improvements in student and resident evaluations. Training was significantly expanded on inpatient units, chemical dependence units, a research unit, and an outpatient clinic. The authors offer suggestions that may be helpful to those developing psychiatric education at other academically affiliated VA medical centers. (Academic Psychiatry 1996; 20:56–63)

Education is one of the specific mandates of the Department of Veterans Affairs (VA) hospital system. Nationwide, the VA is a major provider of graduate and postgraduate medical education, with over 130 VA hospitals affiliated with medical schools. The VA supports over 14% of all U.S. psychiatry residency slots (1,2). Our service is affiliated with the Department of Psychiatry at the University of Texas Southwestern Medical School at Dallas in a relationship similar to major partnerships between medical schools and approximately 35 full-service, tertiary-care VA medical centers nationwide. Given the magnitude of the VA's role in psychiatric training, relatively little has been written about developing psychiatric education programs at VA medical centers. We describe the transformation of our VA psychiatry service into an active teaching program, and we suggest ways others can use our experience to improve the teaching capabilities of their VA services.

In 1987, our VA service served as an inpatient training site for 3 third-year medical students and 3 second-year psychiatry residents. Six VA faculty psychiatrists participated in teaching on the inpatient ward but had limited involvement in lectures, seminars, or the medical school's education policy and administration. At that time, planning for educational improvements began. The authors, using their multiple roles...
as VA clinicians, academic faculty, educators, and medical administrators, focused on five major areas of concern discussed in the sections to follow. A process of problem identification, development of possible solutions, plan implementation, and results will be described.

ADDRESSING NEGATIVE PERCEPTIONS

At the beginning of the improvement process, the students and residents expressed concerns that psychiatric diagnoses at the VA are seldom seen in “pure” form. In 1987–1988 approximately half of the narrative feedback forms returned by the students and residents included some complaint that VA patients were too old and medically ill, had excessive substance abuse comorbidity, or lacked the social support to be “good teaching cases.” The residents often unfavorably compared the VA patient mix with the carefully screened cases they had seen at a private hospital rotation. The themes of the complaints were that VA patients were too complicated, hopeless, and dangerous to engage in treatment. Therefore, we got the impression that the trainees perceived that faculty working with such “hopeless” cases could not be of high caliber.

Having identified a perception problem, we met with our faculty to examine the validity of the feedback. It was clear that many perceptions about VA patients and faculty were distorted or bordered on negative stereotypes. The faculty concluded that these misperceptions derived from trainees’ lack of appreciation for the potential rewards of working with chronically mentally ill patients, therapeutic nihilism related to inexperience, or unexamined countertransference feelings. We believed that such misperceptions would be highly amenable to educational enlightenment.

As a first step in changing resident attitudes, our staff physicians had to examine their own attitudes and abilities. The staff examined the extent to which they were conveying negative feelings about difficult patients. In many cases, it was clear that faculty were not communicating the rewards that come from ongoing therapeutic relationships with chronically mentally ill veterans. We discovered that some faculty had accepted the idea that the only “good teaching cases” were those with pure nonsubstance abuse disorders, although such cases were rarely found in our patient population. In the staff discussions that ensued, these distortions were recognized. The staff acknowledged that they had developed skills in managing difficult cases that required a combination of treatment approaches. They resolved to communicate the message that every case, given the appropriate supervision, can be a good teaching experience.

Having recognized their expertise in conceptualizing treatment models for complicated cases, our VA faculty chose to emphasize the value of training with a challenging population. The management of difficult and complicated patients became a focus of our teaching program. An important step in this process was developing specific written training objectives and methodologies. In objective planning sessions, our faculty focused on developing the trainees’ competence in addressing chronic severe mental illness, psychiatric comorbidity with chemical addiction, trauma-related emotional disorders, geropsychiatry, and aggression management. A formal “hands-on” training module for managing psychiatric emergencies on the wards was established as part of the orientation for the students and residents. As a result of this training, the trainees enter the wards prepared to safely run an aggression crisis code and are less anxious about their VA inpatient experience.

To further address the perception problem, our faculty met with groups of residents to let them express their attitudes about working with VA patients. The residents often raised issues related to the patients’ social class, compensation seeking, and sub-
stance abuse. For many students and residents, their negative feelings stemmed from the patients’ violent combat histories. By examining these issues in an open forum, the residents were better able to deal with their misperceptions and countertransference feelings.

DEVELOPING AN EDUCATION-ORIENTED STAFF

From the start of the improvement process, we realized the importance of developing a faculty dedicated to the educational mission. We approached this objective through focused recruitment and support of staff psychiatrists interested in participating in psychiatric teaching. Making the best of the rather high staff turnover rate that existed then, the psychiatrists who had not been academically oriented were replaced with educators and researchers.

By fostering areas of expertise that would be pertinent to both the VA mission and the needs of the university, we were able to garner support from our academic department chair. In addition to demonstrating to staff applicants his direct involvement in the strength of our academic affiliation, the chair helped identify potential high-quality candidates through his many contacts across the country.

Recognizing that research and teaching often go hand-in-hand, we recruited faculty to develop research initiatives in schizophrenia, chemical addiction, mood disorders, and geropsychiatry. The importance placed on the teaching program was strongly emphasized during recruitment. As a result of these expectations being made explicit, from the inception faculty researchers set up their programs to include student and resident education.

To administratively encourage staff to participate in teaching, we included education and training competence ratings in all staff performance evaluations. The annual performance review of each clinician provided a formal incentive for faculty teaching activities. Student and resident evaluations were monitored, and regular feedback was given to the faculty. For example, copies of the student evaluation forms were distributed after each rotation, and any pattern of supervision problems was discussed with individual faculty members. Reports from student and resident education committees were given at each monthly staff meeting. With these encouragements from VA administration, the faculty based at the VA hospital became increasingly more active on university education and recruitment committees, assuming a greater role in giving student and resident lectures, seminars, and small group presentations.

MAKING THE SYSTEM “USER-FRIENDLY”

We frequently noted complaints from both formal and informal student and resident feedback that the VA health care system is not “user-friendly.” The trainees’ most frequent complaints were that caseloads were excessive, charts were not available, and there was too much “scut work.” In addition, because of eligibility rules in the VA—which paradoxically make access to outpatient care more difficult than access to inpatient care—our trainees had difficulty arranging outpatient aftercare for their discharged inpatients. In our experience, these are problems commonly seen at many VA teaching sites. To respond to the trainees’ concerns and to foster their suggestions for improvement, we established mid-rotation and end-of-rotation debriefing meetings with students and residents.

In response to these concerns, we attempted to change our view of trainees so that we no longer saw them primarily as service providers. Their training was the principal reason for their presence on the units. Reasonable levels of workload were set, both in number of inpatient cases (aver-
age of 6–8 patients per second-year resident), and new outpatient evaluations by the third-year residents (2 per week). An after-hours crisis intervention program has decreased inappropriate admissions to the trainees’ teams (3). To minimize interruptions, the faculty cover the wards and clinic while the residents attend weekly didactic sessions.

Although we had little success in improving chart availability, a VA-developed computer package was implemented (4). A computer terminal was installed in each resident’s office to allow trainees to instantly obtain on-line discharge summaries, progress notes, medication profiles, laboratory results, and radiology reports. Although our service was the first in the VA system to implement an expanded version of this package, the basic configuration to use this package now exists at all larger tertiary-care VA medical centers.

The students helped us identify the scut work they most disliked: transporting patients for tests, delivering consult requests, and collecting routine lab samples. We negotiated with the Chief of Volunteer Service to have hospital volunteers escort patients for tests in radiology and other areas and to hand deliver routine consultation requests. Our laboratory service provided routine lab collection twice a day after we offered to have psychiatric staff accompany their phlebotomists when drawing blood from the most disturbed patients. Hospital management was supportive in allowing us to use funds designated to improve training to hire support staff to relieve students and residents of scut work.

To facilitate the trainees’ experience with managing patients through different levels of care, we authorized our Mental Health Clinic and Partial Hospitalization programs to follow teaching cases discharged from the inpatient wards, without regard to eligibility, since eligibility discrepancies have been cited as a barrier to high-quality ambulatory-based education at the VA (5).

**USING DIVERSE SETTINGS**

As we considered enlarging the role of teaching at our VA center, it became apparent that a variety of clinical sites would be needed, in addition to our acute inpatient units. We considered specialized treatment programs being developed by the VA’s Central Office as ideal substrates for new educational rotations. Funding for specialty programs such as chemical addiction and posttraumatic stress disorder (PTSD) is periodically available on a competitive basis through the VA’s Central Office. Successful competition for these programs provided funds that allowed us to enlarge our teaching staff. When new psychiatry residency training guidelines required experience in addiction treatment, a chemical dependence treatment unit enhanced by these funds became a first-year resident training site. Medical students now regularly train in the Chemical Addiction Program, recently made a full-fledged clerkship site. The psychiatrist specially funded by our PTSD Clinical Team has become one of the most popular psychodynamic psychotherapy supervisors in the department.

Faculty researchers contribute with a third-year student clerkship and second-year resident rotation based on an inpatient research unit. This rotation incorporates experience in aftercare and structured clinical evaluations. Our trainees gain experience in using recently introduced antipsychotic medications and participating in clinical trials while on this rotation.

The Mental Health Clinic was developed into an integral component of the Dallas VA teaching program. Third-year medical students from the inpatient wards spend part of their week in the Mental Health Clinic, where they see new clinic evaluations under one-to-one supervision from the outpatient faculty. A core outpatient rotation emphasizing psychotherapy training was developed for third-year residents.

Excellence in clinical training depends
on the presence of quality patient care. A full spectrum of care was developed at this VA facility, so that our students and residents could learn in a setting that allows them to coordinate care and interact with outpatient, inpatient, and partial hospitalization programs. During the period described we have also developed case management programs, a homeless domiciliary, a residential care program, and an outreach program to local shelters.

EMPHASIZING TRENDS WITHIN PSYCHIATRY AND THE VA

As mentioned before, early in the improvement process faculty identified trainees' concerns about the relevancy of VA psychiatry. We recognized that trends affecting the field of psychiatry as a whole could be used to draw attention and perhaps emphasize the value of the VA's educational offerings. It appears probable, given the trends in both private and public sector funding, that residents will be asked in their future practices to efficiently treat the sickest and most complicated patients, similar to the current VA population. We elected to emphasize this in our student and resident orientations and teaching conferences.

Based on their feedback, the residents have responded by saying that VA rotations have prepared them for the future.

Specialty and fellowship programs in chemical addiction and geropsychiatry are increasing in number across the country. Data from the Epidemiological Catchment Area Study highlight the prevalence of substance abuse and dependence (6). The literature reflects a growing awareness of the frequent clustering of comorbid psychiatric diagnoses (7). Media attention to the problems of dementia and traumatization have also increased. These developments assist our efforts to highlight the value and credibility of a training experience in VA psychiatry.

The VA has been partially insulated from socioeconomic pressures that have complicated psychiatric education at some non-VA sites, such as excessively managed care and the necessity of faculty devoting more time to meet the financial needs of the hospital (8,9). Like other public sector systems, the VA is under pressure to manage expensive interventions, such as inpatient hospitalization, as efficiently as possible. Nevertheless, as the administrators in charge of psychiatry at our VA medical center, we supported our faculty's decisions to use extended evaluations and therapeutic trials when clinically indicated. This approach allowed our trainees the chance to observe extended treatment response in an intensive setting.

RESULTS

Table 1 summarizes third-year medical student evaluations during the period we have worked to improve teaching on the VA Psychiatry Service. The number of students on site at any given time has increased from 3 in 1987 to 7 or 8 currently. The VA student offering has grown to now include three distinct clerkship sites: General Inpatient, Inpatient Research, and Chemical Addiction Program. Fifteen staff psychiatrists are actively involved in teaching the approximately 55 medical students who rotate through VA psychiatry clerkships annually. VA faculty coordinate the department's chemical addiction education, third-year student clerkship, freshman behavioral science courses, and numerous lectures and seminars. Teachers based at the VA received the academic department's student education award in 2 of the last 3 years.

Figure 1 presents the changes in resident evaluations, which were collected the last 3 academic years of the development period. Evaluations of the resident rotations at the VA steadily improved in the 3 years between 1991–1992 and 1993–1994, from 59% of the residents rating their attending supervision as above average or superior, to 100% giving the experience this rating; VA rotation ratings have similarly improved during this pe-
iod from 71% to 96%. Mirroring these improved ratings, the residents, in their narrative evaluations, now consistently cite the high quality of supervision and the ready availability of dedicated VA faculty.

In addition to those trained on ward and clinic sites, 35 residents received psychotherapy supervision (often for non-VA patients) from VA faculty during the same 3-year period. VA faculty provide supervision in a variety of therapeutic modalities, including psychodynamic therapy, cognitive-behavioral therapy, and hypnotherapy. All of these residents evaluated their VA psychotherapy supervision experience as either above average (n = 5) or superior (n = 30).

The number of residents at the VA site at any one time increased from 3 to an average of 12, rotating at 4 core VA rotations. At a given time, 1 or 2 postgraduate year (PGY)-1 residents are training in the Chemical Addiction Program. Four PGY-2 residents are on General Inpatient, and 2 are on Inpatient Research. Four PGY-3 residents are based in the Mental Health Clinic. Each year 2 or 3 fourth-year residents take 3- to 12-month long VA electives in chemical addiction, research, or teaching.

One of the VA faculty was designated by the department as Assistant Residency Training Director to help coordinate this expanded venue.

ONGOING CHALLENGES AND PLANS

Some problems inherent in the VA experience provide an ongoing challenge. For example, only 4%-5% of our patients are female, limiting trainees' experience with this gender. To address this problem, we have recruited a faculty member with an interest in women's emotional trauma. She co-leads a group for physically and sexually traumatized female veterans in the clinic, provides psychotherapy supervision, and presents seminars to students and residents on female trauma issues.

Nondiscretionary workload is another issue. Appropriate patient admissions into clinical programs cannot be stopped to control the size of trainees' caseloads. We assigned physician assistants, supervised by the faculty and functioning as interdisciplinary team leaders, to help with the extra work in teaching areas. For the faculty, balancing these nonacademic clinical demands

<table>
<thead>
<tr>
<th>TABLE 1</th>
<th>Percentage of Veterans Affairs-based students rating the following evaluation questions</th>
<th>&quot;agree&quot; or &quot;strongly agree&quot;</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>(N = 31)</td>
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<tr>
<td>Increased knowledge of managing difficult patients</td>
<td>65</td>
<td>84</td>
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<tr>
<td>Increased skill in developing psychiatric treatment plans</td>
<td>81</td>
<td>89</td>
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<tr>
<td>Improved psychopharmacology skills</td>
<td>77</td>
<td>89</td>
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<tr>
<td>Increased confidence in managing psychiatric patients</td>
<td>87</td>
<td>95</td>
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<tr>
<td>Increased comfort in interviewing disturbed patients</td>
<td>90</td>
<td>100</td>
</tr>
<tr>
<td>Increased diagnostic skills in psychiatry</td>
<td>94</td>
<td>97</td>
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</tbody>
</table>

*Students were asked to rate their rotation experience on a 1-5 scale of agreement: 1 = strongly disagree, 2 = disagree, 3 = neutral, 4 = agree, 5 = strongly agree.
with the time required for teaching and research remains a continuing challenge.

Our efforts have not completely resolved many of the issues that we addressed. Instead, we are finding a need for the continuous application of the approaches we have described to maintain an excellent teaching environment.

SUMMARY AND SUGGESTIONS

We have found the following ideas helpful in developing our educational programs. These suggestions are offered to those interested in enhancing a VA medical center’s psychiatric education process.

First, VA faculty must actively address misconceptions that the patients or staff are somehow “second-class.” It is important to convey that the veteran patient population presents a fascinating and important mix of clinical problems. Aspects of the VA patient population often derided by beginning trainees as “uninteresting,” “dangerous,” or “hopeless” can provide a foundation for rewarding educational experiences when motivated, capable faculty accept the challenge of teaching in the VA center.

Second, an environment that values education must be created. The development of specific written educational objectives and the day-to-day support of faculty teaching efforts are important. VA management, with the support of the affiliated academic department chair, should emphasize educational programs during faculty recruitment efforts. Highly valued educational programs attract quality VA faculty. We feel that the educational emphasis has significantly helped our recruitment efforts.

Third, realistic problems in the system have to be acknowledged, and efforts must be made to address them. Students and residents respond well to efforts to make the teaching experiences as “user-friendly” as possible. Rather than reacting defensively, faculty should invite trainees’ suggestions and involvement in the improvement process.

Fourth, training should be integrated

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**FIGURE 1.** Percentage of Veterans Affairs (VA) residents rating satisfaction with VA supervisory experience and VA rotation as “above average” or “superior”\(^1\)

![Bar chart showing satisfaction ratings](chart)

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\(^1\)Residents were asked to rate their VA supervisory and rotation experiences on a 1-5 scale corresponding to 1 = unacceptable, 2 = below average, 3 = neutral, 4 = above average, 5 = superior.
into a diversity of programs and levels of care. Developing specialty and research areas into training sites can add important experiences for students and residents as well as provide an important source of funding for new faculty. Special emphasis should be placed on creating teaching programs in the outpatient clinic, research programs, and chemical addiction programs.

Finally, it is helpful to emphasize that the VA experience prepares students and residents for many issues that future psychiatrists will face. The process of working within the limitations of a treatment system will likely be a familiar exercise to the next generation of psychiatrists. To maintain an academic environment, VA psychiatry services should retain the flexibility to allow extended evaluations and clinical trials when indicated.

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Academic Psychiatry 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.
Information for Contributors

The American Association of Directors of Psychiatric Residency Training and the Association for Academic Psychiatry have joined together to sponsor Academic Psychiatry, a peer-reviewed quarterly journal published by American Psychiatric Press, Inc. Formerly the Journal of Psychiatric Education, Academic Psychiatry is dedicated to the publication of work concerning educational efforts by and for psychiatrists, and articles addressing teaching, research, administrative, clinical, organizational, and economic issues relevant to the academic missions of departments of psychiatry. The Editors invite high-quality submissions that further knowledge in psychiatric education and stimulate improvements in academic psychiatry.

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