Perceptions of Treatment Value, Therapeutic Orientation, and Actual Experience of Psychiatric Residents

Jorge I. Casariego and John F. Greden

ALTHOUGH A FAIRLY EXTENSIVE literature exists on how psychiatrists develop professionally,[1-9] three important areas remain inadequately documented. First, doubts remain about the ideologic orientation of residents toward psychiatry. Second, how psychiatry residents perceive the value of various treatment modalities used in psychiatry is essentially undetermined. Third, the actual experience that residents accumulate in using various treatment modalities requires considerable elaboration. These deficiences of information are striking since a psychiatrist's professional identity is clearly related to what he believes valuable and what experiences he incorporates in his practice.[10] The investigators that have evaluated these three topics have concentrated on the attitudes toward treatment approaches mainly of practicing psychiatrists,[11-15] although the work by Stone and his colleagues is a major exception.[16]

In this era of concern about the question "what is a psychiatrist?" (as shown by the existence of an American Psychiatric Association Committee to study this subject), renewed attention must be given to the possible danger of premature theoretic closure among psychiatry residents. If ideologic closure occurs early in residency, the acquisition of new knowledge will clearly be impaired.

The present study evolved from our observations that residents in several residency programs in the Washington, D.C./Baltimore, Md. vicinity seemed to share the same opinions about the worth of various therapies regardless of level of training and orientation of their programs. Most residents also seemed to be firmly set in their opinions at an early stage. To provide some data for these subjective impressions, we decided to survey a relatively large population of psychiatry residents. Several main questions were formulated:

How do residents from different training programs rate the value of various psychiatric treatments when applied to three hypothetic psychiatric conditions?
Do residents in different levels of training rate treatment modalities differently?
What is the self-reported treatment orientation among the population of psychiatry residents?
Does premature ideologic closure appear to be present?

MATERIALS AND METHODS

The questionnaire used in the survey consisted of a computer-tabulated, 21-page form containing 120 questions. Following an introductory page that emphasized anonymity and confidentiality, 49 ques-

From the Veterans Administration Hospital, Miami, Fla. and the University of Michigan Medical Center, Ann Arbor, Mich.

Jorge I. Casariego, M.D.: *Director, Crisis Intervention Program, Veterans Administration Hospital, Miami, and Clinical Instructor of Psychiatry, University of Miami School of Medicine, Miami, Fla.* John F. Greden, M.D.: *Associate Professor of Psychiatry, University of Michigan Medical Center, Ann Arbor, Mich.*

Address reprint requests to Jorge I. Casariego, M.D., Director, Crisis Intervention Program (116A8), Veterans Administration Hospital, 1201 N.W. 16th Street, Miami, Fla. 33125.

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tions assessed demographic characteristics, educational background, the resident's primary orientation towards psychiatry, personal experience in psychotherapy, experience with various treatments during residency, and plans for future practice of psychiatry. A second part of the survey contained 13 questions on current psychiatric controversies previously published elsewhere.[18]

The final segment of the survey asked the respondent to give his opinion of various treatment modalities for 55 items. The ideal treatments were matched up with three hypothetic clinical conditions: schizophrenia, depressive neurosis, and hysterical personality. These conditions were arbitrarily selected as representative of the spectrum of psychiatric entities.

For each of the diagnoses listed, the resident was asked to give his opinion of the therapeutic value on a five point scale, ranging from "contraindicated or absolutely no value" to "minimal value," "moderate value," or "great value." A "no opinion" clause was also available. On the survey, therapeutic value was operationally defined as "the treatment's potential for relieving symptoms and reducing psychopathology." The respondents were asked to assess each modality as if it were the principal treatment, rather than part of a combination therapy. Twenty-five treatment modalities were assessed, some for each of the clinical conditions, and some used more specifically.

The questionnaire was disseminated and collected during the months of May and June, 1973. This was near the end of the academic year in all of the institutions included in this study. The programs surveyed, the number of residents within each program, and the percent responding to this survey were as follows:

(1) Sheppard and Enoch Pratt Hospital, Towson, Md., N = 17 (65%)
(2) Bethesda Naval Hospital, Bethesda, Md., N = 8 (100%)
(3) Georgetown University Hospital, Washington, D.C., N = 24 (63%)
(4) Walter Reed Army Medical Center, Washington, D.C., N = 26 (96%)
(5) Freedman's Hospital-Howard University College of Medicine, Washington, D.C., N = 4 (67%)
(6) George Washington Medical Center, Washington, D.C., N = 7 (88%)

Of the 112 psychiatry residents actually enrolled in six programs at the time of the survey, 86 of

Table 1. Percentage Breakdown of Residents Rating Treatments as Valuable* in Patients With Schizophrenia

Treatment Modality	Year of Residency: First (N = 26)	Second (N = 31)	Third (N = 29)	Total (N = 86)
Major tranquilizers	96	96	100	97
Hospitalization	96	94	96	95
Family therapy	89	80	89	85
Milieu therapy	88	81	89	85
Group therapy	81	71	75	75
Brief, supportive therapy	73	71	70	72
Analytically-oriented, long term psychotherapy	50	48	56	53
Behavior therapy techniques	65	52	43	53
Inpatient ECT	34	23	32	30
Tricyclic antidepressants	12	23	29	22
Lithium carbonate	4	10	15	10
Outpatient ECT	4	16	4	8
Encounter group†	15	0	0	5
Minor tranquilizers	8	0	4	4
Hypnotherapy	8	3	0	4
Psychosurgery	0	0	7	2
Megavitamins	0	3	0	1
Amytal/Pentothal interviews	4	0	0	1
Transcendental meditation	0	0	4	1
Psychomimetics	0	0	0	0

* Respondents answering "Moderate Value" (3) or "Great Value" (4) on a four-point scale.
† χ^2 analysis revealed $p < 0.05$, $df = 2$.

them (77%) completed the form. Of these, 30% were first year residents, 36% were in their second year, and 34% were completing their third year of residency. The majority of those we were unable to survey were on vacation or assigned to elective programs in other places. Completion of the questionnaire required approximately 20 min. Questions were answered by one of the investigators (J.I.C) during the administration of the questionnaire. No forms had to be discarded because of inadequate completion. The majority of respondents were enthusiastic, although guarded skepticism about the survey was occasionally observed.

RESULTS

Attitudes Toward the Value of Treatment Modalities

In the hypothetic treatment of patients with schizophrenia, the 86 residents were asked to assess the value of 20 therapeutic choices. As illustrated in Table 1, the first line of defense for virtually all respondents in each year of training included major tranquilizers and hospitalization. A second cluster of choices included family, group, and milieu therapies, all rated as being of moderately great value by more than 70% of residents in each year. More than half of all respondents also felt that analytically-oriented psychotherapy and behavior therapy techniques were valuable in treating patients with schizophrenia. No other modality, including electroconvulsive treatment (ECT) was rated highly by more than one-third of respondents. In fact, it was striking to note the almost complete absence of approval for controversial treatments, such as megavitamins, psychotomimetics, transcendental meditation, and encounter groups. Encounter groups was the only treatment for which the rating was significantly different (χ^2, $p < 0.05$) among the year groups.

In the hypothetic treatment of a depressive neurosis, 15 therapeutic modalities were rated. As illustrated in Table 2, 85% of respondents rated analytically-oriented long-term psychotherapy, brief supportive psychotherapy, and crisis

Table 2. Percentage Breakdown of Residents Rating Treatments as Valuable* in Patients With Depressive Neurosis†

	Year of Residency			
Treatment Modality	First (N = 26)	Second (N = 31)	Third (N = 29)	Total (N = 86)
Analytically-oriented, long term psychotherapy	88	84	82	85
Brief, supportive therapy	88	84	86	85
Crisis intervention	75	81	93	85
Couple therapy	92	71	86	82
Family therapy	80	71	86	79
Tricyclic antidepressants	85	74	68	75
Hospitalization	65	47	57	56
Minor tranquilizers	50	29	39	39
Inpatient ECT	42	33	39	38
MAO inhibitors	39	32	25	32
Behavior therapy techniques	23	32	28	28
Outpatient ECT	31	26	14	23
Major tranquilizers	19	10	18	15
Hypnotherapy	4	10	4	6
CNS stimulants	4	0	4	2

* Respondents answering "Moderate Value" (3) or "Great Value" (4) on a four-point scale.

† No comparisons among first-, second-, and third-year residents were statistically significant utilizing the χ^2 test (df = 2).

Table 3. Percentage Breakdown of Residents Rating Treatments as Valuable* in Patients With Hysterical Personality†

Treatment Modality	Year of Residency First ($N = 26$)	Second ($N = 31$)	Third ($N = 29$)	Total ($N = 86$)
Analytically-oriented, long term psychotherapy	96	91	92	93
Group therapy	88	90	89	89
Behavior therapy techniques	38	23	37	32
Psychopharmacologic agents	15	0	15	10
Hypnotherapy	16	7	8	10
Amytal/Pentothal interviews	8	0	4	4

* Respondents answering "Moderate Value" (3) or "Great Value" (4) on a four-point scale.

† No comparisons among first-, second-, and third-year residents were statistically significant utilizing the χ^2 test ($df = 2$).

intervention as being of moderate or great value. Couple therapy and family therapy were rated valuable by 82% and 79%, respectively. The value of tricyclic antidepressants was supported by 75% of all residents. Psychobiologic agents, such as minor and major tranquilizers or MAO inhibitors, and inpatient and outpatient ECT received the support of less than 40% of all the residents. Only 28% supported behavior therapy techniques, 6% would use hypnosis, and a mere 2% would prescribe the much advertised central nervous system stimulants for treating depressive neurosis.

In the treatment of the third clinical condition studied—hysterical personality—six treatment modalities were assessed (Table 3). Ninety-three per cent of all residents considered analytically-oriented long-term psychotherapy to be of significant value in the treatment of this condition. Eighty-nine per cent rated group therapy as being valuable. The remaining four choices were all rated rather low: behavior therapy techniques (32%), psychopharmacologic agents (10%), hypotherapy (10%), and amytal interviews (4%).

Effects of Level of Training on Treatment Preferences

Level of training was noted to be of absolutely no statistical significance in the rating of any treatment modality in any of the three conditions, with one isolated exception. This exception was encounter groups for the treatment of schizophrenia, rated valuable by 15% of first-year residents; no second- or third-year residents approved of it (χ^2, $p < 0.05$). None of the remaining 24 treatment modalities was rated significantly different by any year group.

Personal Psychotherapy

We obtained extensive information on a number of demographic characteristics of the surveyed residents, including age, sex, race, marital status, religious heritage, current religious activity, medical education, and involvement in personal psychotherapy before and since the beginning of residency. These characteristics have been extensively reported elsewhere.[18] An important area of findings relevant to this study is the number of residents who were receiving or had received personal psychotherapy. We found that 28% of all residents had received therapy prior to residency, and that 35% had had therapy by their first year, 42% by their second year, and 52% by their third year. A total of 43% of all residents were engaged or had been engaged in psychotherapy at the time of the survey.

Residents' Psychiatric Orientation, Experience, and Future Career Plans

When residents were asked to give their self-described psychiatric orientation, 62% of all residents felt that they were dynamic- or analytically-oriented, 32% felt that they were eclectic, and only 6% said they were oriented toward behavioral, biologic-organic, community psychiatry, or other ideology. No significant differences were noted across the year levels for any orientation given. Almost equal numbers of residents rated themselves dynamic-analytically oriented among first-year (65%), second-year (65%), and third-year (57%) groups. Eclectic orientation was second in popularity with 23% of first-year residents, 32% of second-year residents, and 43% of third-year residents. Behavioral, organic, community psychiatry, and "other" were least popular. This category included 11% of first-year residents, 3% of second-year residents and no third-year residents. When asked to rate which of the psychiatric orientations were "best taught" in their training programs, a resounding 90% of all residents rated the dynamic-analytic theory as the one most effectively taught. The remaining 10% chose one of the others. This attitude clearly carried over to the choices for postresidency practice. For example, a large majority (57%) planned to emphasize the dynamic approach after residency, whereas only 33% would emphasize the eclectic approach and a scant 10% said they would emphasize behavioral, biologic, or community psychiatry concepts. On the question of their career choices after residency, most residents (68%) planned to enter private outpatient practice, 11% foresaw an academic career, only 7% said they would practice in a hospital setting, and the remaining 14% would chose a military career, community psychiatry, private group practice, or other types of practices.

The resident's actual experience with a treatment modality was also assessed (Table 4). Eight arbitrarily selected treatments were rated: the classical analytic format, the analytic couch, ECT, hypnosis, i.v. amytal interviews, behavioral therapy techniques (type not specified), family therapy, and outpatient group therapy. Three treatments were statistically significantly different by year of training. First was outpatient group therapy, which had been utilized by 65% of all residents. However, only 27% of first-year residents had ever utilized the treatment as opposed to 81% and 82% of second- and third-year residents, respectively. The classical analytic format (defined as 3 or more sessions/week, of explorative-reconstructive psychotherapy) had been used by 31% of the first-year residents compared to 42% of second-year residents and 57% of third-year residents. The third treatment was hypnosis, which 32% of third-year residents

Table 4. Percentage Breakdown of Residents' Previous Experience With Various Treatment Modalities

Treatment Modality Used at Least Once	First ($N = 26$)	Second ($N = 31$)	Third ($N = 29$)	Total ($N = 86$)
Classical analytic format*†	31	42	57	44
Analytic couch	0	0	0	0
ECT	42	58	50	51
Hypnosis*	4	13	32	17
i.v. amytal interview	31	42	32	35
Behavioral therapy techniques	27	42	46	39
Family therapy	39	52	68	53
Outpatient group therapy*	27	81	82	65

*$p < 0.05$, $df = 2$.

† Defined as three or more sessions per week of explorative-reconstructive psychotherapy.

had utilized, compared to 13% and only 4% of second-and first-year residents, respectively. Interestingly, no resident had ventured to use the "analytic couch."

DISCUSSION

There were several noteworthy findings in our survey. First was in the area of residents attitudes about the value of treatment modalities. Judging from the responses to this questionnaire, it is evident that all residents had very definite opinions of the value of all the treatment modalities investigated, and that they had no difficulty discriminating sharply among the various treatments examined in the questionnaire. They were able to distinguish among all the 25 modalities when applied to an individual pathologic condition, and also when the modality was used for more than one clinical condition. Possibly the most striking trend we found was the remarkable predilection of the group as a whole for the "individual therapies" and the "social therapies" such as analytically oriented psychotherapy, group therapy, etc. Almost without exception, these therapies were considered highly valuable by all residents in all years. Inversely, the respondents collectively showed a consistent tendency to subtly devalue most somatic treatments regardless of level of training and of clinical condition tested.

In general, modalities like ECT, minor tranquilizers, amytal/pentothal interviews, and psychopharmacologic agents were consistently rated much lower than the nonsomatic therapies. Two exceptions to this trend were the almost universal selection of major tranquilizers and hospitalization as the treatment of choice for schizophrenia and the use of tricyclic antidepressants in the management of depressive neurosis (although this was rated significantly lower than the psychotherapies). The magnitude of the psychotherapeutic predilection is significant even considering the obvious complexities in a questionnaire approach. How can we explain this phenomenon?

Various investigators have tried to classify the ideologic orientation of psychiatrists. Work done in the late 1950s and early 1960s[11,19] distinguished three main ideologic lines in psychiatry: (1) the directive-organic or somatic, (2) the analytic-psychologic or psychotherapeutic, and (3) the sociotherapeutic. We agree with Armor and Klerman's most recent suggestion that the sociotherapeutic line is really part of a broader psychotherapeutic one.[10] In fact, our resident's choices tend to support this hypothesis, especially when one considers the clustering of individual psychotherapies and group type therapies near the top of all tables. Using this classification, it is obvious that our resident population showed a strong psychotherapeutic and a weak somatic orientation.

Substantiating evidence of a psychotherapeutic identification was obtained when the residents' self-reported orientation was determined. Sixty-two percent actually labeled themselves as "dynamic/analytic" and 57% planned to use analytic approaches in their postresidency practice. Furthermore, those who stated they were "eclectic" differed from the analytic group only in greater enthusiasm for behavior therapies, not for other somatic treatments. As stated elsewhere, we feel those residents who labeled themselves eclectic and those calling themselves analytic are all essentially psychotherapeutic in their orientation (nearly 95% of the residents in this study).[18]

The next major area of findings that warrants comment is the remarkable similarity that we found among the year groups in their ratings of the value of treat-

ments. No statistically significant preferences were noted for any treatment condition except for the use of encounter groups in the treatment of schizophrenia by first-year residents. This isolated finding, we believe, may actually reflect first-year residents' genuine ignorance of the psychiatric body of knowledge. Otherwise, the three year groups were basically homogenous in their attitudes toward the value of treatments. From a purely statistical point of view, the findings suggest similarity. However, there were interyear differences noted, especially in the first-year group. First, the 31 first-year residents tended to rate all modalities higher than their second- and third-year counterparts. We believe this may reflect the beginning residents' more genuine enthusiasm and closer adherence to the "medical model" than their more advanced colleagues. Third, the neophytes showed a greater aversion to the analytic and eclectic model.

The answers to questions on demographic characteristics, psychiatric orientations, personal psychotherapy, and actual experience with treatment modalities give us a very interesting body of data. The statistically significant steady progression in the per cent of residents involved in psychotherapy since starting their residency is remarkable indeed. This survey shows that over half of the residents in our population had received some type of personal therapy by the end of their third year. We believe it is possible that the preference shown by these 86 residents for all types of psychotherapy can be explained by the residents' personal experience with therapy. However, we feel that various factors, including resident program selection, identification with teachers and supervisors, and the long-standing tradition and general emphasis of psychotherapeutic and analytic techniques in the Washington-Baltimore area, are probably more important. Whatever the case, it was evident that these residents showed a deep respect for the dynamic theories regardless of level of training. Not surprisingly, we see that the overwhelming trend of our population was toward a career in the private practice of outpatient psychiatry with a strong emphasis on the analytic approaches.

It is noteworthy how early this ideologic parochialism develops. Although we suspected it, the findings did indeed confirm our suspicions. As noted, first-year residents soundly agree with their second- and third-year counterparts in the choice of ideology and in their ratings of treatments. No blanks were seen on the question of self-rated ideology. Whether stemming from anxiety inherent to the current psychiatric training scene, from the perils of "overchoice," from identification with faculty, or perhaps from the resident's own ideologic set predating residency, it seems that the resident is pressured to choose sides early in his training. All residents committed themselves to a distinct theoretic framework quite early. By the end of the first year all residents knew what their orientation to psychiatry was and presumably would be for the rest of their professional lives!

A relevant question for psychiatric educators is whether early identification with any ideology is really desirable. By espousing a rigid theoretic framework in the first year of residency, a resident undoubtedly hinders the accumulation of knowledge and experience with other treatments outside his conceptual framework. Our findings tend to support this hypothesis, as we note that the majority of the residents had never used amytal interview, hypnosis, behavior techniques, or ECT even after three years of training. Obviously, these trends may be confined exclusively to the Washington-Baltimore area and would need validation in other

areas of the country before generalizations can be made. However, if our findings are in any way representative, it would appear that premature ideologic closure is indeed taking place to a significant degree. It certainly appears so judging by our residents' self-described orientation, and to a lesser degree by their strong preference for the psychotherapies in general.

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