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AN INVESTIGATION OF PSYCHIATRY RESIDENTS' IMPORTANT EXPERIENCES

by

Jody Long

A Dissertation

Submitted in Partial Fulfillment of the

Requirements for the degree of

Doctor of Education

Major: Higher Education

The University of Memphis

December 2011

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ACKNOWLEDGMENTS

I want to express my gratitude for the people who have helped me complete my dissertation and degree. I start with my wife, Carol, and my family, Mark and Katie. Without their encouragement and support, I could not have taken on this task. I am sure Carol grew weary of my asking her to read numerous drafts to see if it made sense. If not for her, I may not have continued during challenging times. She supported me with unconditional love through classes, exams, papers and my dissertation. Also, my cat, Harry, was by my side during study times and preparation for classes.

My committee was awesome. Thanks to each of you. Dr Meyer, thank you for being my advisor, mentor and chair of my committee. I remember during one trying period deciding to not return for classes the next semester. However, I received an email stating we need to meet for advisement. Your guidance was crucial for my development as a writer and student. Dr. Mullins-Nelson, I thank you for your committee participation despite never having me in a class. Dr. Cross you were my qualitative research expert and advisor. I appreciate you immensely.

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ABSTRACT

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This research study was conducted to explore the phenomenon of the third-year experiences of the psychiatry residents. A review of the literature identified themes and subthemes related to the third-year of psychiatry education. The study was conducted at a university health science center. Data were collected from five residents using participant interviews, focus groups and research observation. The research question was, "What are the important experiences of psychiatry residents and what meaning do they ascribe to these experiences in their acquisition of psychiatric skill?" Qualitative methodology provided a systemic approach for answering the research question.

This study revealed four themes common to the students in the study. The first theme, Residency Choice was a Momentous Decision, disclosed that the psychiatry residents in this study saw their choice of residency as one of the most important decisions in their lives. The second theme, Observation and Reflection Should be Modeled Prior to Practice, displayed how psychiatry residents preferred observation and reflection of the psychiatric skills taught. The third theme, The Value of the Third Year was the Shift to Psychotherapy Training, revealed that the residents did not see prescribing medications as their sole training objective. The fourth theme, Competency was Overcoming Class Discord to Acquire Their Psychiatric Skills, showed that residents were able to maneuver class conflicts to acquire a competent skill set. In conclusion, this research study revealed that psychiatry residents saw the third year of their psychiatry education as foundations to build the careers.

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CHAPTER 1: INTRODUCTION

There is a principle which is a bar against all information,

which is proof against all arguments and

which cannot fail to keep a man in everlasting ignorance-

that principle is contempt prior to investigation

- Herbert Spenser -

I initially became curious about mental health during my first year of college in 1981. A friend became depressed and sought psychiatric treatment. Before treatment, she was gloomy and down most of the time. After treatment, she was more jovial and genial. When she returned to our small town, she received support and encouragement from her close friends and family but she suffered disparaging remarks from some of the townspeople. They said she was nuts, disturbed and crazy. They described the psychiatrist as a shrink, quack and head doctor. However, she was able to complete her undergraduate studies and move forward. During her last year in college we met frequently for lunch with close friends. She was fond of saying her shrink spiritually saved her life.

I was struck by two major incidents surrounding my friend. The first was her perseverance and her ability to recover with the help of psychiatric care. The second was the insensitive labels she faced. This stigmatization created a second obstacle to overcome. My curiosity about the profession of psychiatry became ardent during this time. Who were these people . . . these psychiatrists? What did they do to my friend exactly? Did they practice hocus pocus or a legitimate medical craft? Why were these

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derogatory terms bantered among the people in our town regarding the psychiatry profession?

After college, I developed skill with listening and supporting people as well as a strong desire to pull for the underdog. This guided my decision to pursue a graduate degree in social work and practice in mental health. During my career, I have worked with many psychiatrists and witnessed the recovery of a multitude of diverse patients. I have seen a wide spectrum of skill with therapeutic individuals and psychiatrists. However, my curiosity and fascination about the differences between a gifted psychiatrist and a so called quack or inept psychiatrist has persisted over the years and led to my choice as a research topic.

Few studies exist regarding psychiatry residents' experiences and how they contribute to their becoming effective psychiatrists. Understanding the experiences that residents deem as important and valuable during their training is a critical aspect of residency education. Identifying important experiences shaping residents' professional development may enhance the abilities of faculty and staff to make better decisions regarding residency education (Hilty et al., 2005, p.405).

Much importance has been placed on the educational curriculum but few studies evaluate psychiatric residents' views of their education. This study adds to the current body of research by conducting a phenomenological study investigating the lived experiences of students in a psychiatric residency program. Specifically, this research addressed how residents assess their educational experience and their important experiences. Further, this study explored the residents' experiences and identified prevalent themes which contributed to their professional development.

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I was interested in this topic because I became a clinical social worker to help people overcome their problems in life. My easy-going nature and ability to listen have served well in this profession. I have a passion for helping clients' cope with challenges along their life's journey. During my career, I have worked with numerous psychiatrists. At my current employment, I have been invited to teach behavioral classes, co-lead group therapies, design treatment plans and supervise assessments with psychiatric residents.

I have been granted the opportunity to work with some wonderfully gifted psychiatrists and some less skilled psychiatrists. Over the course of my career, I have wondered what attributes a good psychiatrist possesses versus a mediocre psychiatrist. What factors contribute toward a caring, knowledgeable physician in the helping profession? Is it textbook knowledge, business acumen in the face of managed care, compassion for patient suffering, ability to communicate, intelligence, psychiatric strategy or personal approach to treatment? These types of questions do not fit into tightly measured answers. My personal questions about the development of a competent psychiatrist led me to select this topic for my research.

Background

The common belief is that psychiatry residents learn by didactic lectures, supervision of patient cases, and clinical rotations (Touchet & Coon, 2005). Medical school and residency education are depicted as a 24 hour a day and 7 days a week sprint with the student barely able to keep up with a grinding caseload. This education stresses the quantity of knowledge rather than the quality of the experience (Conrad, 1988). Several major factors have impacted psychiatry training in the past two decades including the "advancement of neurobiology and its application to psychiatry, the influence of

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managed care on psychiatrists' practice styles, and the need to demonstrate accountability in higher education" (Giordano & Briones, 2003, p. 145).

Recently education for this profession has shifted from a narrow psychopharmacology to neurobiological training. Psychopharmacology is the study of medication interaction and changes in mental disorders specifically thinking ability, mood and behavior. Neurobiological education focuses on overall neural functioning, neurotransmitters and cellular mechanisms. Neural systems curriculum includes clinical electrophysiology, dementia, obsessive compulsive syndromes, tics, movement disorders, catatonia, neuroimaging, epilepsy, sleep disturbances, violent behavior, developmental neuropsychiatric syndromes, and focal brain disorders (Etkin, Phil, Pittenger, Polan, & Kandel, 2005).

Decreased financial resources have created turbulence in academic health centers over the past decade. Kirch (2005) stated that revenue constraints, diminishing fees for clinical services, declining appropriations, and pressure to control tuition are to blame for medical schools' financial insecurity. Academic psychiatry departments must demonstrate their productivity and economic stability in the face of financial, efficiency, and accountability demands.

This means that medical school residency programs are operating with reduced financial resources but still need to train as many medical students as possible. Managed care has negatively affected psychiatric education because managed care organizations refuse to pay for resident training and will not reimburse for trainee time. Most psychiatry residencies are under increasingly severe financial pressure (Kirch, 2005).

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As a result, residency training has become complex and demanding. Not only are psychiatry residents required to cultivate a vast knowledge of medicines, but also competencies in the following areas: Family therapy, psychopharmacology, psychodynamics, care for the chronically mentally ill, suicidal/homicidal patients, major forensic and ethical issues, transcultural training, neuroscience, cognitive behavioral theory and practice, group therapy, public/community issues, alcohol and drug abuse, spirituality, evidence-based medicine approaches, and short-term brief therapies such as hypnosis (Serby, 2000, p. 164). In addition, there are 312 psychiatric disorders, hundreds of psychiatric medications and over 400 different recognized models of psychotherapies based on different theories that residents are required to know and understand (American Psychiatric Association, 2000). Each year new medicines are developed and psychotherapies created to address this diverse set of mental illnesses.

For decades, colleges and universities have recognized psychiatric training as an important issue. In recent years, psychiatry residency has changed due to new mandates, increased demands on the profession, dwindling number of psychiatrists in private practice, and increased numbers of fragile psychiatric populations suffering from geriatric and childhood disorders. According to Carlat (2010), America has a shortage of 45,000 psychiatrists creating a huge vacuum in the near future as many practicing psychiatrists near retirement age.

In January 2001, the Accreditation Council for Graduate Medical Education (ACGME) revised program requirements for training in adult psychiatry (Sudak, Beck & Gracely, 2002). The new ACGME mandates included competency requirements and specific training objectives. However, with the new requirements and objective standards,

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residents assessed the quality of their training program differently than administrators. Administrators focus on the positive benefits of didactic lectures and exam scores while residents focus on the quality of patient interaction (Hilty et al., 2005). Medical schools have kept the same curriculum approach because that is the way we have always done it (Tweed, 1994, p. 1229). This may not serve residents well and may not develop the therapeutic skills needed by psychiatrists. While many authors have studied the curriculum of residency training, few have focused on the phenomenon of residency training for psychiatry students and the development of the therapeutic professional.

Statement of the Problem

The societal demand for effectively qualified psychiatrists has increased at an alarming rate (Goldman, 2001). The 2001 ACGME mandates, competencies, and requirements for medical school and residency education increased pressure to educate competent psychiatrists. Due to multiple factors, the United States ranks 24th in the world in life span (World Health Organization, 1999), 37th in medical care (World Health Organization, 2000), and 23rd in happiness ratings (Kamenev, 2006). Suicide is the 11th most common cause of death in the United States (Centers for Disease Control, 2007). The main complaint from primary care physicians is the difficulty in making necessary referrals to a qualified psychiatrist (Goldman, 2001).

In order to cope with these critical circumstances, attracting doctors into the field of psychiatry and assuring effective education of psychiatrists has become crucial. Due to the high demand for effective psychiatrists, some states, including New Mexico, have debated and granted prescribing privileges to individuals with the Ph.D. in psychology after they complete a standard period of pharmacological training, typically one year

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(American Psychological Association, 2002). The American Medical Association fought against psychologists' having prescribing privileges by arguing the limited training required by certified psychologists is an insufficient substitute for the extensive training required by licensed psychiatrists treating severe brain illnesses (American Psychiatric Association, 2007).

This research study contributes to a better understanding of how the residency experience affects the educational and professional development of psychiatric students. This in turn can identify solutions to improving the preparation of psychiatrists or addressing the shortfall of trained psychiatrists as identified above.

Purpose of the Study

The purpose of this study was to discover, through qualitative methods, what factors psychiatric residents experienced as important and as being influential to enter professional practice as psychiatrists. The purpose was to gain a unique view of the phenomenon of residents' important experiences. With the increased need for psychiatrists, I was interested in the resident's important and meaningful experiences during their psychiatry education. This study expanded the current literature base regarding residency training and how residents defined their experiences as psychiatrists.

Definitions of Terms

It is important to clarify terms used in the mental health profession and psychiatry practice. *Psychiatry* is a medical specialty which studies, prevents and treats mental disorders. The clinical application of psychiatry has been considered a bridge between the social world and those who are mentally ill. Psychiatrists are physicians who specialize in the doctor-patient relationship who have graduated medical school and four years of

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residency education. They prescribe psychiatric medications, conduct examinations, order and interpret laboratory tests and order brain imaging studies (Barker, 2003).

Residency is a graduate medical training program in primary care or referral specialty. Residents are physicians who have received a medical degree or diploma and in the United States are composed almost entirely of caring for hospitalized or clinic patients with direct supervision by senior physicians. Residency can also be followed by a fellowship during which the physician is trained in a subspecialty. Medical school teaches doctors a broad range of medical knowledge, basic clinical skills, and limited experience practicing medicine. Medical residency provides in-depth training with a specific type of medicine (Barker, 2003).

Psychologists have obtained academic doctoral degrees. These academic programs typically take four years of post-graduate work to complete. Psychologists must complete one year of psychological supervision under the guidance of a licensed psychologist before they are able to take a written licensure examination. Psychologists conduct psychological testing (Barker, 2003).

Clinical Social Workers have obtained a masters or doctoral degree. Clinical social workers graduated from an accredited graduate school for the advancement of social conditions of a community, especially the disadvantaged by providing psychological counseling, guidance and assistance in the form of social services. Mental health treatment typically comprises a treatment team. The psychiatrist and clinical social worker conduct assessments with the psychologist responsible for psychological testing. All conduct psychotherapy with psychiatrists prescribing psychiatric medications (Barker, 2003).

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Theoretical Framework

I chose to conduct a qualitative research study to explore the lived experiences of psychiatry residents. Denzin and Lincoln (1998) described the fundamental differences between qualitative and quantitative research:

> The word qualitative implies an emphasis on processes and meanings that are not rigorously examined, or measured (if measured at all), in term of quantity, amount intensity, or frequency. Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is being studied, and the situational constraints that shape inquiry. In contrast, quantitative studies emphasize the measurement and analysis of causal relationships between variables, not processes. Quantitative research is concerned with a large sample and results that can be generalized to a larger sample (Creswell, 2007, p. 8).

Epistemology is the study of the nature of knowledge. It defines the relationship of the researcher to the subject being researched. Qualitative researchers interact with and observe their research subjects over an expanded period of time. The researcher limits or minimizes the distance and separateness between the research and the subjects. Constructionism or Constructivism is the epistemology that informs this qualitative research (Bhattacharya, 2007).

The theoretical framework for my study was that people construct their own meanings based on their interactions with the world. Ontology is the way one understands the nature of reality based on multiple social interactions. People develop meanings of their experiences. The goal of qualitative research is to simply understand and explore a subject in an in-depth approach through varied and multiple meanings (Creswell, 2007).

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The research epistemology influences the axiology or roles of values in the study. In a qualitative study, the researcher accounts for his or her values and predispositions. The qualitative researcher reports these realities, and relies on the interpretations of the subjects and enhances the data of these different perspectives on each identified theme (Smith, Flowers, & Larkin, 2009).

The phenomenologist's focus is describing what the participants have in common as they experience a phenomenon. The basic purpose is to reduce the individual experiences with a phenomenon to a description of the universal essence (Denzin & Lincoln, 1998). The researcher collects data from persons who have experienced the phenomenon and develops a composite description of the essence of the experience for all individuals. This description consists of what they experienced and how they experienced it (Creswell, 2007).

Phenomenology includes collecting data in a natural setting where the participants experience the phenomenon. The researcher is the key instrument and obtains multiple sources of data. Inductive analysis is utilized by organizing the data into increasingly more abstract units of information. Qualitative researchers are not bound by tight cause-and-effect relationships among factors (Bhattacharya, 2007).

Emergent design allows the initial plan for research to change and shift after the researcher enters the field and begins to collect data. This allows questions to change and forms of data collection to shift. A holistic account of the data involves reporting multiple perspectives, identifying the many factors involved in a situation and generally depicting the larger picture that emerges (Creswell, 2007). My chosen method and framework provided a meaningful and reasonable exploration to the research question. My study

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focused on a small sample with the goal being depth of expression. The qualitative research seeks to establish trust, rapport and authentic communication patterns with participants (Denzin & Lincoln, 1998, pp. 39).

Importance of the Study

In order to improve psychiatry education and training, it might be beneficial for educators and administrators to know what experiences psychiatric residents believe are important and enhance their educational growth. This study expanded the current literature on psychiatry education by using a phenomenological research design to discover residents' important or valuable educational experiences and the influence of those experiences on their development as psychiatrists. Specifically, it explored which experiences with faculty and supervisors, lectures, classroom experiences, journal club, peer interaction and patient contact were vital to their professional growth.

The results of this study were important to the psychiatry residency program where the research was conducted. A pseudonym was used for the research university, Soho University. There was no record within the department or elsewhere of a previous qualitative research study regarding resident experiences. Results from the interviews provided administrators and faculty with rich in-depth descriptions of residents' educational experiences and the meanings attached to these experiences. The results may help faculty and staff to understand both positive and negative attributes of psychiatry training. This type of information might enable educators to improve the quality of psychiatry training and modify approaches to increase positive educational experiences for residents.

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Limitations

Limitations of the study included the challenges of interpreting the experiences of participants. Inevitably, these interpretations reflected my own values and predetermined thoughts regarding residency education. One of the philosophical assumptions was that qualitative research is value laden and that biases are present. These assumptions included the language that becomes personal and is based on definitions that develop rather than being defined at the beginning of a study (Denzin & Lincoln, 1998). In Chapter 3, I have discussed the ways I attempted to address my own values and beliefs to best represent the experiences of the residents.

Research Question

The research question for this study was: "What are the important experiences of psychiatry residents and what meaning do they ascribe to these experiences in their acquisition of psychiatric skills?" This study sought to investigate the lived experiences of students in a psychiatric residency program, and identify themes that describe their important and valuable experiences.

Summary

This chapter provided an introduction and overview to the phenomenological study of the lived experiences of psychiatric residents. Chapter 2 presents a review of the literature based on the research question. Current themes and subthemes were identified and discussed. Chapter 3 describes the research methodology and design including sampling procedures, participant selection, data collection, data analysis, and academic rigor and trustworthiness factors. Chapter 4 discusses the presentation of the data including themes

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generated from an extensive analysis. Chapter 5 reports the findings, conclusions, implications for additional research opportunities and implications for practice.

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CHAPTER 2: REVIEW OF THE LITERATURE

This study's purpose was to discern how residents experience their educational growth, what experiences were valuable, and which experiences were important as psychiatric residents. First it was necessary to understand the background and educational factors in the field of psychiatry residency training. This review of the literature identified three major themes: Traditional instruction challenges, competency in psychiatric training and curriculum verses learning needs. Each theme included several subthemes.

Background of Psychiatry Residency

I have described the key aspects and further defined terms that portray psychiatry training. Mental disorders are disorders of the brain shaped by a complicated interaction of genetics and experience. Psychiatrists are medical doctors who specialize in treating mental disorders including affective, behavioral, cognitive, and perceptual disorders. Psychiatric assessment starts with a mental status examination and a case history. Psychiatric treatment consists of a variety of modalities including medications and psychotherapies. Treatment involves either outpatient or inpatient depending on the degree of functional impairment. Psychiatry as a medical specialty has recently reemphasized the combination of both the social and biological systems on a patient's disease diagnosis. Since the late 1990s, the field of psychiatry has shifted toward a more biological focus and inclusion in the field of medicine (Academic Psychiatry Association, 2010).

Psychiatry subspecialties include the following: Addiction psychiatry (treatment of patients' with alcohol, drug, or other substance related disorders), Biological psychiatry (branch that focuses on the biological capacity of the nervous system), Child and

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adolescent psychiatry (medical care of children, teenagers, and their families), Community psychiatry (public health treatment conducted in community mental health centers), Emergency psychiatry (approach administered in emergency locations), Forensic psychiatry (treatment of mental disorders regarding legal and criminal cases), Geriatric psychiatry (approach that treats clients' who are older in age), Liaison psychiatry (specialty that treats the combination of medical and psychiatry illnesses), Military psychiatry (treatment in a military environment), and Neuropsychiatry (treatment of diseases of the nervous system)p Academic Psychiatry Association, 2010).

Psychiatry is one of many residency specialties (anesthesiology, dermatology, emergency medicine, general surgery, internal medicine, neurology, obstetrics, pathology, pediatrics, and radiology) that medical schools offer. After graduating from medical school, students receive training in a specific medical specialty. Students begin rotating through specialties during their third year of medical school. Psychiatry education is the training of psychiatric disorders in all age groups, differential diagnosis for clinical and laboratory methods, and treatment by a full range of psychological, biological, behavioral and social techniques. Education centers on the psychological, social, economic, ethnic, family and biological factors that influence development as well as psychiatric illnesses and its treatments. Training is a combination of teaching and supervision and interaction with other medical specialties in a variety of community and institutional settings. Treatment modalities embrace psychopharmacology, cognitive-behavioral, time-limited, group, family, long-term dynamic and supportive therapies. Most curriculums compose a strong biological component along with integrated lectures on neuroscience and psychopharmacology. Didactic lectures stress human development

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and clinical work with patients. Patient populations range from psychotic to neurotic with a wide range of age, socioeconomic, and cultural backgrounds (American Psychiatric Association, 2010).

Residents work in a variety of settings including inpatient, outpatient, emergency service and consult liaison. Most are 4-year general psychiatry programs accredited by the Residency Review Committee of the Accreditation Council of General Medical Education. Specialties include child and adolescent psychiatry, geriatric psychiatry and forensic psychiatry. Training includes biological, psychological and social cultural aspects of psychiatry emphasizing clinical practice, scholarship, teaching and research. Didactic curriculums typically include theories of the mind and psychotherapy, neuroscience, psychopathology- diagnosis and pharmacotherapy, professional leadership and systems, child and adolescent psychiatry, and human development (Academic Psychiatry Association, 2010).

Traditional Instruction Challenges

A criticism of residency education was that residents partake only in didactic lectures and practice medication management (McCarthy, Birnbaum, & Bures, 2000). Traditional psychiatric residency instruction consists of two major formats: supervision and didactic lectures. The overall goal of the supervision student-teacher relationship is modeling future effective doctor behaviors. However, complaints about the resident-supervisor dynamic have been cited. Residents encountered dilemmas in psychotherapy supervision 40% of the time stating advice-giving was a hindrance and not helpful because residents are seeking constructive feedback to form their own conclusions (Sinai, Tiberius, de Groot, Brunett, & Voore, 2001, p. 80). A second resident objection was supervisor

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criticism and harsh judgments. Residents who complained during supervision were seen as weak and frazzled. Another negative factor was an imbalance of power. Because supervisors exert control over the residents' learning objectives, residents feel obligated to accept whatever the supervisor dictates. This at times better serves the supervisor than the resident needing supervision (Whitman, 2001).

To be effective, supervision should not only critique the resident's clinical performance, but also provide feedback, offer encouragement, support residents during difficult sessions and crisis, and serve as a role model (Mohamed, Punwani, Clay, & Appelbaum, 2005). This rarely happens. An Australian study found that educational neglect by supervisors was considered one of the five most adverse experiences during psychiatric residency and was experienced by almost 60% of psychiatric residents (de Groot et al., 2000). Yet, with recent recommendations of clear communication of expectations, support and collegiality, role modeling and time for reflection in place, the problems outlined still persist (Sinai et al., 2001).

Residency medical education is conducted primarily through lectures and supervision of a resident's evaluation and treatment of patients. Lectures accentuate the transfer of information from the professor as the expert to the student, who is the passive receiver. Weaknesses of the lecture format include students' expectations that all significant knowledge on the subject will be presented in the lecture and the notion that passive reception of information will result in student expertise. McCarthy et al. (2000) reported that medical school residents are taught with stale traditional medical school methods consisting of didactic lectures.

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Lectures are the heart of traditional instruction but students only recall and retain a small amount of information (Touchet & Coon, 2005). Essentially, the lecture format is a less effective mode of teaching (McCarthy et al., 2000). Another concern with traditional instruction is that it fails to provide a balance between models of psychotherapy disciplines and psychopharmacology approaches; something that residents request but rarely receive (Serby, 2000). The challenge for residency programs is to teach a variety of approaches, have faculty with strengths in these areas, and produce graduates who are capable of providing state-of–the-art treatment.

To keep up with an expanding knowledge base, changing patterns of healthcare delivery, and increasing societal demands, the current challenge is not how to balance clinical practice with education needs but how to make clinical experiences educational. Ludmerer and Johns (2005) report residents in all disciplines spend as much as 35% of their time in activities with no educational benefit such as taking vital signs which could be completed by support staff. Restoring balance to residency education depends on residents having sufficient time for meaningful clinical encounters, critical thinking, study time and reflection. Improving residency education involves reducing the chores that provide minimal educational value to the resident and that could be done by non-physician staff (Ludmerer & Johns, 2005).

Training programs need to reevaluate their instructional methods and increase resident learning efficiency (Touchet & Coon, 2005). Most residents struggle to gain mastery over different approaches (family therapy, psychodynamic, cognitive behavioral, group therapy supportive therapy, existential therapy, client centered) and artificially apply only a couple of approaches such as cognitive therapy or behavioral interventions. There needs

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to be a greater climate for integrating diverse methods of practice (Prochaska et al., 2006). Developing effective learning skills allows residents to learn certain information and acquire needed clinical skills. Adult learning theory and learner–driven models of educational change transform lecture-based curricula into self-directed, problem-based learning programs (McCarthy et al., 2000). Improvements of residency programs involve responding to feedback and modifying curriculum based on the learner's needs. However, the old-school lecture format predominates (Touchet & Coon, 2005). Criticisms of the old-school lecture format have increased in recent years, leading to the advancement of alternative instruction formats including problem-based learning, team-based learning, evidence-based medicine, and experiential learning.

Problem-based learning (PBL) typically depicts a scholarly gray-haired doctor presenting a set of symptoms and asking for a diagnosis from a group of young enthusiastic residents. The residents debate a course of treatment by generating hypotheses to explain the patient's condition. The faculty's role in PBL is to facilitate the small group discussion rather than provide a didactic lecture. The educational benefits of PBL include learning self-directed skills, enhancing subject interest, and increasing the students' desire to learn (McCarthy et al., 2000). Medical school students reported that they gained more knowledge when taught through PBL than they did with traditional formats (Schultz-Ross & Kline, 1999). Schultz-Ross and Kline further report that students enrolled in PBL courses gave the program high ratings.

Another psychiatry residency challenge was the reduced time for residents to achieve competency. Certain medical education departments (dental schools, orthopedics, and cardiology) have addressed this by implementing team-based learning. Team-based

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learning (TBL) is similar to PBL in that team learning is based upon dividing the class into small groups of students and applying a case-based method. Both attempt to engage students though increased levels of interaction (Pileggi & O'Neill, 2008).

The main difference between problem-based learning and team-based learning is that problem-based learning is learner-centered and conducted in small group classrooms without interaction with the class as a whole. Students are given a problem before studying the course concepts and are asked to problem-solve the case over the next few days while receiving additional case and concept materials. Team-based learning is instructor-centered and conducted in a large classroom with students breaking into small group discussions. The students receive content information first and then are asked to solve the case scenario by applying discussion- generated information. At the end of the group discussions, the class meets as a whole to review their cases and share feedback. TBL focuses on application-focused coursework and teamwork (Pileggi & O'Neill, 2008). Criticisms of TBL consist of it being relatively new and untested in psychiatric education. The instruction also requires more pre-class preparation for the instructor and the students. Students not only are responsible for their individual learning tasks but also the group's activities (Touchet & Coon, 2005).

Evidence-based medicine (EBM) is another new instructional format in residency education. This approach has been implemented due to the conflicting opinions associated with subjective decision-making. Timmermans and Angell (2001) report, "In some parts of the country, radical breast cancer surgery was performed 33 times as often as breast-saving lumpectomies" (p. 343). The wide variations of medical treatment options establish a need for evidence-based medicine training. Evidence-based medicine

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is the conscientious and judicious use of the current best evidence in making decisions regarding the care of individual patients (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p. 72). EBM practice integrates clinical expertise with the best available external research evidence. However, only 15% of medical decisions are based on rigorous medical evidence (Welch & Lurie, 2000). Although EBM is a relative new format, advocates state that every medical decision should be supported with scientific evidence (Timmermans & Angell, 2001).

Negative aspects of EBM include the practical aspects of implementation. Searching complicated evidence and conflicting studies takes time that residents who practice at a frantic pace may not have. Medical school students complain about managing the vast amount of medical literature and research when decisions are needed immediately. The major benefits of EBM are addressing medical uncertainty and increasing evidence-based clinical judgments (Welch & Lurie, 2008). EBM is most useful with high-risk treatments, decisions that a practitioner faces regularly, and decisions where high-quality evidence exits.

Kolb’s experiential learning theory has gained acceptance across higher education. Recent authors cite its applicability to residency education (Ballon, Silver, & Fidler, 2006; Kayes et al., 2005). Experiential learning theory identifies the initial steps of cognition and understanding that doctors pass through when learning from experience. The subsequent steps of interpretation and construction of meaning enhance residents’ personal knowledge (Teunissen, Boor, Scherpbier, Van Leuten, Van Diemen, Steevoorde Van Luijk et al., 2007). Residents who study in small groups retain more information than by studying alone (Kayes et al., 2005).

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The experiential curriculum emphasizes that learning and curriculum are based on the practical and realistic experiences of the resident (Tweed & Donen, 2006). Knowledge is created by the combination of grasping, reflecting and transforming experience (Kayes et al., 2005). This framework highlights the main role that experience has in the learning process.

Experiential learning features two main methods of grasping experience. *Concrete experience* learners observe and reflect on learning. Concrete experience learners prefer case studies, demonstrations, and recalling past events. *Abstract conceptualization* learners think about and analyze new information. These learners opt for textbooks and journal articles, lectures and authoritarian guides. Transforming information and experience is defined by two learning styles. *Reflective observation* learners prefer to witness a model and reflect on this experience. Reflective observation learners favor structured small group discussions, Socratic dialogue and connections to prior learning experiences. *Active experimentation* learners prefer to jump right in and start doing things. Active experimentation learners prefer group projects, videotaping of practice sessions and problem-solving activities. These methods represent a learner's preferred manner of integrating learning (Kolb, 1984). Learning efficiency depends on the selection of the most time-effective learning strategy and learning resources that match the student's learning style preference. Overall, experiential learning enhances residents' empathetic responses and shapes their attitudes toward the clients they are treating (Kayes, Kayes, & Kolb, 2005).

Treating an intensely challenging array of medical illnesses, disorders, diseases, ailments, afflictions, syndromes, and maladies can be overwhelming. In order to

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effectively treat this multitude of psychiatric illnesses, residents are required to complete a history and physical, diagnose, order lab tests, prescribe medications, and carefully oversee hospital admissions. The challenge for residents is applying their book knowledge and best practices to real-life patients (Timmermans & Angell, 2001).

Effectiveness depends on the learning environment being hospitable and inviting students to voice their insights during the classroom conversation. If the aim, of a course, is delivering large amounts of data, non-stop lecturing fails to deliver because the brain becomes unable to process massive volumes of facts (Kolb, 1984). Experiential learning methods increase retention of materials, satisfaction of learners and complexity of the learners' skill.

Competency

In January of 2001, the Council on Graduate Medical Education's Residency Review Committee (RRC) for Psychiatry and Accreditation Council of Graduate Medical Education (ACGME) stipulated that "programs must demonstrate that residents have achieved competency in at least five forms of psychotherapy including brief therapy, cognitive behavioral therapy, combined psychotherapy and psychopharmacology, psychodynamic therapy, and supportive therapy" (Yager, Kay, & Mellman, 2003, p. 125). Brief therapy has specific goals and the numbers of sessions are predetermined. Cognitive behavioral therapy focuses on changing current behaviors with directive time limited interventions. Combined psychotherapy and psychopharmacology is the study of the effect of drugs on the mind and behavior, particularly in the context of developing treatments for mental disorders. Psychodynamic therapy focuses on the unconscious processes as they are manifested in a person's present behavior. Supportive therapy is

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directed at helping patients maintain adaptive patterns. Several considerations influenced this change that emphasized psychotherapy competence in psychiatry education.

Prior to ACGME's revisions, managed care greatly influenced the profession of psychiatry. Due to the rising costs of healthcare, managed care became the insurance company's fee setting and treatment authorization tool. As a result, psychiatry was then relegated to the medication management specialty of the treatment spectrum (Mellman & Beresin, 2003). Specifically, managed care stipulated fewer psychiatrists and redefined the profession's roles as consultants for diagnostic evaluations and complex medication management issues.

Psychiatry's changed role was entrenched by the pharmaceutical companies exerting their financial power through funding clinical psychiatric research with large-scale drug studies (Mellman & Beresin, 2003). Managed health care coupled with pharmaceutical companies' clout and society's impatience seeking immediate solutions led to an increased demand for psychiatric drugs for a wide range of convoluted problems (Allen, 2010). However, this further devalued psychotherapy skills in the profession.

Since World War II, psychiatry psychotherapy education has diminished from 3000 hours of training to the current number of 200 to 600 hours of psychotherapy training for psychiatry residency programs. This shift has been attributable to reimbursement trends which promote attention to current symptoms only and pharmacologic interventions. This practice trend impacted and influenced this decrease over time of psychotherapy training in psychiatry residency programs (Giordano & Briones, 2003). The field of psychiatry reacted to these financial restrictions by scheduling patients for shorter visits, practicing medication management, and providing less psychotherapy. From 1996 through 2005, the

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percentage of psychiatric visits involving psychotherapy treatments decreased from 44.4% to 28.9% (Allen, 2010). These factors have caused psychiatrists to be more dissatisfied with their profession than any other medical specialty (Sturm, 2001).

When it appeared that the erosion of psychotherapy training would continue, the RRC and ACGME redefined the guidelines regarding psychotherapy education to combat the current trend of medication only practices. The psychiatry profession has shifted from pharmacology treatment based on the brain disease model to an integrated model including both pharmacology treatment and psychotherapy (Yager et al., 2003). Yet some psychiatry residency programs continue to teach the biological model as opposed to an integrated model (Allen, 2010).

Current competency requirements now include both psychotherapy and medication management. ACGME psychiatry residency competency requirements in the following 6 areas: Patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication, professionalism and systems-based practice. With this significant development, the profession abounds with diverse competency definitions. Most definitions include a fundamental demonstration of basic knowledge and sufficient medical experience resulting in clinical skill (Khursid, Bennett, Vicari, Lee, & Broquet, 2005). Both psychology and psychiatry agree that a competent therapist must apply textbook knowledge and form effective therapeutic alliances in order to treat unique patient characteristics (Weerasekera et al., 2003).

Psychiatry residency programs require additional and different study areas than psychology programs. Due to the recent changes by accreditation boards, residency programs must now address facets of combined treatment (Mellman & Beresin, 2003).

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Residents need to know how prescribed medications will interact with the complex and varied psychotherapies practiced (Giordano & Briones, 2003).

Clinical expertise is multifaceted and contributes to the unsettled definition of competency. Several factors affect skill development: motivation to learn, self-efficacy, and emotional well-being. Typically, psychiatry programs teach general psychotherapy skills first such as assertiveness training, and then follow with more detailed sophisticated models such as experiential techniques. Each additional model learned adds another layer of competency and skill (Sudak et al., 2002).

Competency development constitutes an important distinction between acquiring new knowledge and actually applying new expertise. Development is a gradual process along a continuum with the end result being professional authenticity and competence. Although skillfulness varies over time and circumstances, most successful therapists possess a high degree of empathetic understanding and directive task knowledge (Shaw & Dobson, 1988). Acquisition of skill, layers of expertise, new knowledge interpretation, development assessments, and professional authenticity have created various uses of different assessments of competency.

A multitude of issues impact current psychiatry training programs including managed care financial restrictions, research funding by pharmaceutical companies, decreased financial support from state and federal governments for residency education, increased need for accountability, public need for competent practitioners, and professional redefinitions of psychiatrists as psychotherapists (Mellman & Beresin, 2003). During the past few decades, other mental health practitioners have claimed psychotherapy as their mental health domain including psychologists, social workers, counselors, and nurse

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practitioners. Yet, these current demands have provided an opportunity for shifting from nonspecific competency requirements (pass/fail didactic lecture grades) to concentrating on distinct goals, quality and quantity of psychiatry education, skill development, and accountability (Bhugra & Holsgrove, 2005).

These new priorities have generated discussion about changes in psychiatric residency training. Psychiatry programs face a triple challenge: "They must redefine what they are already doing in terms of residency competency, add specific, systematic training in the five psychotherapies, and devise reliable and valid assessment measures for all activities (Mellman & Beresin, 2003, p. 152). As demand has grown, the field of psychiatry faces the additional task of determining how competency is measured (Mohl, 2004).

Psychiatry requires an empathetic, active clinician, who collaborates with patients to provide effective treatment outcomes (Sudak et al., 2003). Defining an acceptable level of skill enhancement and growth is a major challenge. Assessments typically serve a dual purpose. Assessments performed to further the learning process are formative, whereas assessments implemented to determine adequate performance or acquisition of knowledge are summative. Both are needed to be effective (Weerasekera et al., 2003). Individuals who administer residency programs and psychiatric residents report that competency measures are beneficial by providing assessments of skill and feedback for improvement. Current methods of assessment include direct observation, progress note review which involves reviewing a patient's session documented note regarding description of problems faced and interventions utilized, audio-recorded and videotaped interview analysis, and chart reviews which entails reviewing documentation of a patients chart including a initial assessment, treatment plan, and individual progress notes.

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Updated methods have been implemented recently such as psychotherapy skill tests (residents are given a set of patient characteristics and problems then are asked to choose an appropriate treatment plan and intervention) and cognitive behavior checklists which provide a list of necessary steps to ensure the procedure was conducted effectively. As each step is completed it is checked off the list (Khurshid et al., 2005).

Measuring residents' skills include numerous formats. Self-evaluations and global ratings are widely used and simple to implement. Global ratings are broad conclusions about the quality of skills and knowledge demonstrated by a resident and are typically conducted at the end of each rotation. However, self-evaluations and global ratings possess poor predictive validity because they provide only limited information and direction for remediation. Checklists and benchmarks (standards of performance) both assess components that are essential for the performance of a task. Benchmarks are observable or measurable skills that reflect accurately the level of mastery for an assessed competency. A 360-degree assessment was created for business environments and uses assessments from all persons involved with the employee's duties and has recently been implemented in residency training. Direct observation involves faculty scrutinizing residents performing clinical duties, with performance checklists. Unless direct observation is conducted with specific criteria and checklists, reliability is questionable with this mode of evaluation. Standardized written examinations (psychiatry uses the Psychiatry Residency In-Training Examination or PRITE and the American written board examination) are well known and have established reliability. Strategic management simulation is a newer approach that evaluates decision-making in complex situations (Swick, Hall, & Beresin, 2006). It is a computer-based program with six half-hour tasks

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or clinical vignettes. Residents are expected to complete different scenarios while the program assesses their planning, implementation, use of information and strategy. Lastly, rating scales performed by faculty to assess residents performing certain therapeutic tasks are common but do not consider contextual variables such as patient characteristics, therapist characteristics, presenting problems, and stage of therapy (Weerasekera et al., 2003). Problems occur as a result of rater errors including leniency/severity and failure to distinguish among dimensions of competence such as generalizing from perceived talent to all areas of competence. Also a permanent record of specific resident problems based on rater errors creates an added risk for medical schools by the threat of legal consequences (Swick, Hall, & Beresin, 2005).

The PRITE is the most common examination of psychiatry skill assessment. Examinations are limited to assessment of textbook knowledge. Khursid et al. (2005), reports "The instruments used by [psychiatry residency] programs in teaching and assessing competencies varied widely across the programs. The various instruments used by programs included use of case formulation (65%), video-taped sessions (45%), progress notes (44%), audiotapes (21%), multiple choice exams (20%), portfolios (12%), patient outcome measures (9%) and other not specified methods (5%) (p. 454)". Although use of multiple forms of assessment increase validity, no consistently accurate and reliable measures are in practice today. Overall, a number of rating scales exist but they are either cumbersome to use due to time constraints and lack of available money dedicated for assessments or have reliability issues such as global ratings and validity issues such as self-evaluations (Swick et al., 2005).

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Curriculum verses Learning Needs

While learning their craft during residency, many residents feel incompetent and pulled in different directions by their roles and responsibilities. The dilemmas, struggles and development of residents are now critical issues. Residency instruction has been focused on the technical aspects of doctoring: diagnosis, treatment, and intervention. As a result, medical school does an excellent job with imparting medical techniques, but struggles with providing humane and caring approaches (Fauth, Gate, Vince, Boyles, & Hayes, 2007). Technological medicine places little emphasis on teaching doctor-patient relationships (de Groot et al., 2000). Years after psychiatric intervention, clients remember successful treatment consisting of trust, empathy, understanding and acceptance, not a specific antidepressant medication or a problem-solving intervention (Yalom, 1995).

More attention has been given to providing the resident with learner-centered, competency-based education. Psychiatry curriculum should be designed from the perspective of how students learn best, what their needs are and upon proven educational principles (Conrad, 1988). Stale formats that transmit core knowledge and skills with students receiving an identical comprehensive curriculum are questionable (Tweed & Donen, 1994). At the same time, the restrictions on residents' working hours necessitate a more efficient approach to graduate medical education (Conrad, 1988).

Psychiatry residents are expected to learn core fundamentals consisting of 1) substance abuse disorders; 2) anxiety disorders; 3) mood disorders; 4) personality disorders; and 5) somatoform and factitious disorders (disorders characterized by a patient's long complaint history about symptoms not caused by physical disease). Other

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skills and abilities needed to ensure competency include 1) patient education; 2) patient assessment; 3) building rapport; 4) dealing with angry/agitated patients; 5) managing patients who have serious/chronic mental illness; 6) discussing serious news; 7) recognizing and understanding strong negative or positive reactions to a patient; and 8) understanding therapeutic process versus content (Thornhill & Tong, 2006, p. 24).

In addition to these fundamentals, residents need to understand the essence of the practice of psychiatry including the following considerations. Persistent serious disorders like schizophrenia, bipolar disorder and severe recurrent depression are at the core of psychiatric practice. Diagnosis is currently based on phenomenon and function but is likely to transform into a biological marker and psychopathological diagnosis. Psychiatry comes with a rich history filled with many socio-cultural and theoretical factors, and is complicated by stigma, misconceptions and prejudice. Psychiatry's boundaries with related specialties and disciplines like neurology and psychology are in flux with the possibility of increased collaboration (Thornhill & Tong, 2006, p. 25).

Relying solely on concrete therapeutic techniques and core basic knowledge may not suffice in certain clinical situations. In addition to developing cognitive skills, mastering the art of psychotherapy involves developing a high level of relational and emotional responsiveness (Zeddies, 1999). Emotional availability includes the therapist's willingness to develop a deep and sustained emotional contact with clients. This emotional availability within the therapeutic process represents a difficult task for young therapists and is often lacking in traditional instruction methods (Thornhill & Tong, 2006).

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True teaching and learning the art of psychotherapy involves more than applying techniques presented in treatment manuals. If therapists attempt to rely solely on explicit rules detailed in therapy manuals, their application of these techniques may be awkward. The foundation of psychotherapy is a unique human relationship (Vakoch & Strupp, 2000). However, novice therapists may seem mechanical when applying their new knowledge with actual clients.

Traditional psychotherapy training practice (didactic teaching methods, manual-guided techniques, supervised training cases) provides a basic format but lacks an overall holistic approach improving the effectiveness of psychotherapists. Improvements for medical education include systematic practice, open dialogue, and on-going reflection (Fauth et al., 2007). The most successful training programs emphasize a supportive treatment context (Ludmerer & Johns, 2005). Education is based on mentorship, role models, guidance, socialization, interaction, and group activity (Vakoch & Strupp, 2000). This is developed through more than textbooks and lecture format.

Optimal development occurs when therapists maintain an awareness of therapeutic practice, and its complex intricacies reflect upon their experiences, and critique their own performance. Training programs should not be rigidly structured but flexible in terms of allowing students to engage with numerous professionals and educators. New practitioners need to encounter and deal with problems and continually reflect on their educational experiences (Ronnestad & Skovholt, 2001). The educational process of acquisition rather than transmission of knowledge is important.

As a result of traditional approaches, the older instructional methods have been shifting toward more vibrant techniques that increase student participation such as team-

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based learning, problem-based learning, evidence-based medicine, and experiential learning. Teacher-centered methods highlight imparting information, transmitting structured knowledge and facilitating understanding. The teacher-centered method places the teacher in charge of imparting knowledge and thinking. Learner-centered instruction concentrates on helping students develop expertise, negotiating understanding, preventing misunderstandings and encouraging knowledge creation. Learner-centered instructional methods view learning as a life-long developmental process that leads to the acquisition of knowledge, attitudes and skills. It views teaching not in terms of dispensing knowledge but as a challenging two-way street (LeCouteur & Delfabbro, 2001).

The frustrations and disappointments expressed by residents might be reduced if the long standing model of repetition and rote-learning of subject matter continues to change. Shifting from teaching-centered instruction to learning-centered instruction increases reflective practices. Learner-centered instruction embraces making sense of broader realities and generating knowledge and skills useful for interacting in the professional world (Samuelowicz & Bain, 2001).

Summary of the Literature

During the past few years, residency training has undergone some change. However, the overall delivery of residency education remains entrenched in didactic lectures and faculty supervision format. Requirements and standards have changed with the demands of the profession. Current residency training requirements have a dual purpose of combining medication management and current psychotherapies. With such a great need for psychiatrists, their training has become critical.

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A major curriculum problem at any level is that without regular revision and updating, it becomes rapidly obsolete (Tweed & Donen, 1994). A complex subject, such as psychiatric medicine, cannot be reduced to small well-defined units of instruction (Touchet & Coon, 2005). Medical educators have begun to express serious concerns about conventional and traditional approaches to curriculum design and instructional delivery (Tweed & Donen, 1994).

There has been an ongoing debate regarding pharmacological medication versus psychotherapy focus due to the recent surge of psychiatric drug treatments for behavioral problems. Society has embraced the blaming of behavioral problems on miswired brains and seeking pharmacological treatments for mental deficits. Some colleges of medicine have adopted a moderate approach which accepts the problems in living and diseases of the brain as overlapping categories and teach both pharmacology and psychotherapy treatment approaches in their clinical settings. The national accreditation associations, Accreditation Council of Graduate Medical Education (ACGME) and Residency Review Committee (RRC) mandated the inclusion of psychotherapy and certification that graduates are competent in several different types (Allen, 2010). Psychiatry residents now study both molecular genetics and emotional discord along with the interaction between genes and environment. Since Freud, there has been an ongoing nature versus nurture argument which is currently prominent in graduate medical education.

The other key transition of psychiatry residency education is from the traditional lecture format to inclusion of problem-based, team-based, evidence-based and experiential learning formats. Both team-based and problem-based learning possess the economic advantage of instructing large numbers of students with only one professor.

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Both utilize reflective thinking skills that are critical in learning settings. In the medical field, problem-based learning and team-based learning showed greater learner-to-learner engagement that lectures by faculty (Pileggi & O'Neill, 2008).

Evidence-based medicine practices are based on the best available researched methods. EBM attempts to clarify uncertainty by relying on proven researched decisions. Experiential learning accentuates students gaining knowledge, skill development, professional competency and empathetic abilities (Ballon et al., 2007). Experiential learning protocols have been cited as valuable additions to residency education (McCarthy et al., 2000).

Residents cite the need for better educational training (Teunissen, Scheele, Scherpbien, Van der Vleuten Boor & Van Diemen-Steen Voorde, 2007). Postmodern perspectives of instruction value teaching as a two-way or shared experience between student and teacher (Samualowicz & Bain, 2001). Professional growth is as important as memorizing didactic information. Many studies exist on what educators and administrators believe is important to residency education but the resident's description has not been addressed in the recent research literature. Lecouteur and Delfabbro (2001) cite the need for educators to take into account the students' conceptions about the phenomenon of learning.

There is no single theory explaining the processes at work as a resident gradually develops into a proficient psychiatrist. Recent trends highlight the need to assess the processes of how a trainee develops into an expert professional, and how these tasks can be improved (Thornhill & Tong, 2006)). One neglected aspect of current instruction is to explore contemporary residents' experiences (Bhugra & Holsgrove, 2005). In moving

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forward from traditional models of instruction to competency-based programs with emphasis on skill-development, it would be beneficial to include resident’s experiences (Hilty et al., 2005). Empirical research has not that clarified how educational programs train residents to develop into proficient psychiatrists. Therefore, this study asked residents which experiences shaped their abilities as therapeutic individuals.

Qualitative studies have explored a typical resident’s day (Hilty et al., 2005), residents’ experiences with patient suicide (Fang et al., 2007), views of supervisory relationships (Ratanawongsa, Wrights, & Carrese, 2008), beliefs concerning clinical activities (Teunissen, Scheele, Scherpbier, Van Der Vleuten, Boor, & Van Diemen-Steen Voorde, 2007), experiences in developing professional identity (Pratt, Rockman, & Kaufman, 2006), and experiences with dialectical behavioral therapy training (Sharma, Dunop, Nina, & Bradley, 2007). However, little has been identified in the literature regarding the psychiatric residents’ experiences with their education, training, and overall development. A comprehensive search of the research literature showed that no recent phenomenological study had been conducted to explore residents’ experiences with their development as a therapeutic individual and professional psychiatrist.

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CHAPTER 3: METHODOLOGY

As a young child, I vividly remember traveling with my family. Vacations were spent visiting with extended family members throughout the state of Georgia. We lived in the North Georgia Mountains and the rest of the family lived in South Georgia. It was a full day's drive from one end of the state to the other. My parents would leave at a certain time, pull over for planned stops at certain times, and drove a scheduled number of hours and a set number of miles. We sped down the highway as blurred landscapes passed by the window of our car. Traveling was an exhausting, unsatisfying all-day chore.

Upon our arrival, the topic of conversation consisted of such things as the number of hours the drive took, the number of miles driven, the number of times we stopped, the number of times required to refuel, how long we stopped for lunch, what were our miles per gallon, the average miles per hour. My nuclear family was interested in the numbers getting to our destination not necessarily the journey. This might seem like extreme Type A behavior, but as a young restless traveler it seemed like the norm.

When my children were little guys, I decided to take a different approach. Because money was tight with a young family, we went camping. We decided to slow down the destinations conquered and glide through the day. We were less interested in the number of miles covered and more interested in the experience. Having thrown a tent, sleeping bags, and a cooler in the car, we skimmed the map for different campsites along our way and set out. With no predetermined destination in place, we stopped when we were hungry and decided to pull over when we grew weary and restless. We would pick a camping destination by looking for state parks along the way. We enjoyed our day by traveling the back roads.

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I relate these two traveling approaches to my understanding of quantitative and qualitative research. Quantitative research is concerned with the number of miles traveled, the starting and ending odometer readings, the hours and minutes elapsed, the number of regular and aberrant stops, and the mileage counts. Although camping involved demanding work (setting up the campsite, unfolding tents and cooking over an open flame) and enduring challenges (bugs, outdoor facilities, no air conditioning), the rewards (hiking in natural forests, experiencing scenic sunsets, roasting marshmallows over the campfire) have provided a lifetime of stories to be told. Qualitative research is much like camping. It is about exploring the essence of nature and the people camping next door. Qualitative research exits the numbered highways and travels the scenic back roads and wooded campsites. Qualitative data description provides a deeper richer meaning of the information through fewer but extensive interviews and allows the researcher to acquire closeness to the participants (Moustakas, 1994). To fulfill my educational degree requirements, I set up camp to explore the psychiatric residents' important and meaningful experiences.

This chapter outlines the research design, setting, participants, data collections procedures, data analysis methods, and the strengths and limitations of the study. The goal for this research was to understand more deeply the experiences of psychiatry residents that were significant in their professional development. To reach this goal, a phenomenological research study was appropriate.

Research Design

Phenomenology distinguishes itself from other qualitative studies by "describing the meaning for several individuals of their lived experiences of a concept of phenomenon"

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(Creswell, 2007, p. 57). Creswell further defines phenomenological research by collecting data from persons who have experienced the phenomenon and developing a composite description of the essence of the experience for all of the individuals. It explores an understanding of the nature and meaning of the participants' everyday experiences. Phenomenology best correlated to my research interests and the goals of this study.

I sought to understand the residents' views of the world in which they learn and their important experiences during residency. The phases of data collection evolved and shifted as the interviews were conducted. The key idea was to learn about the essence of residents' development through the residency experience from the participants. Phenomenological research provided the study's framework because it described the meaning individuals ascribed to their lived experiences of a phenomenon and utilized systemic data analysis procedures to assess the participants' experiences (Creswell, 2007). This study drew from three sources of data: individual interviews, personal observation, and a focus group. Additional details on these data sources will be given in the section on data collection.

Setting

This study's research setting was a public health science higher education institution, Soho University, which offers medical education and residency training, located in a large southeastern city in the United States. The university health science center offers training in medicine, dentistry, pharmacy, basic sciences and allied health professions and is part of a large urban medical center. The research was conducted in its psychiatric department, which offers both residential training and clinical services to the community.

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The psychiatric department is the location where psychiatric residents get hands-on experience. They treat clients under the supervision of faculty members through individual psychotherapy, group therapy, and family therapy. The residents are scheduled for didactic lectures, supervision of individual cases, clinical rotations and group therapies during the third year. The outpatient psychiatry clinic serves adults who have been clinically judged appropriate clients for outpatient therapy. The clinicians assess patient's need for hospitalization and/or detoxification, mood stability, suicidal thoughts, and support in the community. The outpatient clinic is a major training site during the second through the fourth years of residency. The mood and anxiety teaching seminars highlighted both pharmacologic and psychotherapy approaches with the goal of educating residents in clinical and research techniques during the beginning of the third year.

The psychiatry program is divided into a child adolescent division and an adult division. The psychiatry adult division employs full-time and part-time faculty including the chair, co-chair and residency director who are each psychiatrists. One part-time psychiatrist supervises resident caseloads and their treatment. Faculty members also include three psychologists and a licensed clinical social worker. Full professors included the chair, co-chair, one part-time psychiatrist, and the three psychologists. Associate professors included two psychologists and one assistant professor who was a psychiatrist. Compared to other university departments, the department was small (class size of five) with psychiatry training services located in one building floor.

The psychiatry residency training program is fully accredited. The goals of the first year of residency centered on primary medical skills with rotations in internal medicine or pediatrics with residents being introduced to inpatient psychiatric treatment. During

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the second year, goals addressed enhancement of the residents' inpatient psychiatric treatment with inpatient, emergency, and chemical dependency treatment programs. Third year goals included outpatient treatment of both adults and children. The fourth year's goals were devoted to skill development with the consultation-liaison psychiatry service (branch of psychiatry that specializes in the interface between medicine and psychiatry usually taking place in a hospital setting) at a general medical hospital and the Government Hospital. Didactic lectures and seminars were coordinated with the rotations such as the alcohol and drug treatment program at the local Government Hospital. Most instruction occurred in small classes and group settings. Class size for each year is five residents. Typically the residents start and complete residency at the same medical school.

Participants

This researcher was employed by the medical group which was a nonprofit income-generating organization associated with the university. However, the medical group was its own separate entity with a board of directors, division of human resources, and different goals and nonprofit status from the university. This department of psychiatry was chosen as the setting for this study because of interest in development of psychiatry residents, access to the psychiatric residents, and therefore its convenience. The residents knew the researcher from being housed in the same facility thereby increasing access to the research participants.

Five third-year psychiatric residents were interviewed. These five residents were chosen through purposeful sampling. Creswell (2007) identified the concept of purposeful sampling as a means of selecting participants and sites because they can

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purposefully inform an understanding of the research problem and phenomenon of the study (p. 125). Specifically, criterion purposeful sampling was selected because the participants are residents who have experienced the phenomenon for at least three years during their residency training. These five residents comprised the entire class at Soho University for one academic year.

Smith et al. (2009) recommend interviewing three to six participants for a phenomenological study because the meaning created by the inquiry is more valuable than the size of the sample. Creswell (2007) generally cites a narrow range of participants but specifically recommends five to 25 interviewees. deMarrias (2004) suggested less is more by implying that the fewer number of participants, the greater the depth of data collection. Moustakas (1994) defined the criteria for my participant selection: Experience of the phenomenon, an interest in understanding its nature and meanings, a willingness to participate in interviews and follow-up interviews, willingness to partake in recorded interviews, and a willingness to have the data published in a dissertation (p. 107). My sampling strategy was to gain a rich in-depth description of the experiences from the participants. The participants included four females and one male with three Americans and two foreign residents. Their ages ranged from 28 to 49.

Data Collection

Moustakas (1994) advised employing multiple data collection methods to triangulate the research design. Triangulation adds credibility through the use of multiple sources as evidence (Denzin & Lincoln, 1998). Creswell (2007) stated that multiple methods of data collection characterize good research methodology and demonstrate an in-depth understanding of the research. My three sources of data collection were interviews,

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researcher observations, and focus groups. For my study, focus groups took the form of group supervision.

Institutional Review Board Approval and Consent

Institutional review board approval was received from the University of Memphis and Soho University where the research was conducted. Potential participants were informed of the purpose of the study and asked to either accept or decline participation. All accepted and signed the consent form that described the purpose of the study, any possible risks, the choice to end participation without any consequence, the estimated time to complete the interviews, and intent to publish the data in my dissertation.

In my opinion, the primary risk for the participants was confidentiality. However, I took extra safety measures to ensure the participants felt at ease during the research process. Each participant was assigned a pseudonym. All information gathered from the interviews was locked in a file cabinet in the researcher's private office. Any descriptive details of the participants were held to a minimum. The year of the residency class was not included in the description of the participants.

Interviews

Three individual interviews were conducted with each participant. The benefit of an unstructured interview approach allowed the experiences of the participants to guide the conversation in a more meaningful way (Seidman, 1998). Creswell (2007) elaborated that phenomenology data collection is drawn from first person accounts of their life experiences. My experience with psychiatry residents was that they are extremely busy people. Residents rarely had time for idle chit-chat and coffee pot conversations.

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To fulfill the research purpose and the psychiatry resident's needs, I scheduled one-hour initial interviews with each of the five residents in their offices. The first interview centered on exploring the participants' experience in the context of their lives. They were asked to reconstruct their early experiences in residency that were important and valuable to their career development. A second interview was scheduled to add depth to the initial information by gathering concrete details of their experience with the phenomenon. Lastly, a third meeting was scheduled for further resident reflections regarding how their experiences during residency made sense in their present lives and for validation purposes (Seidman, 1998). The focus for the interviews is listed in Table 1

Table 1

Focus of the Interviews

Interview	Focus
1	Life History as a Resident
2	Details of the Residents' Experience
3	Reflections on Meaning

The interview questions were broad and general so that the participants could construct meanings without being influenced by this researcher. The intent was to interpret the significant experiences and important factors from the residents regarding their development as competent psychiatrists. For the phenomenologist, the hope was to gain an intimate view of residency development from those whom may have a different premise about their development (Creswell, 2007). The research question for this study

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was: “What are the important experiences of psychiatry residents and what meaning do they ascribe to these experiences in their acquisition of psychiatric skills?”

Short, open-ended, clearly worded questions provide for detailed responses and exploratory questions allowed for specific event responses (Seidman, 1998). Close-ended short-response questions create an interrogative atmosphere. The key was developing a safe, trusting, pleasant atmosphere for the participants so each felt comfortable while sharing his or her experiences (Seidman, 1998).

According to Smith et al. (2009), the goal of phenomenology research interviewing is to understand the experiences of people and the meanings they make of these experiences. An example of an initial interview question was “Tell me about your experience as a psychiatry resident.” My specific task was listening attentively with understanding and empathy. Follow-up questions explored narrative accounts, overall meanings, specific experiences, accounts of events, significant occurrences, and clarification of contradictory statements.

The interviews ended when the information was saturated and no new information emerged. Qualitative research interview questions do not explore why the participants think a response, action or behavior occurred. Qualitative research seeks responses that describe experiences that allow the participant to tell his or her unique story. Typical research questions include “Tell me the first time you experienced this phenomenon or describe a typical day in your life” (Bhattacharya, 2007, p. 43). Interview effectiveness depends on gathering in-depth full descriptions of the phenomenon. Each interview lasted for 45-50 minutes and was audio recorded and transcribed. The last 7 interviews were transcribed by a professional transcription service company.

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Research Observations

Research observation was the second part of triangulating my data collection. Creswell (2007) described observation as a series of steps beginning with obtaining permission to observe the research participants. For my study this involved scheduling time to observe the third-year residents during their didactic lectures and patient clinics. Determining my role as observer was the next step. Initially, this was as passive observer (Creswell, 2007). I did not see my observer role as a problem for the resident or their clients. During the faculty supervised residents clinics, an additional observer was not disruptive. Observing didactic lectures did not prove inconvenient for the residents or the faculty member. The residents and their clients shrugged off having a clinician observe the sessions.

I utilized an observational protocol form consisting of both descriptive and reflective aspects to document. Factors recorded included the physical setting of the lectures and offices, specific events and dynamics, the residents' behaviors, facial reactions, and words, plus my own reactions noted after the observation; additional detailed notes were recorded immediately afterward describing the observational session. Memos and notations written in the margins of the field notes helped organize my initial thoughts. Jotting notes and writing memos about key concepts again helped with exploring the transcript data. Creswell (2007) cited the benefit of an observation protocol form for recording data which allows the researcher to organize thoughts along categories and headings. I constructed a draft form used during the observation sessions which is included in the appendix. The specific purpose of collecting observational data was to

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present the observational data to the resident and explore their reflections of observed behaviors. This occurred during the resident's interview.

Focus Groups

My third data collection method was focus groups. Smith et al. (2009) cautioned that the use of focus groups must meet the research purpose of the study. This method was chosen because it was a conventional choice as a data collection method in the social sciences. Focus groups possess advantages when the participants' communication yields beneficial data (Creswell, 2007). Focus groups are best used when interviewees are accommodating and cooperative allowing multiple voices to be heard at one meeting. The researcher roles for focus groups included facilitating the discussion, monitoring the interaction, and maintaining an ethical environment (Smith et al., 2009).

Successful group interviews yielded exploratory key information allowing the respondents to recall descriptions of specific events. My approach followed the individual qualitative interview format and focused on the research goal exploring meaning and purpose (Seidman, 1998). This was an open-ended question and non-directional approach used in a natural setting. The skills required for a focus group interview were flexibility, objectivity, empathy and listening proficiency. The objective was to obtain responses from each group member by ensuring that one member did not monopolize the group discussion.

The form of qualitative focus group for my study was group supervision where the group of residents presented and reflected on challenging cases. Group supervision of complicated new cases is part of the residents' curriculum. Self-exploration and self-understanding were the most cited outcomes associated with group supervision (Yalom,

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1995). Group supervision involved student learning and growth through the interactions occurring among the group members. Supervision allowed participants to experience mutual support, reflect on common experiences and complex tasks, review learned new behaviors, enhance personal competencies and increase insight (Whitman, 2001).

I scheduled an hour on Fridays for five weeks to review with the residents their weekly client caseloads. Thus, the focus group met each Friday in my office. The focus groups were recorded and transcribed. Important experiences encountered guided the focus groups. Each session began with what were your impressions of the groups this week and the new intake cases. The focus group sessions concluded when the data were saturated. Data saturation occurred when the researcher no longer heard or saw new information. This satisfied both the residents' curriculum needs, my employment duties and fulfilled my dissertation requirements.

Each interview, observation, and focus group was unique due to the distinctive differences that make up human beings and educational experiences. With respect and honor of the research process and research participants, I included special consideration (sympathetic regard and careful reflection) regarding the setting and the style and substance of each participant response. I expressed to the respondents that their participation was important. Specifically, I said that there are no right or wrong answers, only genuine answers. When information no longer added to the understanding of that category, it signaled the end of the data collection method and indicated that saturation had occurred for the collection method (interview, researcher observation, and group supervision). The data collection plan is listed in Table 2.

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Table 2

Data Inventory

Data Collection Method	Table		
Interviews	3 x 1 hour	=	3 hours per resident
Observation	3 x 1 hour	=	3 hours per resident
Focus Groups	1 hour	=	1 per week for 5 weeks per one group

Data Analysis

Qualitative methodology provides a systemic approach for answering the research question through a detailed data analysis of the data (Creswell, 2007). I used a method of data analysis recommended by Creswell (2007) and Moustakas (1999) labeled the Modified Stevick-Colaizzi-Keen Method. I have paraphrased the data analysis steps listed by Moustakas (1994) and will explain how I utilized this model.

> The first step begins with a description of the researchers own experience of the phenomenon. This attempts to set aside the researcher's personal experiences, called Epoche or bracketing, so the study can focus on the participants' experiences.
>
> The second step generates a list of meaningful, significant and important statements from the verbatim transcript of the participants' experiences. This is conducted by utilizing horizontalization which treats each statement with equal value and develops a list of non-repetitive, non- overlapping statements.
>
> The third step takes each non overlapping significant statement and groups them into larger components of information called meaning units or themes. The meaning units are clustered into themes or related categories.
>
> The fourth step composes the meaning units or themes into a description of the textural structures of the experiences. Textural description is derived from the first three steps narrating what was experienced by the participants. The textural

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> description is a description of the meaning the participants have experienced. Verbatim examples were included.
>
> The fifth step consists of writing a description of how the experience happened. This structural description reflects on the setting and context in which the phenomenon was experienced.
>
> The sixth step constructs a composite textural- structural description representing the group as a whole from the individual textural and structural descriptions. This section is the essence of the experience and represents the interpretation of all individual textural and structural descriptions. It consists of what the participants experienced with the phenomenon and how they experienced it. (pp. 121-122)

Step 1: Epoche and Bracketing

I applied the first step of data analysis by writing my experiences with the phenomenon. My own experiences with psychiatry were a source of both insights into the phenomenon under study as well as a source of bias. A full description of my experiences with psychiatry started with my first job out of graduate school at a state psychiatric hospital in rural south Georgia. I experienced the golden age of psychiatry (before managed care limited and decreased financial reimbursements 20 years ago) and the present managed care era. I have practiced a wide spectrum of care, including personal growth holistic approaches during my early career and symptom management approaches in recent years. I have experienced psychiatric treatment with long-term chronic schizophrenic patients and the high functioning worried-well patients. Over the years, I have worked with seasoned veteran psychiatrists and young enthusiastic psychiatrists. I have witnessed psychiatrists who possessed excellent skills and abilities and witnessed others who were less able and endured career stagnation. Data collection analysis included my own personal experiences.

Bracketing my viewpoints of the subject made sure the participants' themes were

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derived from the voice of the participants. After describing my personal experiences of the phenomenon, the participants' transcripts were read several times. My mission was gaining an overview and acquiring meaning of their statements. Before these readings, I again applied Epoche, bracketing my preconceived notions, so that I could better understand the interviewees' statements.

Step 2: Meaningful Statements

This step of analysis created a list of meaningful and important statements taken from the participants' transcripts. My tactics for this step incorporated horizontalization, memos and journaling, and identifying meaning statements.

Horizontalization. Step two created a list of meaningful statements by utilizing horizontalization. Horizontalization treated each statement with equal importance and consideration. It considered every expression with relevance by granting the same weight as other statements. These expressions contributed to an understanding of the phenomenon. I gained a sense of the entirety of the transcript before breaking it down into parts.

Note Taking and Memos. I read and reread the transcript data, sketched ideas, wrote notes in the margins, described my reflective thoughts in the transcripts and highlighted certain information that I deemed important. In general, the key words, phrases and explanations which the respondent used were recorded. Significant and relevant statements were identified from the interview transcripts and participant descriptions by studying the notes taken, conducting a close line-by-line analysis and drafting a summary sheet. For example, jotting notes and writing memos about key concepts helped explore the data. Then, for each underlined segment I wrote in the margin an explanation of why I

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thought this segment was underlined and therefore important.

Identifying Meaningful Statements. I identified each participant's thoughts about certain significant experiences including key relationships, pivotal events, emotion-laden statements, life-defining moments, the understandings that mattered the most and those that presented a clear phenomenological focus. Identifying these significant statements reflected the participants' strong emotional descriptions, emphatic disagreements with their studies or other residents' perspectives, striking or contrasting phrases, surprising declarations, and considerable detail regarding a point of view, decisive views about the phenomenon, distinctive agreements and dissimilarities. Part of this involved recording some of my own persuasive recollections of the participant interviews and my more striking observations about the transcripts. I reflected back on these notations with the knowledge that my first impressions were captured. At this early stage in the analysis, I organized my data into file folders, notes on index cards and computer files. This assisted with locating data when needed. I noted information that was conceptually interesting or unusual. This created a list of statements, the primary patterns of the data I considered meaningful, and created structure for the phenomenon.

Step 3: Themes, Clustering, and Categories

The phenomenon of residency was based on the residents' descriptions of the experience. Inductive analysis assured that patterns emerged from the data rather than being imposed by possible preconceived biases. I interpreted the phenomenon by the elements and structures uncovered in the transcript data. During step 3, I was interested in the sequence of the data that each participant provided in response to the major research question. My aim was to generate a comprehensive and detailed set of notes, themes,

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clusters and categories of the data.

Themes. Developing themes included observing patterns of commonality and uniqueness for each specific participant's transcript and then across multiple transcripts. This stage of analysis was the most detailed because of the volume of data analyzed, 15 individual interviews 5 focus group interviews and 3 days of observations. I cultivated these significant statements into themes and analyzed each line of the transcript by asking how the word, phrase and sentence relate to the research question. At this point, I adopted an old school approach by analyzing the data with a hard copy of the transcripts with wide margins.

I started by looking over field notes from the observations, interview data, and focus groups. Next I scanned all the organized data folders to uncover major organizing ideas. Reflecting on the larger participant ideas presented in the data began to form my initial theme categories. This step entailed developing dimensions of the themes and providing interpretation of the participants' views. Detailed description meant describing "what is seen" and providing details within the context of the setting (Moustakas, 1994). My idea was to highlight use of pauses, laughter, tone and degree of fluency. Analogies such as the complexities of camping were an important component because of its linking of concepts and pragmatic description. Themes described the meanings for the participants which mattered the most such as key objects of concern, relationships, processes, places, events, values and principles. As I developed these meaning statements, I anticipated a descriptive core of comments, which had a clear phenomenological focus.

Clustering. During this step of analysis, I identified and clustered the significant statements into themes or meaning units and removed repetitive statements that stated the

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same ideas. I began to cluster the transcript data into meaningful groups that eventually revealed constant themes. This task moved from the particular to the shared and from the descriptive to the interpretive. Clustering organized the themes into categories by noting how one theme related to another theme. My initial theme categories were based on reviews of the major organizing viewpoints, notes on how the themes related to each other and reflections on the larger developing ideas. Multiple forms of evidence (individual interviews, observations and focus groups) defined each categories specific meaning. This phase of analysis brought order and meaning to a large amount of data by retaining the themes that provided meaning and structure to the phenomenon.

Clustering the initial categories of significant statements and themes used a unique characteristic of the research process by sorting through the database regarding similarities, consistencies, and inconsistencies between participants' experiences through notes and memos. Searching and then searching again the collected data allowed me to sort the initial themes, investigate new ideas, connect additional ideas, and process my own reflections about the participants' meanings. Other possibilities for uncovering meaningful moments included examining silent moments or what is not said, noting disruptions and contradictions (places in the transcripts where the dialogue fails to make sense or does not continue), and interpreting metaphors described by the participant.

I stepped aside and formed an overview and summary of what had taken place within each initial theme category. My objective was to practice flexible, creative thinking regarding the expansion of certain categories and the revision of others. I started reducing the clustered themes into related categories by identifying patterns and themes between categories and counting the frequency of certain themes. I harvested tentative themes

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through the practice of reduction, trial and error and categorizing specific meanings that were common across all transcripts.

Creswell (2007) described reduction as "winnowing the data (p. 152)." He stated not all information is used in a qualitative study, and some may be discarded. Creswell (2007) further stated data analysis is preparing and organizing the data for analysis by reducing the data into themes through a process of clustering and condensing the clusters and finally representing the data in figures, tables or a discussion. For example each resident cited the benefit of observing their professors model certain psychiatric techniques. The modeling of techniques and observation were clustered into a theme. Creswell's "winnowing" approach reduced and combined the themes into clusters of categories. Statements that were repetitive or overlapped another statement's meaning, repeated the same idea, duplicated an earlier statement or occurred repeatedly were eliminated during this step. Certain themes were evaluated for their inclusive importance and certain themes were discarded if the theme became redundant or could be combined with other themes. Combining and reducing themes produced the major categories of themes.

My strategy was to cut and paste sentences and thoughts from the original themes into a separate labeled word document. I determined if the identified themes contained information that was necessary to understand the experience and if the statement could be summarized and labeled. Next I eliminated statements that did not meet these criteria and repetitive statements. I studied each theme to identify thoughts or experiences that were overlapping or were unable to be labeled. I read through this list of statements numerous times. When I found a statement that appeared to overlap, I cut and pasted it next to the

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similar horizon (significant statements that provide an understanding of how the residents experienced the phenomenon) in order to combine and create a single statement that captured the participant's statement. The residents' citation of the benefits of observation and their professors' modeling techniques were identified as a prominent theme. This resulted in a series of individual, non-repetitive statements. This step drew together the emergent themes into categories.

To add clarity, I catalogued my internal dialogue by recording memos, journaling my thoughts and detailing field notes and refining my pre understanding about the phenomenon. I used my own understandings to make sense of the participant's descriptions. These notes provided a system to document my thoughts and insights as I proceeded through data reduction. During this task of analysis, I created notes in a word document that detailed my reactions, interpretations, observations and reflections of potential categories of themes.

I clustered the themes listing major themes chronologically in the order each was identified. I examined the number of participant theme citations as an indicator of their interest in a particular theme. However, the objective was to see how the themes fit together which was the goal of the overall research question.

Categories. Creswell (2007) used the metaphor of viewing themes as a family by initially identifying five to seven themes (p. 153). These themes have children or subthemes and even grandchildren or subthemes represented by segments of data. I again evaluated the differences and similarities between themes, the frequency of occurrence of the themes across participant transcripts, the connections across participant responses, compelling emphasis of certain themes, and relabeling of themes (Moustakas, 1994).

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Rearranging and reordering themes in the form of a master table assisted me during this methodical but important stage of analysis. Some themes connected to other themes. An alternative I liked was printing out a list of themes and cutting out each labeled theme so that each theme was on a separate piece of paper. Then with a large piece of poster paper, I moved themes around exploring how the themes related to each other. Those possessing similar understandings were placed together. Those in opposition were positioned on opposite sides of the poster. I also highlighted collections or emergent themes which related to particular participant interview moments or key life events.

Next I examined themes for their positive and negative descriptions in the interviews. Development of theme categories involved charting and mapping how the themes fitted together. Organizing themes in more than one way enhanced the analysis. Grouping and clustering important themes into larger categories resulted in the core themes of the experience. This step compared the theme categories against the complete transcript record and resulted in consistent and clearly expressed clusters of categories. The categories of important and meaning statements and meaning units provided a unique characterization of the research descriptions. The end result captured what is crucial for the participants' experience. These theme categories laid the ground work for the descriptive writing that followed.

Step 4: Textural Description

The next steps consisted of developing a structure or frame illustrating the relationships between themes. The development of a full narrative included a detailed commentary with participant citations and a theme-by-theme interpretation. The interviews became a set of parts as each was analyzed, but then came together in another

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new whole at the end of the analysis. Step four was constructing a sense of the whole experience which required examining each phenomenological experience from the different themes and at several times in the process. Textural description was taken from the first three steps in data analysis and describes *what the participants experienced*, a description of the meaning individuals have experienced. Moustakas (1994) stated the essential structure of commonalities of the lived experiences are described as a whole (p. 100).

Step 5: Structural Description

Step 5 addressed a structural description of the meanings and an essence detailing how the participants experienced the phenomenon, organized the conditions, situations, and contexts of the important themes. Verbatim examples and direct quotes were used to augment and provide evidence for the descriptions. The structural description was an account of the context and setting that influenced how the participants experienced the phenomenon.

Step 6: Composite Description

As a result of these descriptions, a composite description of both the textural and structural descriptions of the phenomenon was assimilated. This was the *essence* of the experience for the phenomenological study (Moustakas, 1994). The composite description captured the common experiences of the participants and the underlying structure of the experiences. Participants were given an opportunity to review their descriptions for accuracy (Creswell, 2007, pp. 150-154).

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Academic Rigor and Trustworthiness

Qualitative interviews were based on coauthoring by the participants and the researcher. The quality of the research interview depended on the interviewer's active listening skill and ability to follow the interviewees' responses. Various types of audits enhanced the quality of the interviewing process. Bhattacharya (2007) defined member checking as an instrument that provided an opportunity for the participants to clarify, edit and correct possible misinterpretations of the data collected. Member checks ensured that the transcribed data matched the constructed experiences from the individuals and groups. Confirmability was contingent on measures such as member checking to verify the data collected. I applied member checks to safeguard the accuracy of my understanding and improve communication with the participants during the interviews. My duty was to interpret and write about the phenomenon of psychiatry residency. Member checks assisted me with this objective.

The interviewees' and researcher's offices were located in the same hall allowing access to confirm data by this researcher asking for clarification when developing the themes. This provided the participants the maximum opportunity to co-author the research.

Anfara, Brown, and Mangione (2002) cite the validity and reliability measures of qualitative research resulted from prolonged engagement in the field, multiple sources of evidence or triangulation, pattern-matching or inductive data analysis, peer debriefing and member checks. Peer debriefing was used to add to the reliability of the study. Peer debriefing involved consulting with a knowledgeable colleague to clarify certain dilemmas encountered in the field. Peer debriefing provided certain benefits such as

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conversations about ethical predicaments, arenas to brainstorm ideas and a colleague's reactions to research quandaries, advice about decisions on which way to proceed, and discussions regarding analyzing qualitative data to achieve validation. A trusted colleague (who had recently completed his qualitative dissertation) served as peer debriefer through the data collection and data analysis process.

Peer debriefing provided another layer of trustworthiness. The role of peer debriefing, meeting with a colleague to review implementation of the research methods, was to ease the researcher's methodological practices and provide feedback concerning the accuracy and completion of the researcher's data collection and data analysis procedures (Schwandt, 2007). These meetings with a colleague (who was familiar with the topic and qualitative research) assisted me with my analysis and interpretations. This outside objective feedback helped keep the analysis true to the research purpose (Creswell, 2007).

Triangulation fortified the credibility of phenomenological data analysis (Creswell, 2007). According to Anfara et al. (2002), triangulation uses more than one method to study a research topic. The goal of triangulation was to increase the researchers understanding of the research subject and the reliability of the research data. My three forms of data collection were participant interviews, researcher observation and focus group supervision.

Subjectivities

My interest in psychiatry began during my undergraduate studies. Afterward, I attended a graduate school of social work. My abilities as a qualitative researcher were complemented by my experience as a clinical social worker. Psychotherapy, which I have

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practiced during my career, possessed many of the characteristics and the principles of qualitative research.

Postmodernist psychotherapy is characterized by a participant-observer dynamic. Therapy is a process where the client collaborates with the clinician in constructing his or her reality. The focus, much like bracketing of preconceived notions, is more on the client than some preconception held by the clinician about what has taken place with the client. There are many possible meanings as opposed to one true meaning that allows clients to create more adaptable views of their problems. The major tenet of psychotherapy is that there are many ways to explain a situation rather than one right or correct way.

Narrative therapy parallels qualitative research with the following characteristics. Narrative therapy is based on the clinician acknowledging the client's experiences are valid and valued. Psychotherapy includes conversations, stories and narratives. Therapeutic objectives seek to empower clients and explore their own unique narrative stories about themselves. Re-authoring is the process of honoring these stories which had previously been denied or suppressed (Barker, 2003). Therapy in this sense is similar to qualitative research interviewing. Common intervention techniques ask clients to reflect on their internal dialogues. This reflecting process occurs during sessions in which the therapist also may reflect on his or her thoughts and the client to reflect on what was said. The use of reflection is cited as a valued qualitative research step (Smith et al., 2009).

The therapeutic dynamic explores examples of client's lived experiences that reveal gaps in their story or denial of their performance. Typically these lived experiences contain inconsistent complaints and problem descriptions. Specific questions include

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“What can you tell me about your abilities that would help me understand how you managed to take this step” “Tell me about the times when depression did not keep you from what you wanted to do” and “Tell me about how you overcome similar experiences in the past”. Therapy is a process of caring, empathetic conversations which evolve into new meanings for clients. Therapy, applied in this manner, is like interview questioning in qualitative research. Both psychotherapy and qualitative research views the clinician/researcher as a co-writer engaged in the co-construction of new meaning. My therapeutic skill, practice and experience with these psychotherapy procedures added to my understanding and ability to conduct phenomenological research.

Wertz (2005) defines Epoche as abstaining from preconceived notions, setting aside opinions, prior experiences, biases, prejudices and predispositions to better understand the participants’ experiences. The purpose is clearing the mind by reducing every thought to equal value and eliminating predetermined evaluations of the research. Epoche is like bracketing and requires special attention and effort on part of the clinician (Moustakas, 1994).

Certain researchers (Denzin & Lincoln, 1998; LeVassear, 2003; Peshkin, 1998) have challenged the possibility of completely clearing one’s mind from experiences, beliefs, and assumptions. Moustakas (1994) encouraged reviewing one’s thoughts and feelings, setting aside prejudgments and returning to the person with a fresh perspective. The objective is a fair representation of the phenomenon being explored. Explorations of my own subjectivities helped me observe the participants with an unbiased view.

I confronted my preconceptions and experiences as I did when conducting psychotherapy sessions. This occurred multiple times. Occasionally a client triggers a

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negative reaction for no apparent reason. Effective psychotherapy requires addressing and processing these emotions and reactions. Although there was no one way to nullify my preconceived ideas, I was observant of the presuppositions that arose during my research. “Phenomenology is committed to descriptions of experiences not explanations” (Moustakas, 1994, p. 58). My duty was to bracket my pre-conceived assumptions regarding psychiatry residents, the profession of psychiatry and psychiatry residency. Once my assumptions were processed, I scrutinized the phenomenon ensuring that the emergent themes were not tainted by my preconceptions. Subjectivity research measures included journaling, peer debriefing, and bracketing.

Summary

Chapter 3 provided an in-depth account of the research analysis utilized for this study. The overall research intent was the development of categories and emergent themes that accurately portrays the participants’ significant statements of their development. The research purpose was to acquire a deeper understanding and insight into the significant factors of psychiatry residents. The data set consisted of the residents’ important experiences and the meaning the residents’ ascribed to these experiences in their acquisition of psychiatry skills. The phenomenological experiences could be an important facet of improving their training.

The data set consisted of obtaining and describing residents’ experiences regarding the research question through individual interviews, researcher observations and group supervision/focus groups.

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CHAPTER 4: FINDINGS

In this chapter, I present the findings from the research with the five participants from a psychiatry residency program. The question I set out to explore was:

> "What are the important experiences of psychiatry residents and what meaning do they ascribe to these experiences in their acquisition of psychiatric skills?"

Each resident's experience related to the research question was explored through individual interviews, observations, focus group interviews and my reflective writings. These descriptions of the individual residents' experiences revealed unique dissimilarities between the participants. In Chapter 4, I present the themes that depict the essence of all five participants' experiences during their third year of residency training. The five participants in the study were Dr. Toney, Dr. Vann, Dr. Christie, Dr. Reno, and Dr. Pulling. All names are pseudonyms.

Dr. Toney

Dr. Toney was the oldest of the participants. At the time of the interviews, she was in her late forties. She had transferred from another residency program. She voiced initial reservations about participating in the study. When the residents were informed of the study's purpose and the researcher's desire to conduct interviews, Dr. Toney replied that she needed time to think about it. This cautious approach was identified in her themes. However, when consulted individually, she agreed to participate.

After approaching Dr. Toney with a degree of apprehension, I presented the study's research question. I allowed her to lead the interview at her personal discretion. The first few minutes of the interview were dedicated to placing her at ease so that she felt comfortable discussing a wide range of personal experiences and self-reflections. It was

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important for her to realize the confidential nature of the interviews. She had professional interaction with and knowledge of my position with the medical group associated with her university residency training. Initially, the goal was to develop trust so that her experiences with residency could be explored deeply and thoroughly. After the first few minutes, she sensed that this interview was not to blind side her with difficult questions. She developed a sense of comfort that was necessary for the interview process. She embraced talking about her experiences from both positive and critical perspectives. A number of diverse themes emerged from the interview descriptions of her experiences. These themes consisted of 1) Learning through reflective observation, 2) Perseverance through educational obstacles, 3) The journey of choosing a residency program, 4) Residency class discord, and 5) Vital third year experiences.

Learning Through Reflective Observation

As the interview progressed, Dr. Toney became an insightful participant. The first theme, learning through reflective observation, detailed Dr. Toney's struggle to incorporate psychotherapy skills during her training. After the first interview question was clarified, she eagerly and with much animation, told her story of residency. Specifically, she cited the lack of professors modeling the techniques presented during didactic lectures and reading assignments. Dr. Toney began:

> One of the things I see lacking in the residency program is having people who know what they are doing, just model some of that for us. The most valuable experience that I've had was when I had the opportunity to just watch somebody who's really good at what they do. In my first year of post graduate training, they teach you how to do the physical exam and how to do the interview. That stuff's all pretty mechanical and just recall . . . it's different [in psychiatry] especially in the third year. I didn't realize how valuable it was to just be able to sit back and watch until I got to do it.

She provided a detailed example from her experience with the child psychiatry clinic.

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> I've been kind of frustrated over there because it's different interviewing children. A lot of times there are other family members present and the kid is moving around. It's hard to get their focus. So, it would have been especially valuable, I think, if I could have watched some of them to see how they handle that. I asked them when we first got over there and they were like, no, you do your own interviews. They [her professors] showed us some films that were probably made in the 1950's of some psychotherapist. But I wish sometimes that they would not be so afraid to model [techniques] themselves because nobody does that. Nobody does.

However, when given the opportunity to observe her professors, she readily described this as an important learning experience. She loved seeing patients with her supervisor, Dr. B.

> I get to see him in action and I can't even express how valuable that's been. Also, just to see how he [Dr. B] doesn't say anything. Because as a beginning therapist, that's the hardest thing, I think, sometimes is just shut up. He's good at it. That's great to watch but I just feel like, I don't know, I just feel like the experience is still very limited.

Psychologically Dr. Toney took her learning objectives and assignments seriously. She had high expectations for fulfilling this year's educational goals. Her struggle was considering what to do or say during her patient sessions. She described a prior supervisor's model that was greatly beneficial.

> He's [her supervisor] such a fabulous persona. He's amazing to watch. I also really respect Dr. A. He's terrific and I really respect him as a clinician, all his knowledge and enthusiasm with clients. I prefer to see them do it [conduct a session] because I am getting it reinforced all these direct ways.

She related feeling lost at times during psychotherapy sessions. Much concern was expressed about not wanting to make mistakes. She described her need for skill acquisition early in her third year:

> I don't want to screw somebody up because I don't know what to do during patient sessions. Psychotherapy is just such a struggle to figure out what you're supposed to do. They actually encourage you to start picking up patients before you really have a clue. It really does feel like you a bumbling along and don't have a clue what you are

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> supposed to do. Sometimes you feel like I'm an idiot. I'm just sitting there. It's been really confusing for me.

I was startled by the earnestness and devotion to her craft she disclosed. She described an incident during her medical school rotations that demonstrated the value of therapeutic modeling and its importance to her skill development.

> It wasn't until my fourth month of training that I actually got to work with this guy that had mostly a well-to-do clientele of adult males in the San Antonio area. He had been in private practice for a long time and he told me the first day . . . I don't want you to be offended by this but these are my patients and this is my private practice. I'm not going to let you poke around on my patients. You'll be able to come in, watch and learn what you can and I hope that's enough for you.

She continued with this scenario:

> He seemed almost apologetic that he wasn't going to let me do that. I guess I kind of felt the same way at first. But you have a tendency, when everybody else is throwing you out there and basically having you do surgery on your own. Then somebody tells you, you're not touching my patients. You kind of think, God I am as competent as anybody else, come on. The very first day, I came to see it differently because he was so well liked by his patients. He had such a smooth and pleasant bedside manner that he was just wonderful to watch and to use as a role model, to model some of your own behaviors after.

Dr. Toney identified the transition from didactic learning tasks to her implementation with patients as a struggle. She displayed a deep commitment toward developing competent psychiatric skills by viewing her third-year responsibilities as a foundation for the rest of her education. Her concern with this theme situated her desire to shift from didactic lectures to an experiential learning format. Dr. Toney stated her learning need for reflective observation, specifically observing her professors modeling effective psychiatric techniques. She stated the lecture format did not meet her educational needs. This left her struggling to grasp and learn the information presented. When given an

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opportunity to observe her professors, she was able to understand and embrace her learning objectives.

Perseverance Through Educational Obstacles

The second theme from Dr. Toney's interviews was her perseverance through educational obstacles. She was the first of her family members to attend college. She came from a family with a strong work ethic who valued work over education. Her educational opportunity occurred in a dramatic fashion having overcome multiple obstacles to achieve her education. She described her path to formal education.

> Going to college wasn't really something that was ever on the map for me as a youngster. Plus, I hated high school. So, I thought I never wanted to see the inside of another school once I got out of the 12th grade. But when I got married, I married a guy that had an advanced degree and he encouraged me to go back. He was the first person that I ever knew that said that. College isn't like high school. They don't have their thumb on you all the time. You kind of get to do what you want. I thought okay, I'll try it. I did but then we started our own business and I got so busy. I never got back to it.

This was her first hurdle to overcome. After the first ten minutes of the interview, I was immediately struck by the genuine responses by Dr. Toney. Her responses were captivating. This emerged from the one person I thought would require more prompts and encouragement because of her initial hesitancy when approached about my study. She portrayed her next set of obstacles with only a slight nod of approval:

> It was 1995 when I was in an industrial accident at the place where I worked. It was a serious accident. They gassed us with phosgene gas which is like mustard gas that they used in World War II. It made me blind for two days. I ended going to The Texas Rehabilitation Program and they said we can train you for another job or you could go to school. I was like, hey, I kind of always wanted to go to school. But I was in survival mode as a single mom. I was thinking what can I take that I can get back out in the job market as fast as possible.

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When she paused during the interview, I replied “please tell me more”. After a lengthy description of her educational opportunity, she described an epiphany moment with her daughter.

> One day my daughter came home to me and asked me something about her going to college. It suddenly dawned on me that my daughter was at the age that I didn’t have to be in survival mode. I might actually have an opportunity to dream about what I wanted to do for a change, so I did. I started just taking various courses at college and I found that I really, really liked science and biology.

This life-defining moment fueled her commitment to pursue her educational goals. Yet, she suffered lack of encouragement from her undergraduate advisors. She detailed these battles.

> I decided to get a degree in biology and about halfway through that, I started thinking med school would be cool or maybe psychology. A lot of people that I came into contact when I was doing undergraduate biology, they were all going to med school and so it was always around me. I started thinking, I could that, why not? I went and saw my college counselor and he was like, you’re too old. Don’t even try, they’ll never take you.

Her self-determination identified in this conversation was maintained during her current residency tasks. Although she regarded herself as stubborn, she possessed a fierce degree of resolve and fortitude. Her life experience has been an asset and a source of strength. Her vigilance was portrayed by these recollections:

> I’m just hard-headed enough that when he said that I thought, I’m going to show you. Anyway, that’s how I ended up getting into med school is that this Texas Rehabilitation Program got me started in college. They paid for my first two years of college until I got an associate’s degree. Then I didn’t want to stop at that point so I kept going.

Dr. Toney’s critical incidents, life-defining moment, personal resolve and aspirations for an education emerged as her second theme. She displayed the same attributes during her residency education as she did with her undergraduate studies.

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The Journey of Choosing a Residency

Her third theme was the journey of choosing a residency. Choosing psychiatry residency began as a natural attraction but became a major life decision. Based on her narrative, this was a perfect fit for her interests, life experience, philosophy, determination and learning attributes.

> When I got into med school, I found myself kind of fascinated with the psych part. It just seemed the body was more mechanical. The head is the only place where it is different and that makes it more interesting to me. Whenever somebody has a kidney problem, they all work the same . . . but not up here in the head. Once I started my rotation that was it. I just fell in love with psychiatry. That opened a door to a very fascinating world for me.

After noting her personal attraction and inherent aptitude for exploration, she continued with this theme description.

> I never thought, I want to be a doctor and work with people . . . as I studied psychology. Then when I got in medical school, that started coming back into my mind. As I studied psychiatry and psychology, I was like, wow, how cool is this. Then when I actually did my psychiatry rotation, I just felt like this is it. I found what I love. I did a bunch more psychiatry electives and then I did a couple of other electives. About half of my class went into anesthesiology because it was paying so much at the time. I thought, I guess I better at least do an elective in that just to rule it out and physical rehab and pain medicine because I thought that might be interesting. After my electives, I just couldn't get away from psychiatry after that. I just fell in love with it.

Dr. Toney described a personal account of her experience with psychiatrists and her preconceived notions about the profession.

> When I was in this industrial accident, I think it happened on a Thursday or Friday and that following Monday when I tried to go back to work, I found myself having a panic attack. I didn't know what it was at the time. I had never had a panic attack. I was driving to work and I started hyperventilating and sweating and pulled over on the side of the road. I was like what is wrong with me. I went to my local walk–in clinic and I said you have to give me something to help me calm down because this is what happened to me. I can't make it . . . to work. He [the doctor] just happened to be a veteran who told me of his experiences with PTSD (Post Traumatic Stress Disorder). At that point, he recognized that I was having an anxiety attack. He gave me 10 Xanax

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> and he said this is all I can give you. You're going to have to see a psychiatrist to get some more. I ended up just opening a phone book. I knew nothing about psychiatry.

Dr. Toney continued to need little prompting. I simply nodded my assurance and held her eye contact.

> I looked in the phone book and I just found a psychiatrist that was close to my house. I called this shrink . . . and made an appointment to see her. It was really helpful to see her a few times. That opened a door to a fascinating world to me. I grew up in a small town with just a bunch of country folks, and I didn't know any mentally ill people.

She connected this prior experience to her choice of residency. She reflected on the significance of this episode in her life.

> I never thought, oh, I want to go be a psychiatrist and work with people like this. At that point, I hadn't really thought about going to medical school or anything but when I got back in medical school, that [seeking help] started coming back into my mind. As I studied psychiatry, I was like so that's what was going on with me. Since then it has been absolutely fascinating to be here.

It was apparent that Dr. Toney took her educational opportunities passionately. She carried this into her residency training. She chose psychiatry residency based on her attraction for helping people and the creative aspects of the profession. This theme, The Journey of Choosing a Residency described a strong bond with her residency choice. Dr. Toney gave substantial time for personal reflections of her learning experiences. Her self-efficacy and motivation positively impacted her skill development.

Residency Class Discord

Her fourth theme was a tumultuous account of collegiality and encounters with the other residents. During this interview sequence, I admired her willingness to describe her responses in such an ardent manner.

> I am shocked how childish and unprofessional a group of psychiatrist [residents] can be. People [psychiatric residents] that work in the mental health industry and you would think that they would have a little more compassion for others and more

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> understanding. I've met some really great people but I am also shocked almost on a daily basis how un-nurturing, backbiting and petty people can be. I find myself sometimes . . . I guess people just use up all their compassion and patience on their patients. They don't have any left for each other.

My notes from my observation day further expounded on the lack of collegiality between residents. During one of my observation encounters, Dr. Toney and Dr. Pulling became embroiled in a heated discussion. Dr. Toney submitted a time off request to the chief resident, Dr. Pulling. Dr. Pulling, Dr. Van and I were sitting in the library waiting for the start of a group supervision class. The group supervision class was a weekly one hour class conducted by the researcher. The class reviewed the status of new patients entering the psychiatry clinic and the significant experiences from the weekly group therapies. Group supervision was held every Friday at 9 am. My observation data follows:

> Dr. Toney entered the group supervision room and handed Dr. Pulling the form for her requested vacation time. Dr. Pulling responded the form was incomplete. She bluntly stated that the form needed to have an additional section completed (which was a new requirement) and that an email was sent out 2 weeks ago. She handed the form back to Dr. Toney. Dr. Toney replied that she was sorry but she did not receive the email and that her form should suffice. Dr. Pulling repeated that she would not accept this form until it was completed. It needed another resident's signature agreeing to cover for emergency purposes Dr. Toney in a heated tone, stated "oh come off it, Carol! I know what this is about. We all know what you're trying to pull!" After a tension filled moment, Dr. Toney took back the form and looked over the incomplete section. Dr. Toney in a direct voice, asked if Dr. Pulling would agree to cover and sign the form. Dr. Pulling promptly replied no. Dr. Toney, then, turned to Dr. Van and asked her to cover and sign the form. Dr. Van stated that she needed to check her schedule but would get back with Dr. Toney after the supervision class.

While both residents engaged in abrupt if not rude conversation in this exchange, much tension existed between certain residents during this year's class. Dr. Toney's aggressive response was representative of the contentious interactions that plagued this year's class. I asked Dr. Toney to talk more about these resident interactions. At times, these conflicts

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have been a detriment to educational skill attainment. She responded with a rather extensive description of her psychiatry rotations.

> I remember one of my formative experiences in medical school. I did a rotation on a psychiatry unit at the VA (Veterans Administration Hospital). A couple of their people were out. The ones that were still there, they were all overworked. One of them had back surgery and was out for a long time. They tried to pick up the burden. At a meeting, they asked when is Sue Smith or whatever her name was coming back from her surgery. One of them said she is coming back next week. They all talked about it and decided that was too soon that she needed to take another two weeks off from work to get over that kind of major surgery . . . I thought, oh my gosh, because I had worked in surgery and they just dog each other about taking time off. Then, in psychiatry [VA] people were thinking in a compassionate way. I remember thinking this is the only place that you would ever find this attitude and compassion.

She detailed her current experience with these prior rotation descriptions.

> Ever since I've been here, it's like man, was that ever a fluke. I don't think I've ever seen that again. Instead it's like, I won't or I don't know. I think these people (other residents) used up all their compassion and patience on their patients. They don't have any left for each other.

Learning environment and resident interactions were topics that were unavoidable for Dr. Toney. I was impressed with the way she reported her experiences with this theme. These conflicts detract from potential meaningful clinical encounters. This type of ongoing conflict negates certain aspects of team-based and problem-based learning collaborations. She described a group of residents embroiled in an immature clash. My observation of the conflict between Dr. Toney and the chief resident symbolized the interactions of this group of residents. Part of these conflicts originated from the lack of negotiating strongly held opinions between the residents.

Vital Third-Year Experiences

Vital third-year experiences emerged as Dr. Toney's fifth and last theme. This included her surprise at enjoying certain training aspects. She detailed her preconceived

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notions of the current year's educational goals. Again, she was generous with her discussion of accepting this year's different approach from previous years.

> I guess the one thing that surprised me is I thought I would be really bored in the third year because I liked emergency psychiatry. I like working with very decompensated patients and psychosis. I think psychosis is fascinating. I was telling myself before I started this year, you're going to have to get through this year because you're going to have all these stable patients just coming in for med management or whatever.

She continued with her personal account from her second year when working at an inpatient hospital.

> It wasn't like that at all. It's been a lot more interesting . . . having the time to actually spend with patients. When you're on inpatient services, you don't have time to sit with a patient for an hour and talk. You're kind of doing the evaluation and then you're going to the next patient. You're writing all your notes and then before you know it, your day is done. Then you're on call and you're sleepy the next day and all that.

As she continued, she spoke of both the benefits of her third-year didactics and the drawbacks of certain lectures.

> We have a lot of didactics here. The program that I was in before didn't matter which year that you were in, you had, every Wednesday afternoon, didactics four hours. Here we have probably three times that in didactics and it seems like a lot when you look at it as far as hours in class. The things that they expect of you, it almost seems like it's still not enough.

She voiced the need for better organization of her didactics.

> It's a lot of didactics and they're good didactics, but I don't know, I think the timing of some of it is just off a little bit and just personally, my personal opinion, I hate it. I know that the teachers don't want to go in there and just talk everyday but I really hate it when they assign topics. Everybody has to take their turn presenting the topic but we end up doing is sitting in there. Some people (her fellow residents) come very prepared with lots of notes written, and they've even looked up on the Internet to get supplemental things to talk about when they present their topic. Some people sit there and just go down the page. Well, the first paragraph talks about blah, blah, blah . . . I've already read the article. Why do I need you now sitting here reading me what each paragraph of the article talked about. That's not helpful. That's not a didactic to me. Sometimes the attending in there with us jumps in and gives examples and sometimes they just sit there and let somebody do that for a whole hour. You feel like,

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> boy, this was a great day. What a waste of my time. I could have reread the article myself and come out of it with more than that.

Dr. Toney addressed the lack of insightful information presented by her fellow residents. Later in the conversation, she shifted to a discussion of the third year being a once in a lifetime experience due to patient interactions becoming a meaningful experience.

> You really just don't feel like you're that invested in each patient but when you get to the third year, they're actually your patients. Even though it's not the most exciting stuff that some of the other rotations are. You feel so much more invested in the outcome when you're seeing these patients regularly over the course of a year. You're making decisions on their medications, their treatments and you're getting to know them.

At this point, she volunteered information with minimal prompting. I inquired gently by stating in a soft voice to please tell me about her psychiatric skill attainment.. She continued:

> Especially in this clinic, we have enough time to see all of our patients for almost an hour if we want to. I know I probably shouldn't but I do that a lot because I really just like to hear my patient's stories . . . I want to be able to luxuriate in the extra time I have right now. I'll never be able to do this again in my life. Where I thought I was going to come into this whole year just thinking, gosh, this is going to be a terribly boring year, it's not. It's fun to be able to really get to know the patients and follow them over the long-term. I think it's helped me see them as more than just patients.

She described practicing a humanistic approach to psychiatry treatment. Humanistic Psychology promotes a holistic approach through emphasizing the healthy parts of a person (Yalom, 1995). Also, she depicted her third year as a transition to becoming a more complete psychiatrist. She described her patient interactions, skill development and the third year as a foundation for her career.

> You have more freedom. I think you feel more confident that you know what you are doing. You've learned to establish rapport with patients relatively quickly and feel good about it. I guess the work schedule is a lot nicer, you have less emergency call and better quality of life in general. The thing I like most is that I just feel more confident in what I'm doing. I feel like I know what I'm doing, except for some of the

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> psychotherapy and the group thing. I'm still struggling with that, but I'm sure that will come.

I asked her to continue with these vital experiences.

> I have a certain patient that I think stands out to me. You just get a patient that really kind of touches you for some reason. Their story or their presentation and their struggles and how they're dealing with it. And I just look forward to every one of those moments. I just really like psychiatry and having that intimate connection with patients.

She identified critical incidents that defined her skill development. Her third-year encounters guided her competency development, skill enhancement and valuable medical experiences. Dr. Toney's degree of reflection and self- analysis revealed her interpersonal commitment. As her interviews drew to a close, I explored her most valuable experience as a resident. I emphasized the word "most" when asking this question. Much of the research literature identified didactic lectures and supervision as the most influential aspects of residency training. Here is Dr. Toney's down-to-earth reply.

> I just like being with the patients, talking to the patients. I can remember when I was younger, I knew a person that used to see a psychiatrist. I used to think you're an idiot, who needs a psychiatrist, this is all just common sense. Life is good, life is bad sometimes, you just deal with it. What I've come to realize through my training, med school and my training here is that it has nothing to do with what the stressor is. I just think I take more into account, my own personal life, more compassion for the human condition and for people in general. I feel like I've become more nurturing, understanding and compassionate. I may not be the most capable, but I have a whole lot more coping skills than a lot of the population and I guess I never knew that. Random acts of kindness, that's it, that's really what it's all about and I think every day that I come to work it reinforces that to me in my real life.

I include, below, my observation notes of Dr. Toney interacting with her patients to substantiate

her above experiences.

> During an initial psychiatric assessment, Dr. Toney had a distinctive ability to place people at ease and assess their diagnostic criteria. She possessed a candid straightforward presentation coupled with an authentic caring approach. Her patients

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responded with appreciation and a sense of hope. In group therapy, she grasped the humanistic dynamics. She understood the therapeutic philosophy of engaging the psychological transformation and the tactics of change. During sessions, she was never at a loss, remained attentive and invested in her patient's well being.

I asked to her continue describing vital experiences for her psychiatric skill attainment. Again, her personal self-reflection was described in both her personal growth and her professional approach.

> The more I'm able to maintain my professional composure in those really difficult circumstances, I get better. I can tell you when we started speaking about losing people too young the other day in group. That was hard for me because my husband just died two years ago and he was only 48 at the time. That's hard, but I think the more you do it, the more you're able to use your own experiences.

She cited life experience as a cornerstone for her learning and skill enhancement. Her comments referenced a previous statement regarding constructionism and making meaning of her experiences.

> I think I'm a pretty patient person and understanding, because of the things I've been through in my own life. I've had a lot of rough times . . . plus I'm older. I guess those aren't really significant experiences but my past has helped me to develop a better understanding of people that are going through struggles and to be more compassionate. I feel like I want to help them instead of just making a paycheck.

With a modicum of encouragement, she continued with knowing her residency choice felt right.

> I've done a lot of things in my past. I've done a lot of different jobs in completely different fields. I feel like I'm not one of those people that grew up with doctor parents and dreamed about being a doctor since I was growing up. I never in my wildest dreams thought I would end up here. And its right, I know it's right for me . . . I feel right doing what I ought to be doing. That makes it so much easier and so much more fulfilling to me on a daily basis.

She brought her past experience full circle by identifying her most valuable experience as her interaction with patients.

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> There's nothing better than to get somebody [a patient] who's really messed up, be able to evaluate them and start them on the appropriate medication. Then see them six weeks later and they're smiling and happy and feeling like you're their hero. That's a pretty good feeling . . . that keeps me coming back to work every day.

She ended with a gratifying summation of her important experiences during her residency.

> I didn't just come here because of some childhood fantasy. I did everything else first and then finally stumbled into the right place and I love helping people.

I thought Dr. Toney would be a guarded participant but she proved to be the most substantial of all. Dr. Toney's willingness to address her psychiatry training, struggles with certain educational formats and benefits of her education was gratifying. She placed importance on her learning and developing abilities as a psychiatrist. She held herself accountable by not minimizing her educational duties and tasks. She placed much meaning on the importance of her skill development and role as a helping professional. Dr. Toney provided a dedicated account of her important experiences. The residency experiences described were not an intellectualized version but more of a personal description of her residency education, her learning style and her challenge to become a skilled psychiatrist. Her inner resolve forged her success in college, medical school and her psychiatry residency. Her ability to overcome obstacles enhanced her skillfulness as an empathetic active clinician. Her account was the most lengthy of the five participants.

Dr. Vann

My next participant was Dr. Vann. Dr. Vann, a Caucasian female in her late 20s, was the youngest participant in the study. She looked younger than her stated age. She attended medical school directly after graduating college and then immediately entered psychiatry residency. She was polite and gracious while agreeing to be interviewed. I met

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her three years ago at a residency graduation dinner. As a first-year resident, she accepted the resident of the year award for her research efforts. I remember one of the elder professors commenting that she looked like she had not yet graduated high school. During the third year, she served as co-chief resident. The co-chief residents present concerns from the residency class to the residency director and supervise the on-call schedules. Her five themes included 1) Lack of Poise and Self-confidence, 2) Choosing Residency, 3) Conflict avoidance, and 4) Constructing knowledge.

Lack of Poise and Self-Confidence

Dr. Vann began with a demure approach requiring more direction and encouragement from me than the other participants. She was slightly hesitant when voicing her experiences. This was more due to her gentle spirit and youthful age than her not having intellectual responses. When asked about her important and meaningful experiences as a resident, she began talking about lack of assuredness when applying her psychiatric skills. This emerged as her first theme, a lack of poise and confidence with applying her psychiatric skills. She explained:

> It [patient sessions] can be really aggravating. I've noticed the first two sessions it seems like we don't accomplish much. A lot of it is getting to know each other. About the third session, for quite a few people, I've noticed that we've had a bit of a rocky start and I always hope I don't lose them. I'm really interested in seeing later if that first session paid off, seeing what we dealt with in those beginning sessions.

She needed mild reassurance to explore this topic's meaning and her skill acquisition. I asked about experiences that might be a building block for her career.

> It's nice to be exposed to all the different types of therapy. One of the things that I'm kind of concerned about is that I'm going to be good enough at any one particular type of therapy. Something that's useful for me to be that good at it. I feel like I need some more training and maybe CBT (Cognitive Behavioral Therapy). Just to have as something that I feel confident in, that I can do when I get out. I do wish there was a

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> little bit more focus on one specific school of training. Maybe I won't end up using that but at least I'll feel confident knowing that one type of therapy.

Wanting to know more about her abilities as a third-year resident, I inquired further by asking tell me about your training experiences. She described her learning needs and tasks:

> If I have a really interesting patient, I'll try to talk to a few different people [residents, faculty] about that case and get their take on it. A lot of times different people have different ideas behind what the best treatment would be or what the best therapeutic goal might be for that patient. So I try to put that together.

She described her use of self-reflection and presented a straightforward account of these patient interactions.

> It's after I feel like the patient's been somewhat successful. You know, a few months later maybe they'll come back. They will have seen me a few times and I'll feel like, okay, they're really doing well with this intervention. Sometimes it's the opposite though. Sometimes they do poorly after whatever intervention I have and I think, uh oh. Those stand out to me in particular. I guess the people who are doing well and I can say, great. I think that's because of what I did or they're doing poorly and I can think, well, maybe I could have done something better in that instance.

I appreciated her modest description of engaging patients with the tactics of change. She was candid with her critique of self and learning experiences. She continued with her description of these approaches:

> I like the variety of different sites that we go to probably the best. I feel like we get a lot of different patient populations, a lot of different settings throughout our training. I feel that really gives me some confidence. I'm not going into a situation that I'm not aware of how to deal with because I've only been at the VA.

Pursuing these concerns, I inquired about experiences outside of her patient interactions. She presented the challenges she faces as a resident.

> Its juggling so many things, that I'm not sure I do a good job with my patients, with my colleagues and my studies. It's probably time management. You have so many different forces that are pressuring you. You always want to make sure you're taking care of your patients. But then you also have your responsibility for learning and

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education, so you have your classes, reading, journal clubs, case conference. You always have lots of things to do. Because of chief residency, I have the administrative part, too. It's kind of a hectic balancing act.

After a moment of reflection, she then addressed utilizing feedback from her supervision which helped with these tasks.

> With my supervision, my attending will tell me, look, this is something that might get you in trouble in the future. You need to pay attention to this type of situation because it might get you in trouble. It [feedback] hasn't been really mean, it's been constructive, but they've definitely said you should have done this instead of what you did. I tried to keep those instances in mind when the situation comes up again.

Dr. Vann was open to corrective feedback. She did not take her critique as a personal criticism but utilized this to better her skills. I asked about experiences that she considered a foundation for her skill development. Specifically, I asked please tell me about specific examples of your educational experience that were important.

> I guess seeing somebody [patient] get better makes you feel like, wow, I can actually do this. Yeah, that's it. Before, I didn't know what I was doing. I felt like, I hope that they're getting better, since they're not in the hospital. But it's harder to know when they are not in the hospital and coming for appointments only once a week or two weeks. It's nice getting to actually see that one patient get better. Even though she'll probably end up back in the hospital some day, but it's been rewarding this year seeing that she has not been there so far. It's been really good.

I supported her responses by noting that she enjoyed her patient interactions. She related that these types of experiences when she saw her patients improve added to her professional competency.

> Yes, because for a long time I sat there and wondered 'do antidepressants really help?'- I mean you read all the studies and everything, but in practical experience, you just don't have that until this year. But when you have an outpatient for over a year, you might actually see that they've got some better which benefits you. It makes you feel like you're getting it right.

Dr. Vann struggled to gain proficiency over the different psychiatric approaches taught during her third year. Her concern was transforming her training into a competent skill

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base. However, I was impressed with the commitment Dr. Vann displayed toward wanting to learn psychiatry. Although her responses were concise, she was sincere about her abilities and skill development as evidence by her humble self description and demur affect during her interview.

Choosing Residency

As our interviews progressed, I returned to my research question by asking about meaningful experiences and circumstances. Dr. Vann described her choice of residency as an important factor which she considered a justification for her career. She described her residency choice as a vital developmental experience. This was her second theme, making sense of residency selections.

> I was one of those people who didn't know what they wanted to do for a while. So I didn't really make up my mind that I wanted to go into psychiatry until the end of my third year of medical school. I always thought that I'd probably end up doing something along those lines like internal medicine, infectious disease, something like that. When I was doing my third year rotations, I realized [choosing a residency] it's a lot different than what I thought it would be.

With encouragement, she continued with these descriptions of her residency choice.

> I don't know, when I was on my psychiatry rotation, I really liked it. I really liked interacting with the patients. I really liked the time that I could spend with them. I liked the fact that I didn't have to feel obligated to do a little bit of everything like in the primary medicine fields. I felt like I was able to specialize some. There were a number of factors that came together that made me decide that's what I wanted to do.

I reframed her response by stating it seems as if she was unsure of her residency choice until exploring several options. She agreed and proceeded to describe these factors.

> Right . . . It was just my interest and experience with rotations in the field. There's a lot of research in the neurosciences and so that was exciting. Part of the reason why I liked it is because it was challenging. There's not just one right way to do something. You don't get a lab test and, okay, this is it. This is what I'm going to treat them, this is the antibiotic that I need to treat them with. That kind of thing, I liked that. Also, well, I enjoyed reading about the field. I thought this is something once I'm done with

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> medical school that I'll still want to continue reading about. I want something that I'm interested in learning about when I'm older as well. You can have a fairly good lifestyle. It's not like a surgeon when you have to put in so many hours to keep up the practice to maintain credentials or things like that.

This depiction reflected her desire for creativity but also her pragmatic knowledge of the field. I asked her to clarify her last statements regarding her experience with psychiatric skill acquisition. She voiced a need to practice biological psychiatry and the art of psychotherapy. Dr. Vann continued:

> I've gotten my MD. I don't really see myself going out and just doing therapy or just prescribing meds. I plan to, of course, use medications and I think for some patients, it's more valuable. I agree that there is a lot of, I guess, artistic license or nurture to psychotherapy and I appreciate that. I hope that I can incorporate it in the future when I practice. I hope to do both because they are both important.

After some initial encouragement, Dr. Vann presented with a mild approach. Although she described a lack of assurance, she held a deep conviction to develop her psychiatric skills by displaying concern for her patients. Choosing psychiatry residency revealed her need for a studious approach and time for reflection. She considered several factors over a lengthy period before making her residency selection.

Conflict Avoidance

After discussing her residency choice, Dr. Vann then initiated a description of her interactions with the residents. This emerged as her third theme, conflict avoidance. She provided the following poignant examples of this theme.

> Well, our class has had a lot of difficulties. It's been very challenging. We spend a lot of time together in class. And we see each other a lot in clinic. I guess there's the opportunity to have a lot of interpersonal conflicts in that setting. I'm sure that happens in the real world too. So, I guess it's a good experience to learn from. But yeah, it's been demoralizing for me at times being the co-chief. Maybe this is not the best subject for me to talk about.

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I explained that I had no preconceived direction for the interview and that her important experiences were the purpose of my research. I asked about the impact this had on her learning experience. She continued to describe these ongoing conflicts.

> I just feel like I just don't want to be there physically because of those conflicts. That makes it challenging when you don't want to be physically in a place because of conflicts, you know. It kind of interferes with you being interested in learning and being engaged in the class topic discussion or when patients are presented. I think it can have bad effects.

I responded that I understood and asked her to please continue. She provided a psychological example of the kind of dynamic that exists between some of her resident colleagues.

> It seems to me, you know, in generalities, that some people like turmoil, and if there is none they'll create it. Then other people just don't like turmoil at all, they avoid it.

I continued by asking her about her personal experiences with turmoil.

> I'm one of those avoidant people, I guess I don't like turmoil. I would rather be by myself and doing my own thing. Just leave me alone. At times, I wish I could just disappear when the turmoil or conflicts break out. If there was a hole, I would crawl in it. Again, it's hard to be a group.

I include an observation encounter that provides an example of Dr. Vann's interactions with colleagues. This example occurred at the beginning of the academic year.

> Dr. Vann confronted Dr. Christie about hijacking the group topic away from the subject she introduced. He [Dr. Christie] simply nodded and did not become defensive. Dr. Vann continued to state her style may be different [than his] but is no less effective. He again simply nodded stating he was not aware at the time but would not attempt to do this again. She ended with "okay" and a gentle smile.

This example depicted her embracing an assertive but congenial manner. Dr. Vann preferred harmony instead of conflicts with her colleagues. These statements reflected this caring and gentle nature. She described these conflicts inhibiting the potential

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benefits of peer collaboration described with team-based learning and problem-based learning formats.

Constructing Knowledge

Noting Dr. Vann's gentle approach with her residency challenges, I inquired about her experiences with learning tasks by stating please tell me about meaningful learning experiences. Her third theme was the experience of constructing knowledge. I asked which valuable experiences with her faculty professors, events with her studies and overall learning objectives stood out in her mind. She followed with this description:

> I liked my interaction with the consult liaison service. I was at the med-consult service probably longer than anyone else my year. That's just the way it worked out and I really liked working with [my supervisor] a lot. He had a way of showing some practical therapeutic interventions on the consult service so it was nice to see how he threw that in.

Dr. Vann cited the empowering benefit of observing other's techniques and modeling specific skills. She seconded Dr. Toney's educational preference for an experiential learning approach. Both stated the value of observing the techniques taught in their didactics and having the opportunity to reflect on these learning experiences. She continued with meaningful examples of this learning style.

> I really enjoyed watching other people interact with patients because a lot of the time the way that I learn the best is mimicking their interactions and then practicing it myself. Sometimes their exact interaction doesn't work for me but if I'm able to play with it, then I can come up with something I feel that I'm comfortable. I feel like that's a good way to learn, otherwise, I'm just kind of guessing. Probably, that's been the most helpful thing to me.

I asked about other learning aspects that were meaningful. She described the value of learning from a team approach at her various psychiatry rotations.

> Different hospitals have different approaches to how they do things, so that's nice. I enjoyed my time at St. Patrick Hospital because I felt like they had a lot more

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> resources than maybe some of the other hospitals did. The social workers and psychologist there were really helpful. They actually sit down and do pretty much in-depth interviews with the patients, then they'd come and talk to me about the information that they had gotten. I'm not used to that at maybe the Government Hospital because the social workers there are so busy doing their job. They don't really have a chance to sit down and get to know the patient. At St. Patrick, I spent a lot of time talking to the social worker there on what her impression was because sometimes patients will present a different way to another person. It was really nice to be able to see how a team should work together. We actually have time to form a therapeutic alliance.

The team-based learning approach had an important impact on Dr. Vann's training. She voiced a learning preference for small group patient care discussions. I inquired further about her experiences with the different psychiatry facility's approaches. She replied:

> A lot of times the social workers [at the Government Hospital] are told, okay, you have to work on placement. You have to find them a place to stay when they get out of the hospital. The social worker is spending pretty much all of their time finding a place for this person to go once they get out of the hospital. I don't feel like they really get the chance to do anything therapeutic. I guess at St. Patrick it seemed like the social workers there, well, they [patients] had places to go. So the social workers didn't have to work on placement so much. They actually got to spend some time working a little bit more therapeutically and kind of get to know the family dynamic. They'd call on the phone and talk to them and it was just really useful for me to be able to figure out what was going on with them [family]. It was more of a team approach. It helped learning about how to effectively treat them.

Dr. Vann reported the usefulness of practicing the team-based and problem-based approaches. Again, she valued small group discussions for patient care. She described her experiences with these approaches.

> It's the integration of the family with the patient's care. Some of the patients, we see, might not need hospitalization but aren't stable enough to be on their own. The problem with [Government Hospital] inpatient is you're just trying to get 'em' in and get 'em' out. You know, get them to just be stable. Really a lot of the time their acute episode isn't completely resolved when you're getting them out of the hospital. And you know you're thinking okay, are they able to be at home? It's just busy work.

After describing her hospital rotations, I inquired about other important learning experiences. She conveyed her experience with supervision and didactic lectures.

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> In my lectures or classes . . . sometimes it just gets to be either too many or too long of time period. I just don't quite get as much as I could get out of that. I don't have a specific person or class, I just don't feel like was useful. But it's kind of the length of time that we're in class. You're just not getting as much out of it after three hours because you're just not paying as much attention at the point. It might be the lecturer doesn't realize that some of the stuff has been covered in another class and is repeating some of the material.

Dr. Vann takes responsibility for her learning objectives with an authentic sincerity. She expressed being humble and less assured about her abilities. Although didactic lectures have shaped residency education programs, both Dr. Toney and Dr. Vann cited the sometimes stale nature of these formats. As our second interview drew to a close, I asked her to discuss her most valuable experience in residency. Surprisingly, this triggered her lengthiest discussion. She related the following:

> It's been kind of nice to see outpatients. We're so used to seeing inpatients our first two years. You kind of see people, they come in, you see them a whole lot for few weeks and they are gone. You don't really know what happens to them after that. So it's really nice, in the third year, to seek how people do during the course of the year when they're not just in an acute stage of their illness. You're seeing them more, doing well and you can see some improvement over time. It's nice.

I asked her to continue with experiences that were meaningful. I specifically allowed her to choose the direction of this final question.

> Seeing patients and getting to know them. Pretty much the ones that stand out are the patient related ones. I feel like that's been the way that I've learned the best. What stands out in my mind the most is dealing with the patients. It helps me in my studies because I've seen them. I've seen something that I can go back and read about. Then what stands out to me in the future is that particular patient scenario as far as my learning goes.

Dr. Vann described a valuable experience that happens rarely during residency. She conveyed the unique circumstances of treating a patient during her second year at an inpatient hospital and then picking up the same patient as an outpatient a year later.

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> Well, it's very interesting seeing how the patients do outside of the hospital. One of the patients I've been lucky enough to have seen in the hospital and now I've picked them up as outpatient this year. It's really neat to see the different level of functioning, the different concerns. It's good to have a longer lasting relationship with them. I anticipate them getting better, I'll see what happens at the end of the year. It will be nice to have that longer lasting relationship with the patient.

With little encouragement to continue, she described how beneficial this particular experience has been for her.

> This patient, I saw her in my second year. She has a diagnosis of schizophrenia. I admitted her to the hospital three times at St. Patrick during my second year because I was there quite a bit, as compared to other residents. I saw her quite a few times, and then I actually picked her up as an outpatient this year. It's been really rewarding working with her as an outpatient because she hadn't had any hospitalizations this year. I thought there would be difficult times this year, especially when she was hospitalized last year. Just hearing her perspective on reflecting back to her experience as an inpatient and as an outpatient. It's really interesting.

I voiced my appreciation for volunteering this experience. I inquired about third-year experiences which were different from her prior two years. She replied with this response:

> I like the groups. Yeah, both in the inpatient units that I've been and outpatient. It's definitely something that . . . I'd like to look into more in the future. I'd like to figure out if that might be an option that I could incorporate in my future practice. It seems like insurance would pay for. It's a good way for giving information to a lot of people, especially psycho educational type of information. The family therapy kind of stands out to me as another that I'd like to use in the future. Those are things, the groups and the family therapy, I'm interested in getting as much experience as I can.

I asked about her specific experiences with patients, therapies and interactions that she considers as a focal point for her development.

> I guess I haven't really focused on one thing so much as the other residents. I mean I've done some research and I like it. I might do it in the future. But I haven't really decided this is definitely what I want to do. I mean, I like seeking patients, and so I'd like to continue doing that. Having a bit of the research exposure opened my eyes in that area. It helped out like reading some of the journal articles and having that perspective of working on a study myself. I also liked working with the medical

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> students. I would definitely like to continue that. Participating in teaching gives a different perspective to psychiatry and to medicine in general. A lot of people, well for the medical students, this is going to be their only interaction with psychiatry, their medical school rotation. So providing them with a good experience and giving them some tools to identify certain illnesses or when to refer, I think is really important.

I followed by asking what was motivating about her educational experiences. Her response was again humble and succinct.

> Seeing the patients, being in the clinic, getting that feeling that you can take care of a patient on your own. It's good to see patients and have that knowledge, I'm good with them. I'm only part way through this year so it's good to have a long relationship with them. It's been so beneficial. I guess that's the motivating factor is the thought of being able to see patients in the future, help people out, be successful in this line of work.

I was impressed with the dilemma Dr. Vann described about her abilities and her learning experiences. She noted her didactics grew stale but that she greatly benefitted from worthwhile clinical encounters. She highlighted a preference for modeling and observing techniques to enhance her educational experience. She described an aspiration to move beyond applying only a couple of cursory psychiatric approaches and to evolve into a well-rounded competent psychiatrist.

Dr. Vann did not possess the past life experience that Dr. Toney had. Although she related a degree of self-doubt at times, she was psychologically engaged in her learning experiences. She did not let her insecurity prevent her from being successful with her studies. She reflected on both the productive and challenging patient interactions. Finding her niche in the profession of psychiatry was depicted throughout her experiences. Dr. Vann presented a humble and sincere description of her important experiences.

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Dr. Christie

My third participant was Dr. Christie. As an international student, he applied for psychiatric residency in the United States. One patient complaint of foreign residents is typically they do not know the nuances of the English language. Dr. Christie spoke English fluently. He was the only male in this year's class. Dr. Christie provided a different candor than most psychiatry residents. He was willing to be interviewed but initially described the various aspects of residency in glowing terms. He was affable and gregarious when asked to participate in my study. He had been involved in several research projects in the department and had the reputation of being well liked by the faculty. My goal was to engage this participant in exploration of the research question. Dr. Christie's identified themes included 1) Blended educational approach, 2) Everything is a learning experience, and 3) Assigning value to patient interaction.

Blended Educational Approach

Dr. Christie displayed much enthusiasm and curiosity regarding my research question. I began by asking about his important experiences during his residency. Being generous with his replies, he identified many of diverse aspects of his residency. He stated everything was "great", "fantastic" or "superb".

> The residency experience has been like enormous for me. Overall, it has blended both in psychotherapy as well as the inpatient exposure I got. The exposure I got, I saw a lot of cases, a lot of psychopathologies. The VA [Veterans Administration] exposure we had a lot of PTSD [Post Traumatic Stress Disorder] from operations in Iraqi Freedom and Afghanistan. Substance abuse was very high during those rotations. At the state hospital, it was an all together different ballgame where you see a lot of really crazy people, people with schizophrenia and suicide attempts. But we were simultaneously taught in didactics how to handle these difficult patients. We were taught how to interview the patients. It was fantastic.

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As I sat in Dr. Christie's office, I was intrigued with his description of important experiences. His replies became more detailed as he elaborated on his training and his psychiatric skill acquisition. He continued this discussion of his first theme, blended educational approach.

> It was like very entrusting because we could test our own knowledge and we could test the waters of our abilities. We were given the independence to work and to diagnose people and to treat them. Our attendings [faculty professors] were kind enough to help us with that. I had exposure to the geriatric population where we had a whole floor of geriatrics [at a private inpatient hospital]. We went through a lot of old people and their problems and a lot of medical problems. A lot of dementia, people with hyper sexuality, ambulation falls and their medical problems interacting with the psychiatric problems. That gave us a lot of ideas and insight about how different pharmaceuticals can affect them, how to monitor their medications, their mood and their family interactions Especially a lot of family work which I learned from geriatrics. In fact, it has a great deal to do with the illness, talking to families about arranging their nursing home placements and stuff like that.

His responses framed as a diverse set of encounters regarding his psychiatric skill enhancement. He then continued with this blended theme.

> We also had a lot of didactics during those [rotations]. We were taught how to read the test, all the neuropsychological testing, how to look at a Rorschach and what do these mean to the patient. Classes were on how to handle different problems related to both physical complaints and psychiatric complaints. At the same time, we would have other didactics on psychopharmacology, how to do medication management, how to handle patients with complexities. Throughout my first and second year, we were also supposed to do our case conferences and general presentations, so it had a very good impact.

I further explored his experiences during his third year of residency. His responses were quickly voiced with much gusto. He detailed this blended approach, the combination of biological psychiatry and psychotherapy that increased his skill set. Dr. Christie described his professors and didactic lectures as valuable educational encounters. In glowing terms, he depicted quality training interactions. I attempted to clarify his responses by distinguishing his favorite important experiences.

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> We have great balance . . . this year, we had more towards therapy but at the same time we are taught pharmacology medications. Sometimes the pendulum swings towards therapy. Sometimes it goes towards the medications but it has been a great balancing exposure especially with this year's therapy exposure. We've been exposed to different schools and there are nearly four hundred different schools [of psychotherapy]. We can't be exposed to them all but we are trying to get the major schools and the major flavor by being more interactive. We've got a great group therapy. We have a great sex therapy and couples counseling. The major areas like family therapy, everything is covered therapy wise. As far as medication wise, we have the treatment protocols we discuss for depression, anxiety, bipolar and schizophrenia. We discuss the treatment protocol and we have great balance. It's been great. We have fantastic faculty. They have been teaching us and taking care of our educational needs.

Dr. Christie described his desire for balance between the models of psychotherapy and psychopharmacology through current approaches. I followed his praise for his faculty and didactics with a more purposeful exploration. I asked about which important experiences he would carry into his career. He championed one specific therapeutic modality by highlighting the following example.

> The CBT's [Cognitive behavioral therapy], which I've learned I will carry out, the relaxation techniques which I've learned, how to make group therapy cohesive and the cohesion of the group therapies will go along with the family therapy. We learned all this will go a long way. My third year was very exciting because we have all year outpatient and we have a very dedicated faculty and teachings. We have group therapy which is amazing. I've been to a lot of other programs as an applicant interviewer and a lot of people don't even have that exposure to group therapy . . . so it's a lot of therapy oriented in the third year. We have been taught a lot of didactics on Tuesday mornings and Wednesday mornings where we have personality disorder didactics . . . we follow for six months and then another six months we follow another personality [disorder] and those are year round. It's very interesting.

Dr. Christie began our interview by describing the development of his skill set. Because his experiences were described in extremely positive terms, I inquired about the experiences he would place at the top of his list. He described the thorough training with the major models of psychiatry. He continued with more details of this third year:

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> We also do case conferences Tuesdays and Wednesday mornings, we have didactics the whole day. The first half of the day we do a lot of readings on psychotherapy, current psychotherapies. Every resident does their own reading one week apart from the others [residents]. Then we discuss how to manage each of the different treatments and watch different videos of different patients. We also are taught how to interview patients preparing us for our oral boards. Although we are not actually eligible, we were taught how to handle an oral interview with a patient in an exam setting. At the same time . . . every Thursday afternoon we go to child psychiatry where we are taught two hours of didactics and do rounds and then we discuss cases. It's been an overall good exposure. We follow our cases in a clinical setting where you see various psychopathologies, mixed types, mental retardation, autism, ADHD [Attention Deficit Hyperactivity Disorder], and a lot of adolescents with behavioral issues. So far it's been very good didactics. There's been a proper blend. For the second year, we had a supervisor. For the third year, we had two supervisors, one psychologist and one psychiatrist. We're supposed to carry four patients for four hours of psychotherapy every week. We tape them and discuss them with our supervisors. He teaches certain things with our patients.

Dr. Christie's ambition in pursuing a wide range of interests created a unique experience as a student, resident, doctor and possible researcher. After citing his didactic lecture experiences within the adult and child divisions, I asked which of these experiences were crucial for his skill attainment. He provided the following energetic response:

> The staff and faculty are very motivating especially Dr. A and Dr. S. They all look after us and give us a heads up when we are lacking and where we are lagging behind. They tell us our loopholes and try to fix those loopholes. This year will give me a lot of insight into therapy and different schools of thought. I came to know how to have an actual conversation with another therapist. I can understand the therapist's language. I can do proper referrals, because I know which therapy is to be done with which person, due to the [educational] requirements of the program. Having four hours of psychotherapy [with patients] is a lot of exposure. So these psychotherapies, were not taught in most of the programs which I interviewed in the past, this is a very learning driven program.

Dr. Christie described a hands on approach by his professors which allowed him to grasp information he might otherwise have missed. His learning experiences were conveyed as dynamic but also pragmatic. He enjoyed the variety of educational avenues his residency accommodated. This diversity, with his training approaches, augmented his learning style

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preference for case studies, presentations, demonstrations, lectures and problem-solving activities.

Everything Is a Learning Experience

Dr. Christie provided the following description of interactions with peers and his learning atmosphere wherein his second theme emerged, everything is a learning experience. He approached possible negative experiences as learning opportunities. He did not refer to these interactions with cynicism.

> Working with them [third-year residents] sometimes can be challenging but usually there's some camaraderie which has kept us together through difficult times. Working with difficult personalities . . . can be challenging. It's different personalities from different cultures and places. It's like there is a conflict down the middle [of the group of residents]. I try to let it go but sometimes it is right in front of you. However, this has been a learning experience for me.

Dr. Christie's experience was similar to the other participants. They described a rift within this year's group of residents. At times, Dr. Christie stated this interferes with the team-based approaches in his psychiatry training. He followed with a description of his contentious experiences with certain patient populations.

> Initially, I had some difficulties adjusting to the people with a lot of entitlement issues, specifically at the VA [Veterans Administration Hospital]. You get a lot of hurtful comments and people with psychopathologies. They behave in different ways. They might be rude to you. Those initially will hurt you if you take it personally. When you talk to your supervisor, you discuss it with them. Those feelings, the transference and counter transferences were dealt with properly. Then you feel much better and you have a great learning exposure.

Dr. Christie framed these challenging encounters with his resident colleagues and certain patients as learning experiences. He shrugged off taking these situations personally by not dwelling on the negative aspects. Due to Dr. Christie's upbringing, including his father's parenting style and Eagle Scout Training, he learned to view difficulties as

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important learning opportunities. Initially overwhelming, these examples of coping with difficult client situations shaped his educational experience and developed his psychiatric skills. He continued with this disclosure:

> The most challenging part of residency is having to do things independently and sometimes being questioned by difficult patients about our credibility. It has been a challenge with people who are difficult patients, who want certain things and who are very manipulative. They might take you for a ride. But if you have the proper supervision and the proper training, then I think you can tackle that.

This theme that "everything is a learning experience" depicted his skills, mentality and resourcefulness as the groundwork for his career. Dr. Christie received exposure to multiple models of psychotherapy and psychopharmacology as well as geriatrics and child psychiatry. He thrived by overcoming obstacles with his learning plans and tasks. On my observation day, I witnessed Dr. Christie's ability to take criticism with a mature perspective. He did not react abruptly or defensively. He responded with a diplomatic, conscientious manner. I was impressed with his efforts to look beyond these conflicts. Although he viewed the rift among the residents as a learning experience, he acknowledged the conflicts as an impediment. After a brief moment to reflect, he listed one last example that exemplified his third year learning experiences. He described his own internal dialogue from sessions.

> I ask myself, am I going too deep on a psychosocial level or am I concentrating on the main problem? Or I ask if I am asking [the patient] too many questions. Should I ask about addictions? It's about working in a time constraint. How to work under pressure and how to do a thorough interview in a given time. I look at did I sit comfortably and my body language, my sitting position and the way I interviewed, my cadence and interpretations with my speech. I give emphasis on different parts [of the interview]. It's valuable to me to better who I am.

The other participants also questioned their abilities and shortcomings. Yet with positive supervision and time for reflection, Dr. Christie was able to view these encounters in

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constructive terms. These specific experiences symbolized Dr. Christie's integration of obstacles as learning opportunities.

Assigning Value to Patient Interaction

I explored Dr. Christie's current third-year experiences by asking about valuable experiences with his academics, training, educational experiences and professional interactions. His reply started with his medical school rotations.

> The turning point was when I was in med school doing my psych electives. I felt very connected and I thought I could make a difference. That's the main reason I chose psychiatry as a profession. When I came into this profession, I really felt that I made a good choice because I feel a lot of people in trauma are in so much agony and pain. I feel like helping them. I feel very connected with to them and I feel like, now I can help them. When I came to the United States, I felt that there's a huge need and dearth of psychiatrists over here, so I would definitely do this.

Assigning value to patient interaction emerged as Dr. Christie's third theme. He revealed a pragmatic but personal appeal for psychiatry. His affable approach, inquisitive ability, need for diversity and interest in family therapy solidified his choice. I inquired about other challenging experiences during this year's residency.

> The emergency [after hour] calls. I'm very independent and I try to come up with a solid plan for a patient. That has been very helpful for me to test the waters before I can go out in the real world.

This example was cited by the other participants during one of the focus groups. The residents deemed on-call schedules as a necessary evil. Part of their professional preparation is handling after hours crises. Although this was not his favorite assignment, Dr. Christie chronicled this experience as an essential duty. I continued by asking which experience stood above the others.

> My professors agree with us when we learn our assignments, but for example, when we were lagging in CBT [Cognitive Behavioral therapy], they arranged CBT classes

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> or other experiences for us. They met our needs but it's not been that easy for certain teachings. Some classes weren't easy.

Dr. Christie described his professors as reciprocating and understanding. He depicted a preference for concrete experiences with his cognitive behavioral therapy training. He described benefitting from case studies, demonstrations of certain therapeutic interventions and small group interactions. He continued with this reply:

> Being a resident, you have the leverage to take responsibility of the patient. At the same time, you have someone, your supervisor, who has your back who is working with you. When I see my patients, I personally think that they are part of my family, like an extended family. It's not like I have a relationship with them, but I feel that they [my patients] belong to be helped and I care for them. I think about them if they're not here . . . I call them and find out what's going on, why they didn't show up. I definitely take their calls when they are in distress and crisis. So, I definitely feel connected to the patient because I think these are my responsibilities as a doctor. This gives me a lot of private practice exposure I'm getting a taste of the real world.

I asked about quality experiences that developed his psychiatric skills. He described this meaningful experience:

> The most valuable experiences are the one-on-one experiences. When I go into the real world, since I am going into child psychiatry, I would like to do family work. I would love to do family therapy. I'm working towards that because a lot of the family dynamic is involved in child psychiatry . . . out in the real world, there's a lot of opportunity where I can practice that and fulfill my goals of what I want to do.

I affirmed his answer and slightly repackaged the question to further explore this avenue.

I asked about his favorite and important residency experience. He responded:

> The great faculty, they're so encouraging for me. I've done some research with my faculty and they were very open. They were helpful to make me do that research. I'm working with Dr. S and Dr. A on a couple of projects. I've gotten a research inclination through these people which turned my life into more academics. I like teaching but it takes extra effort. You should have a love and an inclination towards teaching and I love to do that. I like working with the students and teaching them.

He described the following account toward the end of our interviews:

> My other experience would be my group therapy which I enjoy a lot because the

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> people come with different problems, we discuss it and we come up with a solution for each of them. So that's one experience I think is very, very impressive for me. I've seen during my interviews for child psychiatry and other programs, they lack a group therapy done by the resident. So it's a very good experience. My program has been very supportive for me to go on my paternity leave and my interviews and all that. I've been blessed in this program, so far so good.

An additional and important note was that Dr. Christie experienced the birth of his first child during this year's residency. Although his overall approach and response was slightly scattered, he remained graciously good natured. It was clear that he brings considerable passion to his interactions with his patients. Dr. Christie displayed care for his fellow residents, value for supportive supervision and concern for his patients. Dr. Christie described a preference for meaningful clinical encounters to support his skill attainment. It became evident that he puts forth a heartfelt effort with his patient interactions. He carried this approach across treatment modalities including individual psychotherapy, medication management, group therapy and family interactions.

Dr. Christie's experience was distinctive from the other participants. His learning style was to jump in and get started first and then recognize his limitations. I gained the impression that he enjoys working closely with his faculty professors as well as the support staff. During one of my observation days, Dr. Christie bought pizza for the entire department. This occurred when a snow day was predicted and many patient appointments were cancelled. He possessed a jovial nature with both the faculty and staff. He enjoyed a deep interest in a few but specific facets of his residency training by taking great pleasure in improving his patient's lives. I enjoyed his descriptive comments and his ability to articulate these experiences.

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Dr. Reno

Dr. Reno was a foreign resident in her late thirties and my fourth participant. When her husband accepted a job assignment in the United States, she and her son applied for green cards. Although she had completed a psychiatric residency in her home country, she needed to complete a US psychiatric residency to obtain a medical license. Her responses were concrete and practical. This may have been associated with her second exposure to a residency training program. Her focus consisted of work ethic and a fair distribution of assignments. Her themes included 1) Freedom and flexibility as a resident, 2) Skill development in a different culture and 3) The personal experience of losing a patient.

Freedom and Flexibility as a Resident

I started with my research question, "What are the important experiences of psychiatry residents and what meaning do they ascribe to these experiences in their acquisition of psychiatric skills?", regarding Dr. Reno's important and valuable experiences during her psychiatry residency. She began our exploration with:

> Okay, important experiences. What it's like. I don't want to say one year away from freedom, well, relative freedom. I can enjoy a little more independent freedom the second half of the third year. The first half . . . I was bias because I've already done one residency. It was actually the lack of authority in interactions with my patients. I probably experienced some of that in my first residency but that was my first residency. I guess third-year residency, being devoted to our patient care, pretty much finishes the cycle. It leads you on to the things that you want to improve during the fourth year in terms of electives and specific knowledge. I can say towards the second half of the third year you should be ready to go in the community and start working.

I voiced my appreciation for her reply by framing her response as a desire to make her own decisions. It was interesting that she described her experience as a drive for freedom. I urged her to elaborate on this. With a cautious approach, she continued:

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> Making your own decisions, yes . . . even authority in relationships to some extent with staff members but mainly with the patients. The good significant experience is being in learning environment again, having the opportunity to challenge myself and explore areas that I didn't have time to explore in my other residency or I didn't have enough resources. The fact that there's more science developed in the past couple of years, developed since my last residency [in her home country].

The description of her experiences was different from the other residents. Her initial response was depicted as a course of action for autonomy and freedom. I inquired about her important experiences that compared with her residency training in her country. She identified several features.

> Work hours are very different. It's boxed in. I can say here is busier, the kind of schedule is very different. Pretty much here you work from very early in the morning to very late at night and then have emergency on-call schedule. The lectures and the didactics are more protected. Protected meaning no interruptions, no showing up late or no beepers and no phone calls in the middle of lecture. Most structured here.

Dr. Reno mulled over her responses before voicing her thoughts. I asked her to consider learning experiences that were meaningful for her skill development. Again Dr. Reno voiced a pragmatic description of her experiences.

> Yes, supervision . . . always good, sometimes too much, sometimes not enough. I guess we don't have enough diversity. We have one medical doctor, psychiatrist supervisor and we have one psychologist supervisor and we have one group supervisor, so that's pretty much it. Regarding the everyday supervision in clinic, we probably do need more variety, because it's a teaching clinic, the idea is to learn, so the idea is to have feedback from more than one supervisor. Otherwise everything is fine with some supervision, and assigned time with the caseload. Probably it's going to be good using our own videotaping as a source for supervision, to be able to observe work through videotaping.

Before I could comment, Dr. Reno clarified a common theme identified by the participants. She described the use of videotapes for her supervision. She reflected that videotaping her patient sessions was moderately helpful but observing her supervisors model psychiatric techniques was more helpful.

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> I like the camera and opportunities to record sessions that I didn't have way back in the past [former residency]. We had only the Dictaphone. We could use that, but we didn't have the video camera. That is good. We always use our own videotaping for supervision. In the didactics, we watch some tapes, but it's not our supervisors. Those tapes can be dated. Outdated. I would like to see my supervisors doing session. This is most beneficial.

I simply asked "please continue with these experiences that contributed to your skill acquisition".

> Second year it's going to be better to assign [patients] psychotherapy to observe. This is what I did with one of the attending here, he was the primary provider. I essentially attended the psychotherapy sessions without interfering much. In the end, I document. That was probably most valuable. Observation can be more. We can have the opportunity through the years to observe our attending in different areas and aspects of patient doctor interactions. Observation is still not enough . . . when I did observe my supervisor, it was meaningful, helpful.

Although she commented on lack of modeling cited by other residents, she also mentioned the benefits of her supervision. She stated that supervision fulfilled the purpose of improving her patient care and interactions.

> Some of the supervision. Specifically the supervision that is after each of the patient sessions, the brief supervision that we get from whoever is available or scheduled in the clinic. You have to organize your thoughts to formulate the case to present the supervision details. This organizes the case.

I followed this statement by asking about valuable experiences during the third year of residency, specifically, experiences that were meaningful with assignments and tasks. Dr. Reno reflected on her comments before speaking.

> It's been nice this year compared to being so busy the first three years. You have more time per patient. I guess on one hand, you have time per patient in outpatient settings but overall you have more time to think about your care. The freedom that I have to order quite expensive diagnostic studies to help me with diagnosis and treatment. The use of free access to use diagnostic studies. This supports and affirms what I am doing. That was valuable.

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Dr. Reno valued the freedom she experienced the second half of her third year. She described developing her skills by observing her supervisors and reflecting on her thoughts for case presentations. Although Dr. Reno possessed a vigilant approach, she sought the liberty to make her own choices. She preferred the freedom of choice with her treatment options combined with effective supervision.

Skill Development from a Different Culture

Skill development from a different culture emerged as Dr. Reno's second theme. She highlighted the experiences that led to her choice of psychiatry. Dr. Reno described these experiences as important for her skill acquisition.

> So, when I won a green card lottery, then I started thinking about a residency in the US. It sounded exciting to learn a new language, to explore a new culture, probably to have different type of challenges with different psychopathology. I decided to come here because they do not offer you [US] medical license without repeating your residency. That is how I choose doing residency again. Otherwise, the purpose was to experience something different than I experienced in my country. I chose medicine in beginning but that's a long story.

I felt compelled to ask about her experiences prior to starting her US residency. I inquired about the important experiences related to her choice of residencies. She provided the following description:

> Decision was driven probably by the fact my parents were medical doctors and their siblings being medical doctors. Well, medical doctors usually think about the illness . . . not about the impact that illness has on the person. In school, I started reading some of their medical books and it looked fascinating to be able to know more about how people think. Initially, I thought about psychology, but that didn't seem enough, like medical school . . . so I decided psychiatry probably gives better perspective. I might be bias, again, but psychiatry gives the opportunity to work with medications and to have certain psychological knowledge and psychosocial knowledge. Valuable experiences is . . . very often, encounter with patient during clinical rotation. I knew this was my choice. Some were clinically depressed and desperate. This decision was made many years ago . . . I do not really question that decision much.

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After describing her choice of residency, she continued with the following discussion of certain cultural aspects.

> I am amazed at the sex abuse here. The extent of incest here compared to what I experienced in my country. In my country, I was participant in famous local domestic violence study. I had encounter with people that were victims of molestation or incest. But the extent that I observed here, I didn't know that this is possible to this extent. Even people from rural areas, that amazed me. It's been good experience to help these victims. It's been significant.

Dr. Reno described these encounters as a learning experience. I encouraged her to continue and focus more on her third-year experiences that serve as a basis for her career.

> There is wide extended use of psychotropic medications, the antidepressants here [United States]. Everybody is on one. We rarely observe now pure clinical depression. Because people are for years on antidepressants. Already being on medication, clouds the clinical symptoms . . . not sure of what they describe is pure clinical representation. Also, here, in this area, can be different clinical picture because they are big people [obese] with depression or psychosis. This has been true learning experience for me.

Although Dr. Reno was acquainted with abuse treatment in her country, she remarked how profound this was for her US training. She continued:

> Psychotherapy and group therapy. When we have a good session it's enjoyable. Sometimes can be boring but every type of work can be boring. It's not always the same. When you have especially good psychotherapy case, individual therapy case or group or family therapy case, it's the most wonderful experience.

Dr. Reno detailed how certain experiences affirmed her prior decisions. Although an intense person, she smiled slightly when voicing this experience. I followed by inquiring about other reflective moments that were important with her development.

> The fact that the third year is psychotherapy oriented. It's just that we are the people discussing the psychotherapy approach without actually having a good idea about the approach. So, we talk something that we do not know enough about. I think to myself, I do not know what else to do or what else to say. Otherwise, we talk about the big schools of thought in psychotherapy. The natural development of knowledge during our third year was about learning medication management, then the knowledge about psychotherapy, family therapy and group therapy. This was the progression which

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shaped my knowledge. I just wish psychotherapy started the second year.

Dr. Reno's succinct comments became only mildly surprising. She shifted to describing experiences with her curriculum. Her experiences with the curriculum illustrated a common challenge for this residency class, the lecture format. She identified her critical experience with the on-call emergency service. She stated this rarely contributed to her learning abilities but referenced the overall beneficial experience of her third year.

> I call it scutwork pretty much because it's something that we're required to do but it's not really contributing to our educational experience. Overall it's pretty much the same if I compare my past and present. People [in crises]are not very different across the globe. So, I have good experience. It's good studying for second time.

During one of my observation encounters, I saw Dr. Reno conduct a new patient assessment and lead one of the group therapies. She displayed a detailed but composed skill set. During the group therapy, she was well versed in theory and amicable with the patients. Her patient accepted her accent with no rejection. Her assessment was thorough and well documented. She had accepted the challenge of a new culture, learning American English, and learning new psychiatric treatment which was an intimidating task.

The Personal Experience of Losing a Patient

Dr. Reno was a resident of insight and discernment giving considerable thought before sharing her thoughts. Her description of important experiences was unique. She described her supervisors, the opportunity to move to the United States and her parents as important experiences. As I reflected on our conversation, I wanted to pursue a distinctive tone during the description of her residency choice. I gently asked about a

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statement she stated that she rarely questioned her residency choice. In the midst of our second interview, she disclosed that she had a patient commit suicide.

> Although I can say I have more than ten years' practice behind my back, I lost one patient for first time, here [US residency]. One of my patients committed suicide successfully in the hospital with all the possible safety measures. That was valuable educational experience . . . It taught me that these things happen.

I empathetically asked her to continue. After establishing trust in our previous interview, she further described this experience.

> It was bad experience. I do not think I'm actually allowed to talk about that [for] legal reasons. I had some immediate support from the program director who happened to be my supervisor, but that was pretty much it. I had to handle it myself. I guess in situations like this, there are always other concerns, legal concerns, you cannot go around and widely discuss. But I had support and I had conversation with the program director who was supportive. They were quite accessible. We kind of take that for granted, but I think this is beneficial when you really need it. I can really appreciate more that they are accessible and can discuss our problems.

I voiced my appreciation for sharing this crucial experience. When Dr. Reno began the second interview talking about documenting her session notes, this struck me as odd. No other participant mentioned the important experience of documenting session notes. However, this critical incident explained her describing the importance of documentation. With little prompting, she continued:

> This [learning about patient suicide] is very valuable experience. Very different probably because of the extent that law system is careful and attentive in observation of our mistakes. I learned here how to document correctly. That might be something minor for you, but it was very significant for me. The lawsuits against medical professionals are going to continue to rise because we use more and more chemical substances, medications and it's more specific in psychiatry. Our responsibilities are bigger, so I learn how to document. Actually while you are documenting you start doing more if you're really following the standards of medical profession. You think about side effects, you think about drug/drug interaction. Sometimes your documenting can help you actually to remember to discuss something with the patient, can help you to remember to do a good follow up lab work, blood work or whatever you need to do. Specifically, I am very careful. Even when you are careful, you can

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> have patients whose outcome it's not desirable, so you still keep questioning yourself what you did miss, what you didn't do.

Dr. Reno's reply accentuated the importance of documentation and her skill acquisition. She coped with the calamity of patient suicide by seeking to improve her ability to document. Learning about patient suicide and documentation propelled her to embrace a self-directed learning style. Her cautious approach, deliberate method and at times solemn manner were now framed in the context of this theme, The Personal Experience of Losing a Patient. She finished with her vital experiences that integrated her skill acquisition. She provided a thoughtful and pragmatic reflective description of her residency experience.

> Anything else, I hope not to do residency again. That's enough, two times per lifetime. I'm not quite sure that at the end, we are completely prepared for the reality of psychiatric work in the community and as a private psychiatrist. I do not finish, only our formal education. Although residency will be over, I am a doctor, so I continue to learn. This is what I do.

Dr. Reno expressed a strikingly different description of her skill acquisition that was both practical and discreet. She held a strong conviction to what was just and fair which was slightly different than the other residents. During one of my observation days, I observed Dr. Reno confronting another resident who she deemed was shirking duties. She was not opposed to hard work but wanted an equal division. She made a great effort to ensure she was ready to practice psychiatry. It required much aspiration and commitment completing two different psychiatry residencies in two different countries. I was impressed that Dr. Reno demonstrated sophisticated psychotherapy skills during my observation day. She held her patients accountable but also provided supportive guidance. Although initially tentative, she became willing to extend herself as the

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interview progressed. I appreciated her contemplative descriptions particular addressing the suicide of a patient. Although this event framed her cautious approach, Dr. Reno possessed a genuine style and manner with her patients.

Dr. Pulling

Dr. Pulling was my fifth and final participant. A Caucasian female in her early 30's, Dr. Pulling was the chief of her residency class. The chief of the residency class managed the on-call schedule and met with faculty to voice resident concerns. She transferred from the Midwest to pursue her psychiatry residency. She was noted as a tireless worker. I explained the purpose of my research and ways I would ensure confidentiality. There was no hesitancy or reluctance to be interviewed. She only needed this researcher to start the audio recorder and ask the research question regarding her important residency experiences. Four major themes emerged from our interviews. These included 1) Understanding the value of hard work, 2) Stepping stone experiences, 3) Provocation as chief resident and 4) The resident's journey, a place of enrichment.

Understanding the Value of Hard Work

Because I have known Dr. Pulling for several months, she was immediately at ease. She exuded a go-getter attitude which required little warm-up or introduction. Dr. Pulling's style was to jump in, then figure out the dynamics as she proceeded. She pulled no punches as we began our exploration. She stated "just let me know what you need" and she began.

> There have been a lot of emotions. But for me, my mother had died when I was in medical school, and I took care of her. She never got to see what I had been working so hard for. She was foreign [born] and she had wanted to become a doctor but back in that age, women were nurses. So, she had . . . many different careers. She was a nurse anesthetist, respiratory therapist, and had a teaching degree. Showing up the first day,

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> knowing that I did what I wanted to do and she [her mother] wasn't able to see my graduation or me get the residency that was my number one choice.

As I listened, I became impressed with her willingness and openness to discuss her residency experiences. I thought she might enhance this study with a unique experience but her candid presentation was stirring. I reflected back that her residency was important to her for many different reasons. She agreed and continued to describe these early events which emerged as her first theme, understanding the value of hard work.

> It [starting residency] was a joyous thing because I met my husband when we were in college, and I told him I'm going to be a psychiatrist from day one when he met me. We met quite young and I said this is what I'm going to do with my life. I get that strong-willed personality and drive from my mother. So making it here to the first day of residency was a huge deal.

Dr. Pulling exuded much energy regarding the impact of her heritage on her residency. She did not hold back when discussing these experiences. I inquired about her notable experiences during residency. She gladly continued:

> Getting through medical school was enough of a challenge because I lost my whole family. They died during medical school. My welcome to psychiatry started with my first night on the job on my husband's birthday . . . but I was really grateful and glad to be able to do what I wanted to do. I've known since the fourth grade when I was like nine years old that I wanted to be a doctor. I know I was quirky, very weird but I always loved science and math and liked the geeky science part of it. Also, I like interacting in the social part with people. That was so great that you can combine the two in this field called psychiatry. During the end of my second year and start of the third, I saw this gentleman at the VA, most of the time in the middle of the night, two, three, four, five am. He was so sick and in so much pain. But just to see how caring and interacting a minute of humanity would impact his life. The fact that he looked forward to seeing me even though it would usually be under bad circumstances, when he'd run out of medicine or something wasn't going right. Months later he would see me and remember my name.

I wanted to learn more about the phenomenon of her psychiatric residency and her important learning experiences. When she paused, I responded with much positive regard. She took only a moment to reflect, then continued with a marvelous story of her

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residency experience. During this discourse, I leaned back in my chair and listened with captivation.

> My medicine training was the osteopathic school of the mind-body connection. So choosing psychiatry was very valid and my approach with him [the patient] was appreciated. So this patient that had AIDS and had picked up secondary infections and depression. It became pretty clear to me that he was not going to be leaving the hospital any time soon. He was getting sicker and he was shifted between different floors but he'd stay so positive. He was able to consider and think about people that were worse off than him that had less. We talked, and he got sicker and sicker as he moved from floor to floor. People were less likely to put on the suits to protect yourself from TB [tuberculosis]. So, they would not go in where somebody has got chronic diarrhea or whatever is going on. He would say to me, maybe even say he wanted to talk about the end . . . about dying. Nobody else would talk with him. I kind of became the death-and-dying lady. But in a good way because he wanted to talk and everybody else avoided it. Then he got sicker and sicker and terminal. He would say everybody comes in and tells me I need to talk. Then they all run off. He got to the point where he wanted to have a more reasonable discussion about where his life was going to end. He realized he was dying. He was thinking about death and what is it, and what's it going to be like, and am I going to hurt or be afraid. So how realistic was it for me to leave? He felt like they would sometimes come in, and say you need to talk and then run out or say something with big words . . . he really never knew what to do. He felt they couldn't be honest with him about the fact that he was dying. The young medicine [residents] doctors would come in and say I could be hit by a bus today. You [the patient] could outlive me. This was when his T-cell count showed that he clearly wasn't making it out anytime soon. We talked about the end and he got sicker and sicker. It got to the point where he couldn't even see me, but he could recognize me by my voice . . . that was something that the other residents [in medicine] were afraid of. Nobody wanted to face death. It's an area that maybe we all need a little bit more training on because most doctors pronounce death, but they don't see death. I've done both. I've been there. I know the smell of death. I've known people as they leave this earth and as doctors, who are supposed to be trained or think of saving everybody. There's the quality of life thing and sometimes saving somebody is to let them have a natural end to their life. It was just about comforting him which was comforting to me, that I could be at least something positive at the end of his life.

Her depiction held my attention. I was enthralled with this story of her experiences and development as a psychiatric resident. I voiced my appreciation for sharing this experience. Dr. Pulling described tackling a learner-driven model for her training including problem-based learning aspects. She readily accepted and embraced becoming

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an active empathetic clinician. She began with her experiences with residency then detailed another facet of her learning experiences.

> I lived in a very rural state where the local people had to be tough. They had to work to survive. So, I knew to work. And mother was in a concentration camp. She overcame a lot. I ended up getting straight A's in college to show I could do it. But I had to organize my life as people died [her mother], as I became their caretakers. You didn't see me sweat because residency isn't the hardest part of my life. Having seen 38 patients on only 4 hours sleep . . . Now I'm not perfect on four hours sleep but yeah, I'm glad I was able to get to this point to see 38 patients. The beginning of this year, at the VA, one of the surgeons wanted me to see a patient, come over and talk some sense into this guy. He had protested eating because he didn't like the surgeon. I had to negotiate this and calm everybody down. The drama and the interpersonal stuff and this getting people to talk has never been my thing. But nobody makes me do this. I could have quit so many times. But because I read my books, listened to my didactics and my supervisors trusting me, encouraged me to be myself and take risks. I have a sense of responsibility to my residency.

Her first theme emerged through a fabulous representation of these learning experiences. Her willingness to roll up her sleeves and tackle intense situations was heartrending. These examples were symbolic of Dr. Pulling's educational preference for meaningful clinical encounters and allotted time for critical thinking and skill development. She welcomed the most difficult circumstances without hesitancy. Dr. Pulling's learning preference was to jump right in and start doing things. She grasped knowledge through concrete experiences consisting of case studies, demonstrations and recalling past events. She preferred the active experimentation learning style through group projects, problem-solving tasks.

Stepping Stone Experiences

Her second theme, stepping stone experiences, detailed her ability to embrace certain diagnostic populations. Dr. Pulling accepted learning opportunities with complete

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abandon. I asked about third-year situations where she utilized her skill and developed competency. She replied:

> I had a patient that was given to me because everybody else, in sense, was wrong for him either wrong race or wrong color. Actually female wasn't quite right, but white was least offensive for his personal PTSD [Post Traumatic Stress Disorder]. The irony was that I'm first-generation American . . . but if I don't say that too much, you're not going to know it. I had this really tough African-American young guy looking at me like how can some white rich chick help me out. We got pretty real about it. He talked about what do you know about life? You have a swimming pool and I swim in the Mississippi. I love the vets because you can be a little bit blunt with them. I told him I didn't have a swimming pool. I swam in a lake. So, you swam in a river and I swam in a lake. Can we be done with this and move on? It started a therapeutic relationship where he could be honest and open up and we could talk about philosophy. He got me thinking about PTSD because my mother had been in a concentration camp . . . I had always, even as a little kid, kind of wondered how can somebody have lived through World War II, been in concentration camps, seen all of her family like massacred, heads blown off with grenades and sit and watch the news while reading a Lithuanian newspaper or watch documentaries on World War II and be a perfectly normal person? I guess when you're eight, you don't realize that you're thinking about PTSD. You're just realizing Mom was in something bad and she's handled it really well. Then being with a challenging PTSD patient and realizing this is my area. I really like PTSD vets because I think I have a little bit of an insight into them. The other thing, too, is I owe my existence to American Vets because my mother remembered when the war was over . . . the chocolate candy bars, the food dropped down by Americans. The irony is that I'm actually now with a lot of veterans . . . I'm comfortable with talking about PTSD and people getting shot, blown up, and really gory stuff. They're comfortable enough with me and if they need to cuss, fine. We can cuss. If it's talking about God and philosophy with somebody who looks like rapper, 50 Cent but they are still excited to see some little white chick that he never thought he'd connect with . . . I had this within me and residency brought it out.

Her self-disclosures were gritty but riveting with each patient experience. Dr. Pulling's competency development evolved as her educational experiences expanded. Her two patient interactions detailed acquiring the cognitive skills needed for psychiatry. After a moment to articulate her thoughts, she continued to reflect on her educational experiences.

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> The start of this year was very interesting. I felt I had to reprove myself after staffing the patients at the VA. It was sometimes in the hallway in the last 5 minutes of the day to now having more supervision available during this year. But there's also freedom with the supervision. It's more oversight, reading assignments and concepts. I found out the fact that in this clinic, my new niche was battered women . . . having people feel that they could connect with me. Even though I look about as opposite as most of the people that seem to be attached to me. I learned that people should be comfortable with their doctor. Check out your doctor and see if you're the right fit . . . who you're comfortable with.

I nodded my acknowledgement as I was intrigued by her residency training experiences. I asked about valuable stepping stone learning encounters. She continued:

> I'm a very slow reader. I've always been. The fact that I sometimes feel like I've prepared well and now I'm sometimes reading the same assignments or very similar material over and over ten years later. It's been reading the same thing or discussing the same topic over and over and hearing how you don't know this but you'll learn it. I had gotten quite used to not doing anything on time. But I was approached by Dr. E who said would you like to teach and orient the first-year class? We'd like you to do it. So, my first month of the year was getting to coordinate with the attending [faculty professor]. Then I learned that some second, third and fourth years had never really been placed in this situation. At times, I had to scramble to get an attending and make sure that things were signed and make sure they [first year residents] got into the right locations. I felt honored by the fact they[supervisor and director] allowed me that much freedom, responsibility and they trusted me.

With abundant energy, she highlighted her learning deficit. However, she embraced this as a demand and willed herself to overcome it. Dr. Pulling's experiences added much depth to my research. Her description of experiences was quite engrossing. She detailed that her early drive to become a psychiatrist was rewarded by finding her career niche. Her academic pursuits and diagnostic specialties matched her approach to life, family heritage and psychiatric skill acquisition. Dr. Pulling's third-year development experiences demonstrated her attainment of basic knowledge and clinical skill.

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Provocation as Chief Resident

Although Dr. Pulling expressed much passion and dedication to her psychiatric skill acquisition, she fell prey to some of its consequences. She characterized several conflicts she experienced as chief resident. This was her third theme, provocation as chief resident. All five participants identified a division among this group of residents.

> As chief resident you have to say no to people. I'm used to no in my life, so that's not a problem with me to say no. I can realize that I can be your friend because we were friends a month ago, but I can still say no to you. I can separate my friendships from my role. Maybe other people struggle with that or who they're going to hurt. Maybe its wisdom, age, stupidity, life experience, being tired, some things that other people stress about . . . I can come in and stick to it. Sometimes that's hard for people. That might be callous because they're not getting the way they want. Having that extra stress, that extra burden of people being unhappy with you, I don't dwell on it. It interferes with your life and your vocation because people aren't doing the work, or they are picking fights and then scheduling conflicts that overflow into a significant portion of my personal life and time. That's the balance that I think a lot of doctors struggle with. I never come home and say that the patients drove me crazy. It's the people I work with.

It became evident that Dr. Pulling's fervor for her residency learning plans and tasks did not let her role as chief resident stand in her way of friendships. She possessed a most forthright and, at times, blunt approach with her chief resident duties. She continued to chronicle her determined efforts.

> I guess the other challenge is interpersonal issues because in third year you've got your classes all together . . . other years, you're with upper levels. You're all over the place. Every month it's something different. Now we're in this environment where we're all stuck together whether we like it or not. It's not that you have to be, we're stuck together because of work and learning not because necessarily we want to be best friends. I think it's great to have friendships in residency. In a perfect world we'd all be stuck together and be best friends. It kind of comes out of some competitiveness with people and feeling like they need to show something or portray or come across. I never felt myself really in any competition until this year. I just go to work, I do my job and I never thought that it was a competition, to do your job.

Dr. Pulling referenced a disagreement I witnessed during one of my observation days

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with Dr. Pulling and Dr. Toney. She expounded about the challenges with her resident interactions.

> I think, just for me personally with my career, it's a good experience with leadership and having to work on some of the interpersonal issues. But it can be very challenging to be in a situation where you feel like people [residents] are misjudging your good intentions. You have no idea and you can't make somebody basically stop thinking the opposite of what you're doing all the time. But if you didn't have a chance to send an email out about a schedule, it wasn't that you were trying to hide it from people . . . it's just that you actually had to see your patients and do another presentation. It's been a challenge. Just dealing with how, despite your best efforts, people can always misinterpret anything . . . it's more of a problem sometimes with your co-workers, which you wouldn't think in mental health it would be. The patients are actually much easier. You're not out for any bad motive. You're just trying to do your job and anything you say or do sometimes is wrong. To always have some people, the negative people always talk to higher levels, superiors, it was tough.

This theme was identified by the previous participants. Dr. Pulling's encounters denote her plain-spoken approach. She placed dealing with the facts of a situation as a priority. As chief resident, she distinguished these interactions as both a frustration and a growth experience. She stated the class conflict was difficult for her.

The Resident's Journey Is a Place of Enrichment

Dr. Pulling's ambitious description of removing educational obstacles in her way was a gripping account. As a result, this determined young resident has marched through her residency with purpose. I wanted to get a clear picture of experiences that fostered her educational experiences and psychiatric skill attainment. As we explored this, her last theme emerged, the resident's journey is a place of enrichment. She continued with her depiction of her third year.

> The third-year is very fun, exciting and also very tiring. It's fun and exciting because you're now in the clinic setting, which is completely different after having been on a ward. You lose some of the control over your patient care because they leave you. You don't know how they're doing in between sessions. When they're on a unit, you can see that they take everything because the nurse gives it. You can interact with

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> them every day . . . focus them on target. When you're in an outpatient clinic, you really have to motivate them and do everything you can in that short amount of time. Then kind of hope . . . they do well. You see them at the next appointment doing well or that they're brave enough to call in and talk with you. It's very kind of an interesting time in the third year because we have some different attendings than from our first two years. It's also a time of reproving yourself to people who maybe have heard your reputation but don't know your work directly. It's kind of an interesting challenge . . . at times, it feels like a step back. You have to re-explain this is why I'm doing this, this is why I'm doing that, when other people would just be like, oh yeah, you're fine. You have to justify and sort of prove everything one more time when you thought you were done with it. It's tiring because as a third year there's a lot going on. You have the clinic, the patients, the notes. The notes take a long time if you actually bother to get as much of the history and there's a lot of things to follow up on.

Dr. Pulling displayed an energetic eagerness when describing her growth in confidence, skill set and educational experiences. Her valuable experiences were centered on her patient interactions, typically patients who were rejected by society but have a great need for help. In describing her last theme, she disclosed the following experience.

> The challenging patients I usually like, people send me, so that I can hone in with. Is it a medical problem? Is it pediatric? Is it combination of both . . . being able to sort or tease it out. I had one lady that ended up having a brain abnormality that really needed to be rechecked I think it had been missed because she had gone to so many different facilities. It was lost in the follow-up that really explained her presentation. People get misdiagnosed because you don't ask the full question. One that really stands out to me is a lady that's foreign, she speaks a different language, and she's been treated for schizophrenia. She had lived through a very serious, bloody battle in her village. When you've seen a body sometimes you really have seen a body in some of these gruesome things. It's not in your mind. Then trying to check on the history to see that it matched up and realizing this is PTSD. Maybe if I get a translator, I can get to more of the details that I can't get just from having family members try to talk to me. Well, the anniversary of that war, that incident, is when she's had so many hospitalizations. Three or four back to back. I started treating her in July and she hasn't been in the hospital since. I'm actually weaning her down to a very minimal amount of medicine. You have to be dedicated. Otherwise you're just not going to keep up with it. It has to be something that you want to do with your life.

As she proceeded to discuss her vital residency experiences, it occurred to me that Dr. Pulling's education had enhanced her abilities, nurtured her natural talents and developed her competencies. She preferred problem-based and team-based-learning formats.

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Multiple times she described the joy of applying these learning and self-directed tasks, focusing on subject interests and increasing motivation to learn. As she continued with these situational experiences, I took note of her self-reflections.

> Seeing people get better. Seeing people improve. I've been lucky enough to have a lot of patients where I've picked up on a diagnosis or a problem that other people maybe missed or glazed over . . . I've been able to see people really change from being psychotic, thinking that they're controlling weapons, to shaking my hand, saying they're going to go read at the library getting back to a sort of normal human being . . . or the lady I mentioned that has true PTSD realizing she has that and an abusive husband and sort of trying to find a way culturally to not offend either but getting him to sort of back off give her a little freedom. Just seeing people get better . . . but if I can improve their quality of life, then that's rewarding. I'm applying what we learned.

Dr. Pulling ended this theme by identifying her growth and competency. She related becoming an independent learner through this year of residency. As we spoke, the many educational dimensions of challenge and support became more apparent.

> It's a combination of lectures, inpatient, outpatient, staffing with attendings. Being able sometimes to have the freedom to work on our own and to see that you can do this. Just being able to think and function on your own. Being able to problem solve and work on things because one day you're going to have to do it.

I ended our interviews with an inquiry about her most important experience. I framed this question to have her identify which vital experiences had been the most valuable. She spoke about the impact of her patient interactions. These experiences provided her a baseline for her career.

> I love meeting with the patients. People talk about its stressful and I had to see so many patients today. I don't think anybody's ever heard me counting numbers. They say how many did you see? And I just look at them like what? They think I'm trying to compete or come one up on them. I love interacting with the patients. It's the system that frustrates me, never the patient. I've never been upset with any interaction with a patient.

Dr. Pulling obviously loved learning her craft and meeting with her patients. It was evident that she was willing to take on difficult cases, seize hard work with a passion, and

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invest a large part of self with her learning tasks. She described another example.

> I had a very strange call. This lady called back a few days later to confess that she hadn't been fully honest. She said she's been using cocaine and her husband was beating her. She was terrified and wanted a way out. We got her resources, made sure she got connected with mobile crisis . . . being mindful where she's calling me is a safe place. So, I've had a series of women that have been battered and abused. They feel like this is their safe haven at least to talk and find some resources. Even if it's not getting out, but at least getting out for a while. Not that I'm pushing them out or putting my will on them. I just let them see that it's safe to think of all different things and explore options.

Throughout our conversations, I became aware of her deep desire to help the disadvantaged. Dr. Pulling demanded a lot from herself and others. These responsibilities were portrayed through our interviews. She ended with a vignette of her compatibility with psychiatry residency.

> It's definitely meant that I worked. That's okay, it was reinforcing. There were people that thought why don't you give up and take the easy way out in life, but that's not me. It has been challenging and fun. I never thought I'd be the death-and-dying, the PTSD-doctor. I honestly thought that I'd always be a private tutor or teacher. Being a psychiatrist is the most important part of my life.

The challenges of residency during the third year have provided Dr. Pulling with a solid foundation for the future with rich experiences. I grew to realize that Dr. Pulling had a great inner drive and zeal for her residency experiences and skill acquisition. She was the most detailed of the residents. She fulfilled her learning opportunities with a fierce determination not witnessed with the other participants. She embraced challenges, possessed high expectations and evolved as an independent learner during this third year of residency. These experiences broadened her textbook understanding, motivated her accomplishments and formed her self-directed learning skills.

The five residents provided a unique but rich description of the phenomenon of the third year of psychiatry residency. Each resident depicted her/his important learning

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experiences and attainment of psychiatric skills. Chapter 5 discusses the major themes from the individual resident descriptions and ends with a discussion of implications for residency training, higher education and future research.

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CHAPTER 5: DISCUSSION

This phenomenological study explored the important experiences of psychiatry residents and the meaning they ascribe to these experiences in their acquisition of psychiatry skills. My research question was

> "What are the important experiences of psychiatry residents and what meaning do they ascribed to these experiences in their acquisition of psychiatric skills."

Through a qualitative reduction analysis, I developed a better understanding of the meaningful experiences for the five participants (Moustakas, 1999). The intent was to gain a unique view of the phenomenon of residents' important and valuable experiences. I believe I have accomplished my goal by telling the experiences and stories of the psychiatry residents who participated in this study. My purpose in Chapter 5 is discussing the important findings of my research efforts, the major themes identified from the research participants, my findings compared to the current research on residency training and the meaningful experiences of psychiatry's third-year of residency. I end with a review of skill acquisition and competency.

Considerable research in higher education has been dedicated to medical school and residency instruction. The importance of training proficient and competent doctors has never been greater. With the recent increase of mental and emotional disorders, educating psychiatry residents has taken on intense and important considerations by higher education. The old school approach to medical education has been detailed by numerous studies (de groot et al., 2000; Fauth et al., 2007 & Ludmerer, 2003). However, postmodern perspectives of education value learner-driven models of instruction. Researchers LeCouteur and Delfalbro (2001) specified the need to research residents'

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perspectives regarding the phenomenon of learning. Bhugra and Holsgrove (2005) stated one neglected aspect of medical education was to explore contemporary residents' experiences regarding their instruction. Hilty et al. (2005) stated it would be beneficial to include residents' experiences with competency-based skill development programs. This study contributes to our understanding of psychiatry residents' experiences with their instruction and skill development.

The five residents readily and conscientiously described the phenomenon of psychiatry residency through identifying the vital and important experiences that formed a foundation for their careers. Each of my participants brought a unique flavor to the research. Although the participants understood and experienced their residency education in diverse ways, there were certain commonalities that connected their stories. I begin this chapter by describing the themes across the residents and a summary of the research. I conclude with Implications for Psychiatry Residency Programs, Implications for Higher Education and Implications for Future Research.

Descriptive Patterns Across Residents

My focus as a phenomenologist was to describe the participants' common and diverse experiences and to develop a composite description of the essence of these experiences across the residents. These participants who volunteered to share their inner world possessed strikingly different cultural backgrounds and personalities which shaped their skill acquisition during their psychiatry residency. However, psychiatry residency training has allowed their minds to blossom and develop further. I describe the important conclusions from my research study. The four descriptive patterns are Residency Choice Was a Momentous Decision, Observation and Reflection Should be Modeled Prior to

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Practice, The Value of the Third Year Was the Shift to Psychotherapy Training and Competency Was Overcoming Hurdles to Acquire Their Psychiatric Skills.

Residency Choice Was a Momentous Decision

The first descriptive pattern in this study was the importance of residency choice. Each resident wanted to tell their individual journey of choosing a residency. Psychiatry is one of many medical graduate school specialties among which third-year medical school students rotate among. The pressure of matching specialties is enormous and has life-long implications. During rotations, the residency programs rank the student applicants and the medical school students rank their choices. Medical students possess great anticipation while waiting their selections. At the end of the rotations, selections are announced for all medical school students. Some medical specialties are more structured with little deviation, some medical fields change radically with technology, and others suffer drastic impacts from insurance reimbursement trends and managed care. Matching with a residency determines the course of a medical student's work life for the next several decades.

Each resident attached strong meaning to the experiences with their residency choice. Part of this is due to the tremendous urgency and stress for the students to match with a compatible medical residency. It is an eventful decision for a young medical school student to make. For psychiatry rotations, interacting with patients was a meaningful feature; other residencies may have little patient interaction such as radiology where residents learn to study technology results or anesthesia where patients are given only brief introductions before surgeries. At times, residencies such as infectious disease or

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family practice may be considered since these residencies possess more patient interaction.

Attitudes toward psychiatry as a profession, the psychiatrist's image as perceived by the medical student and accumulated experience during psychiatry rotations make up the persuasive dynamics for choosing a psychiatry residency. Both personal exposures and professional encounters during medical school seem to have an impact on psychiatry as a residency and career. The route to residency may be different; however, the influential factors seemed to be common for these five psychiatry residents. From the resident interviews, these common factors included a strong desire to help people, the recent shortages of psychiatrists, attraction of psychological trauma, interest in human behavior, family dynamics and how the brain works.

For the residents in this study, the decision to choose a psychiatry residency was based on considerations prior to medical school. Although the participants came from diverse backgrounds including two individuals from foreign countries and another first generation American, three of the five residents reflected back to their childhood and adolescent years to an encounter with psychiatry. This set the stage for their interest in medicine and psychiatry as a residency choice.

Two of the residents suffered hardships along their educational path which also predisposed their choice of a medical career. Two resident participants were influenced by their parents who were also physicians with one resident knowing since she was a small child that she wanted to become a psychiatrist. Overall, there existed a fierce determination to enter psychiatry residency. All the residents shared their stories of critical incidents, life-defining moments, personal resolve and fortitude. Their roles,

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personality styles, educational and parental experiences, personal identities and cultures impacted their choice of residency.

Serby (2000) found that residency has become complex and demanding with educational requirements including a vast array of medicines and competencies as evidenced by knowledge of a full range of psychological, biological, behavioral and social techniques. Yet the complex competencies and requirements of psychiatry training were the very qualities the residents found appealing. Several times throughout my data collection, the five residents described benefitting from learning to prescribe medicines and apply psychotherapy techniques. The participants were fascinated with studying how people think. Disliking the mechanical techniques of other residencies, they preferred psychiatry's individualized approach. They were weary of treating the same perfunctory parts of the body that other medical residencies encountered. Psychiatry was not like a surgery rotation where patients were lined up at 5 a.m. for gallbladder procedures with little changes from procedure to procedure. Each patient possessed a unique set of treatment issues that offered the residents the opportunity to draw upon different psychiatric approaches and individual styles.

The multitude of subspecialties in psychiatry ranging from child to geriatric psychiatry and emergency psychiatry to neuropsychiatry was an attractive aspect. This descriptive pattern, Residency Choice was a Momentous Decision, revealed that interaction with psychiatry patients during their rotations was a decisive factor as they wrestled with their residency choice. Yager, Kay, and Mellman (2003) reported psychiatry was a more unique and critically diverse medical school residency program. The patient's diverse characteristics, new research in the neurosciences, challenges of combined

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psychopharmacology and psychotherapy treatments, attraction for working with people with psychiatric trauma and the great demand for psychiatrists are attractive venues for possible residents. The experiences of the five residents in this study appear to be aligned closely with Yager et.al (2003).

Although Timmermans and Angell (2001) found that treating the multitudes of psychiatric illnesses and disorders can be a challenge for novice residents, the residents in this study revealed that their interest in psychiatry was validated by their exposure the diversity of psychiatry practices. The participants reported that their initial inclination for psychiatry was enhanced during their exposure to the psychiatry department. The residents mentioned ruling out other medical residencies, even ones that paid more. The amicable interactions with departmental faculty and staff during their rotations and electives were a decisive factor for this group of residents.

Yager et al. (2003) found that psychiatry included innovative approaches but also pragmatic knowledge combining biological psychiatry and psychotherapy. Three of the five residents in this study voiced their passion for studying psychiatry that began as a personal experience years before entering medical school. They reflected on these prior encounters with psychiatry, the personal attraction of helping people as well as its creative aspects during their interviews. Exploring their residency selection was a vital personal and developmental experience resulting in a psychological bond with their residency choice for all five residents. Each enjoyed a fascination with both brain chemistry and the cognitions of the mind. This along with patient interactions was immensely significant for the selection of psychiatry residency.

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Although their original preference for psychiatry began at some point earlier in life, three of the five participants initially considered pursuing a Ph.D. in psychology before entering medical school. However, medical school and psychiatry residency offered more educational depth for these residents. Also, there exists a critical shortage of psychiatrists. All five residents were aware of the extensive demand for psychiatrists in the US as cited in Carlott (2010) who reported there was a shortage of 45,000 psychiatrists in 2010. This was a compelling factor for residents in this study to choose psychiatry.

de Groot et al. (2000) found that psychiatry rotations have taken on enormous importance due to the reported shortage of psychiatrists. The participants described the intrinsic appeal that medical school psychiatry rotations and psychiatry electives offered. Their psychiatry rotation provided concrete meaning to their early interest in the field. The psychiatry rotation offers close consultation with the department's faculty and residents. The positive interaction with the faculty, residents and staff cemented their decision. The five participants cited this as one of their top considerations agreeing with the findings of de Groot et al. (2000) and Carlott (2010) that the value of the psychiatry rotations has been widely recognized.

Observation and Reflection Should be Modeled Prior to Practice

The second descriptive pattern was Observation and Reflection Should Be Modeled Prior to Practice. For decades, psychiatry residency has centered on two main educational cornerstones, didactic lectures and supervision. Supervision in psychiatry residency serves several purposes with the foremost being review of patient cases to improve the resident's skill and patient outcomes. The degree of quality supervision varies among individual supervisors depending on multiple factors. Directive, supportive or aggressive

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characteristics affect the relationship between supervisor and supervisee. Supervision is best applied when viewed as a two-way street. However, when supervision only meets the needs of one person, difficulties ensue.

Contemporary supervision in psychiatry residency training typically involves a psychiatrist or a clinical psychologist. With the recent competition for mental health dollars and the encroachment from the field of psychology with prescribing privileges, psychiatry residents prefer to be supervised by psychiatrists who have a graduate medical school degree.

In the midst of a patient crisis, supervision serves its most useful purpose. Guidance and solace from supervisors are imperative for less experienced psychiatry residents. Supervisors possess a reservoir of wisdom and experience which is an increasingly valued asset. The professors' insightful recommendations and ideas were described as pivotal when prescribing medicines, assessing acuity of symptoms, reviewing cases, analyzing client sessions, addressing skill development, coping with transference, guiding research efforts, encouraging and supporting residents through difficult situations. Effective supervision is highly regarded in residency training programs.

Sinai et al. (2001) and Whitman (2001) found complaints abounded regarding the resident-supervisor dynamic. They cited supervision was overall critical and harshly judgmental. Whitman stated that often supervision does not fulfill its educational purpose because residents feel obligated to accept whatever the supervisor dictates. The students in this study contradicted the research literature findings regarding stringent critical supervisors. Instead of the dour and punitive supervisor, residents in this study reported supervisors who were constructive and helpful. Dr. Vann reported "It [Supervision]

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hasn't been mean, it's been constructive". Mohammed et al. (2005) found effective supervision was based on a trusting atmosphere where supervisors displayed confidence in the residents to develop their abilities. During the third year, supervisors allow more freedom and independence to diagnose and treat their patients by providing reassuring feedback. For the participants in this study, supervisors were helpful by encouraging the residents to organize and present case details.

I found that supervision was most crucial in times of crisis. Although infrequent, patient crisis does occur. When a resident's patient committed suicide, supervision provided immediate assistance by being accessible and supportive to the resident. After disclosing the patient committed suicide, Dr. Reno stated "I had support and conversations with the program director and my supervisor who was supportive".

Often crisis occur at the end of a long frazzled day. Seeking supervision during these treatment predicaments proves meaningful for an already overloaded resident. All the research participants stated supervision was a positive experience and played a major role with improving their abilities. The residents described supervision as beneficial for their skill acquisition and appreciated the corrective feedback from their supervisors.

McCarthy et al. (2000) reported that residency education only provides didactic lectures and medication management. Touchet and Coon (2005) proclaimed that residents only retain a small amount of information with the lecture format. While supervision was a helpful experience, the residents in this study noted the lackluster nature of their lectures, specifically when the residents were required to lecture. They grew weary of listening to each other drone on about a subject they could have read. They saw these lectures as redundant, providing only passive integration of knowledge. It left the

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residents wrestling to assimilate the techniques taught. One benefit of didactic lectures occurred during their medication prescribing seminars. These were seen as helpful at the beginning of the third year when residents first start treating outpatient cases. The evidence-based didactic lecture by their professors regarding medication guidelines provided concrete guidance for meeting patient's psychiatric needs.

Serby (2000) revealed that traditional education, didactic lectures and supervision lacked balance between models of psychotherapy disciplines and psychopharmacology. My research revealed that an integrated approach including the new formats of instruction (PBL, TBL, EBM, and Experiential Learning) was the strength of the residency program at Soho University. The blended approach advanced the residents' skill development including several major models of psychotherapy and medication management approaches. Ludmerer and John's (2005) research stated that restoring balance to residency education depends on transforming older traditional approaches to a balanced format. The old lecture format appeared to be useful for the residents in the beginning of their third year when learning to prescribe psychiatric medicines but it became less effective as the residents craved more experiential formats.

Prochasta et al.'s (2007) research reported that resident training has undergone a recent transformation from didactic lectures and supervision to include more dynamic learning formats. The residents lamented the lack of observing techniques modeled by their professors during their training. When given the opportunity to observe their professors during patient interactions, participants described this as a meaningful experience and voiced a desire for observation and reflection to be utilized more. The data revealed that learning preference was a significant theme for the resident participants. Being able to

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observe and then reflect on these observations greatly enhanced the residents' skill acquisition. Seeing textbook examples and techniques implemented by their professors adds a progressive dimension to residency curricula.

The old school traditional format of residency education consisting of stale lectures and supervision has shifted to models such as experiential learning formats. David Kolb's model (1984) has some implications for psychiatry residency. He believed that knowledge is created through the transformation of experience. He created four stages of learning that learners move through as they acquire information. These stages- concrete experience (enact), reflective observation (observe), abstract conceptualization (think or contemplate) and active experimentation (arrange or implement)- is grounded in experience and adaptations between learners and the environment. Effectiveness depends on implementing these stages that best promotes learning. The residents voiced the benefit of observation, reflection, contemplation, and implementation of the psychiatric techniques they were taught.

Kolb's research evaluated the relationship between learning style and job disposition. Psychiatry attracts divergent learners due to the humanistic orientation of the physician role in psychiatry. The divergent learning style is correlated with valuing skills such as assessing others with an open mind, gathering information and envisioning implications for certain behaviors. The residents in my study voiced their desire for observation (viewing others and gathering information) and reflection (envisioning implications). As a beginning therapist it is helpful to observe instructors who model psychiatric techniques. After reflecting on their experiences, they adapted these observations to develop their own style, approach, and skill set. Without observation and reflection, it

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was a struggle to learn techniques during patient sessions. They placed pressure on themselves to not make mistakes or harm their patients. The residents learned by mimicking these observations and practicing certain tactics. Otherwise, they were left guessing on how to implement techniques.

Each resident valued the opportunity to embrace their learning preference and described a strong avidity for the aspects of experiential learning. Dr. Toney's request for observation of professor's psychiatry techniques was denied by a professor at the child division of psychiatry. I believe the residents had a legitimate request which would have improved their skill acquisition. Including such educational tasks such as modeling effective psychiatric tactics and reflecting on these observations may increase the full spectrum of instruction methods offered by the department. Residents' psychological well-being also influences learning retention. When denied a seemingly legitimate request to improve learning, animosity often ensues. This sense of hostility has a carryover effect on the individual learner and the class as a whole.

Recent learning formats such as experiential learning and evidenced-based curricula have a place in residency training. During the start of the third year, there is a delicate and tenuous shift from the controlled environment of inpatient psychiatry to the less ordered nature of outpatient psychiatry. Dr. Pulling stated "It's completely different after having been on a ward. You lose some control over your patient". As I mentioned earlier in this theme, some participants cited the value of evidence-based medicine because of its concreteness with prescribing medications. Although evidence-based medicine is a relatively new educational method, its scientific structure assisted the residents to cope with the vast array of psychiatric medications and subjective opinions regarding patient

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interactions. Timmermans and Angell's (2001) research stated that medical decisions should be based on scientific evidence through integrating clinical expertise with the best available research evidence. My research study supported these findings. Evidenced-based medicine provided a framework for effective treatment approaches with the less structured arena of outpatient psychiatry.

Schultz and Kline (1999) found that medical school residents gained more knowledge through the use of problem-based formats than the use of traditional formats by advancing self-motivation and self-directed skills. Problem-based and team-based learning models are newly integrated educational approaches. Although the portrayal of a scholarly gray-haired professor challenging a group of young residents to solve a patient's medical dilemma was not depicted by the residents in this study, problem-based learning (PBL) was described as an effective method of instruction.

The residents in this study stated problem-based learning was advantageous. Inpatient hospital rounds and outpatient supervision with senior faculty creates a forum for discussion of difficult cases, diverse diagnostic criteria, treatment option evaluations, case presentations, medication consultations, major theories and technique reviews as well as geriatric, adult and child psychiatry experience. The residents in this study corroborated this by describing consultation with senior faculty professors allowed the residents to assess standards of practice, explore challenging treatment options and review lab results and patient histories.

In contrast to problem-based learning, team-based learning (TBL) has certain conditions that promote its effectiveness and implementation. Pileggi and O'Neill (2008) and Touchet and Coon (2005) found that team-based learning (TBL) increased

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competency and decreased time for skill acquisition. However the integration of TBL was thwarted by the discord within this residency class. As a result, the participants in this study were only moderately impacted by the team-based educational approach. The benefits included deliberations with various faculty members and with chosen resident colleagues and conferences with nursing and social services at the residents' hospital assignments. However, conflicts within this residents' class disrupted the full implementation of this method. I believe if the conflict had been reconciled with this residency class, TBL may have yielded better results and knowledge retention.

The first time I took my 4 and 5 year old sons camping, I borrowed sleeping bags and a tent that came with no directions. We spent the afternoon wrestling with this tent with no idea about putting it together. After an ill-tempered and frustrated afternoon, we became dysphoric and gave up. Out of necessity we approached our camping neighbors for help. One being a seasoned camper and the other an engineer, they gladly came over and within a short time the tent was assembled.

A similar dynamic affected this year's residency class. As the academic year began, the residency director resigned leaving the class with little direction as they scrambled to assemble their educational campsite. The residents soon became divided while the new director was acclimating to the department. Class discord impacted the residents learning experience by inhibiting team-based learning approaches and class collaboration. The identity of the residency class became partly defined by this schism. Lack of residency class collegiality was reported as a major learning obstacle and a critical factor. Although supervision was described as beneficial by the residents, it did not impact the class

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discord. My conclusion was that the residency class needed a residency director to remedy the class discord. The conflicts continued with the change in directorship.

However, the impact of a divided class demonstrated the significance and value of the residency director position. The past residency director had been in place for 25 years providing a stabilizing educational presence to residency training. For the past 14 years, I have witnessed the department produce a steady flow of skilled psychiatrists ready to enter professional practice. Each year residency classes graduated with ethical capabilities, effective skills, medical expertise and a solid psychiatry education. None were seen on the evening news charged with malpractice or ethical charges. The change in residency director occurred at the beginning of the third year which is a critical period for residents. This left the residents grappling with their own strongly held opinions which divided the class. These conflicts proved the value of the residency director.

At times, these interpersonal clashes created a demoralizing effect. In order to compensate, self-directed learning skills were sought by the residents as opposed to group learning projects and team-based tasks. As the residents' skills developed, they were able to make their own decisions and embrace their positions of medical authority and expertise. The residents began to challenge their skills, explore knowledge deficits, observe and identify their mistakes, question their session content and modify their psychiatric approaches. This group of residents transformed their educational experiences by arranging their own sub-groups and developing a degree of self-directed learning skills. This hybrid format was preferred by the residents as a result of conflicts within the residency class.

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The Value of the Third Year Was the Shift to Psychotherapy Training

Prochastra et al. (2006) found many psychiatric residents struggle to master the various psychiatric approaches including psychodynamic, existential, client-centered, and supportive and group therapies. Residents tend to only apply a couple of approaches such as cognitive and behavioral therapies. Basic behavioral approaches to psychological change are taught at the start of the academic year. Assertiveness training and stress management tactics offer a more concrete model for residents to grasp. The more complex theories and methods are taught later in the year. In my opinion, this is the natural progression of skill attainment. The third-year of training appears to introduce the more complicated psychotherapy models, giving residents the opportunity to explore these models later in the year.

The unique challenges each resident encountered yielded a different flavor to their acquisition of skill. Dr. Toney's perseverance, Dr. Vann's poise and confidence, Dr. Christie's view that everything is a learning experience, Dr. Reno's coping with a patient suicide, and Dr. Pulling's dedication to hard work generated a novel experience for their learning and education. These individualized third-year experiences created a meaningful educational path for each resident.

Ludmerer and Johns (2005) advocated for psychiatry residency programs to create meaningful clinical encounters and learning tasks. The third year afforded a once in a lifetime experience by allowing the residents to meet with patients over an extended period, consult with expert faculty and explore the multitude of treatment options. These experiences provided a foundation for their careers as evidenced by each resident identifying a notable patient encounter that symbolized their attainment of competency.

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These purposeful patient interactions propelled the residents through difficult times and motivated their continued skill acquisition.

What I found in this study is that the combination of several educational circumstances had a cumulative impact on the residents' skill acquisition. Meaningful patient interactions, group and family therapy (which some residency programs do not emphasize) added to their skill set. As a result of a comprehensive approach to psychiatry training, the residents were academically invested with their patient care and learning tasks. Part of their patient care centered on administering to a challenging and diagnostically complicated patient population. Due to the unique characteristics identified earlier, the residents treated complex patient symptoms to enhance their motivation and skill acquisition.

Therapeutic alliance increased the residents' meaningful patient interactions. When first meeting a patient, certain interactions were recalled as noteworthy due to forming effective therapeutic connections. The five residents in this study described key patient sessions as a foundation for their careers. The resident whose patient committed suicide was able to integrate this as a valuable learning experience. Difficult patients such as terminally ill patients and psychologically traumatized patients stimulated the residents' critical thinking skills. These vital experiences combined with reflections of prior life experiences constructed a competent knowledge base for this class of residents.

Many psychiatry residents dream about affluent practices with upscale patients. Yet, the residents in this study preferred meeting with complicated hardship cases because of their strong desire to help. Dr. Pulling reported her joy of treating patients who were chronically distressed when she stated, "I've been lucky enough to have a lot of patients

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where I've picked up on a diagnosis or a problem that other people maybe missed or glazed over". Previous studies did not identify this allure of helping disadvantaged and underserved patients. Psychiatry residency afforded the opportunity to make a positive difference in patient's lives even when treating a chronic patient population.

Competency Was Overcoming Hurdles to Acquire Their Psychiatric Skills

During this study, the phenomenon that captured my attention was the acquisition of skill as resident psychiatrists. Throughout the third year, the residents in this study attained a considerable degree of competency even when considering class discord and differences with their psychiatric approaches. Coupled with their supervision and didactic lectures, observation and refection provided the basis to increase their abilities leading to meaningful patient interactions and competent abilities. Throughout the interviews, the residents coveted the educational components of observation of professors' techniques. All five residents stated that positive patient interaction was the most helpful when combined with observation and reflection.

The residents spoke of their desire to be good enough and competent by questioning their abilities and reflecting on their skills. During formidable educational challenges, the residents dug in their heels overcome learning obstacles. When their patients responded poorly, the residents examined what they could have done better. Dr. Christie voiced self-reflection when he stated, "I look at my body language, my sitting position and the way I interviewed, my cadence and interpretations". These residents placed much pressure on themselves to perform and take responsibility for their learning.

Although several definitions of competency exist, Khursid (2005) defined competency as a fundamental demonstration of textbook technique, effective therapeutic alliances and

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sufficient medical experience resulting in clinical skill. Some of the residents in this study were better suited for a structured organization and some were better matched as a solo practitioner. Dr. Vann voiced a desire to work with a team approach while Dr. Toney related an ambition for a solo practice. In my opinion, this class of residents developed not only clinical skill and effective psychiatric approaches, but also personal attributes, ethical judgment and knowledge of who they are as psychiatrists. They met the standards of competency as defined by researchers.

The profession of psychiatry requires some form of effective assessment to ensure that residents are ready to enter practice. The residents' psychiatric ability and skill were assessed by their assigned supervisors through several competency measures including the PRITE (Psychiatry Residents In-Training Examination) conducted at the end of the second year, video-taped sessions reviewed during weekly supervision, direct observation and progress note review conducted weekly after patient sessions. Each of these assessment modules corroborated the development of psychiatric skill and acumen for these residents. Meeting regularly and frequently with their faculty professors was the most useful form of assessment described by the residents.

Success with patient outcomes increased the residents' confidence, self-efficacy, professional composure, motivation and skills. Critical incidents during these patient session encounters helped the residents derive meaning with their psychiatric approaches. Although lectures and supervision were helpful during the beginning of the third year, patient interaction was the most influential on development of competencies as a psychiatrist. Previous studies identified the importance of residency instructional methods. This study revealed that patient interaction was the most meaningful and

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important experience of psychiatry training. When their patients benefitted from treatment, this authenticated the residents' skill and confidence.

Implications for Psychiatry Residency Programs

I believe this research study has implications for residency training programs. Introduction to psychiatry during medical school rotations has become vitally important. Quite simply, a gracious introduction and pleasant interactions with the faculty and staff to the psychiatry department for pressured and sometimes frazzled medical school students is influential.

Historically, psychiatry training was shaped by didactic lectures and supervision of patient cases. The lecture format and supervision by faculty provided a basic educational approach for psychiatry residency. Although residency has some basic premises, I strongly believe that a combination of newer dynamic formats along with instructional didactic lectures and supervision will benefit psychiatry training. The experiences of these residents suggest implementing approaches such as experiential learning, team-based, problem-based and evidence based formats may enhance the already productive curriculum in place. I would argue that inclusion of observation and reflection of professors modeling psychiatric techniques adds to the beneficial experiences of residents.

I believe that future residency programs should account for how residents learn best and how additional instruction methods impact learning. Residents regard positive patient encounters as a result of modeling effective psychiatry techniques in combination with their didactic lectures and supervision. The recent requirements by the Accreditation Council of Graduate Medical education (ACGME) and Residency Review Committee

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(RRC) emphasizing psychotherapy skills have reshaped psychiatry training programs. I believe that insurance managed care companies only want to pay for medication management but psychiatry residents greatly benefit from a well-rounded psychopharmacology and psychotherapy education.

Implications for Higher Education

My interviews during this study highlighted the conflicts and tension that existed between residents. This ongoing tension plagued the social relationships within this residency class and at times sabotaged their learning with new instructional formats such as team-based learning.

This research suggests that a fragmented class may not attain the same level of learning as a cohesive class. Addressing conflicts early in the academic year by negotiating differences, modeling compromise and accommodating divergent perspectives may increase the learning experiences of residents. Perhaps educational leaders should emphasize communities of practice investing in learning communities and peer learning tasks to enhance team-based and problem-based learning formats. Including social gatherings at the beginning of the academic year may benefit and foster more collaborative efforts for future groups of learners.

Implications for Future Research

This phenomenological study allowed me to explore the rich, deep experiences of a residency class of five in a department of psychiatry. This study offers implications for future research. First, research ought to continue exploring the authentic voices of psychiatric residents in such areas as meeting their required competency standards. Possibilities for future research also include specific attributes of patient care, practice-

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based learning, interpersonal communication, and systems-based psychiatric practices. Other areas might include the exploring the residents' experience with competency assessment measures, learner-centered verses teacher-centered approaches, core fundamentals for specific disorders such as personality disorders, bipolar disorders and other complex diagnostic disorders.

The recent influence of managed care's financial limitations on patient care sessions also creates a research prospect. Research might include building rapport with patients, coping with angry and resistant patients and dual diagnosed patients suffering from mental disorders and substance abuse disorders. Lastly there is the opportunity to investigate the experiences of other classes of residents (first year, second year and fourth year) as well as the experiences of medical school students facing the pressure of choosing and matching with a residency program.

Summary

My intention with this research study was to gather the experiences of the five residents regarding the phenomenon of psychiatry residency education. The participants shared their experiences both positive and negative in a steadfast manner. My responsibility was to tell their experiences in an honorable and trustworthy manner. I judge my effort as adequate and sometimes as proficient. This study of psychiatry residency had a profound impact on me professionally. I was mildly surprised how quickly I established trust and alliance with this residency class. Part of this was attributable to the more objective position I hold as an employee of the medical group associated with the university. Approaching the participants in a humble nonaggressive manner allowed the residents to share their experiences at their own pace to decide on the

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depth of their disclosures. During my career as a clinical social worker, I have worked in many diverse programs of psychiatric care. While working at a university department of psychiatry and its medical group, I have felt more complete as a clinician. My duties as a coordinator of patient intakes and group therapies placed me in direct collaboration with the third-year residents.

This dissertation research has afforded me the luxury of studying and exploring the phenomenon of the third-year psychiatry resident. Since starting my research, I found it fascinating. Never once did I tire of my subject matter. I now have a special connection with the third-year resident. As the residents gained meaning about the essence of becoming a psychiatrist, I gained meaning about the third-year of psychiatry. The third year is clearly the cornerstone of transforming to a psychiatrist ready to enter practice. Not only are the residents learning to prescribe the ever-changing and challenging psychiatric medications available for use, but they are also learning the expertise of psychotherapy. Each is a daunting task. It takes a dedicated person to become accomplished with both these endeavors.

In conclusion, I am fortunate to have been granted my career, the opportunity to study and learn from this research project and to know the five residents in my study. I greatly appreciate each resident for their openness, willingness and honest sharing during this study. All five residents enthusiastically displayed a strong desire to tell their stories of psychiatry residency. Afterward they seemed honored to be included in my research efforts. Alternatively, I developed great admiration for my five residents.

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REFERENCES

Academic Psychiatry Association. (2010). Retrieved from http://www.academicpsychiatry.org.

Allen, D.M. (2010). *How dysfunctional families spur mental disorders: A balanced approach to resolve problems and reconcile relationships.* Santa Barbara: Greenwood Publishing.

American Psychiatric Association. (2008). Retrieved from http://www.psych.org/mainmenu/educationcareerdevelopment.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders*. Fourth Edition, Text Revision. Washington DC.: American Psychiatric Association.

American Psychiatric Association. (2007). *News Release: Hawaii psychologist prescribing bill*.
Retrieved from http://www.psych.org/MainMenu/newsroom/NewsRelease/2007New.

Anfara, V.A, Brown, K.M., & Mangione, T.L. (2002). Qualitative analysis on stage: Making the research process more public. *Educational Researcher, 31*(7), 28-38.

American Psychological Association Online. (2002, March 6). *New Mexico signs landmark law on prescription privileges for psychologists*. Retrieved from www.apa.org/practice/nm_rxp.html.

Ballon, B.C., Silver, I., & Fidler, D. (2007). Headspace theater: An innovative method for experiential learning of psychiatric symptomatology using modified role-playing and improvisational theater techniques. *Academic Psychiatry, 31*(5), 380-387.

Barker, R.L. (2003). *The Social Work Dictionary.* (5th ed.). Washington DC: NASW

المنارة للاستشارات
www.manaraa.com

Press.

Bhattacharya, K. (2007). *Introduction to qualitative methods in education: A student handbook.* Memphis TN: University of Memphis.

Bhugra, D., & Holsgrove, G. (2005). Patient-centered psychiatry training and assessment: The way forward. *Psychiatric Bulletin 29*, 49-52.

Carlat, D. (2010). 45,000 more psychiatrists, anyone. *Psychiatric Times, 27*(8). Retrieved from http://www.psychiatrictimes.com/diplay/article/10168/1632011

Centers for Disease Control and Prevention. (2007) *Leading causes of death*. Retrieved from http://www.cdc.gov/nchs/fastats/lcod.htm.

Conrad, P. (1988). Learning to doctor: Reflections on recent accounts of the medical school years. *Journal of Health and Social Behavior, 29*(4), 323-332.

Creswell, J.W. (2007). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks: Sage.

de Groot, J., Tiberius, R., Sinai, J., Brunet, A., Voore, P., Sackin, D., Lieff, S. & Reddick, S. (2000). An analysis of training activities with recommendations. *Academic Psychiatry, 24*(3), 139-146.

deMarrais, K. (2004). *Qualitative interview studies: Methods of inquiry in education and the social sciences*. Newark, NJ: Lawrence Erlbaum Associations.

Denzin, N.K., & Lincoln, Y.S. (1998). *Strategies of qualitative inquiry*. Thousand Oaks CA: Sage.

Etkin, A., Phil, M., Pittinger, C., Polan, H.J., & Kandel, E. R. (2005). Toward a neurobiology of psychotherapy: Basic science and clinical applications. *The Journal of Neuropsychiatry and Clinical Neurosciences*, *17*, 145-158.

المنارة للاستشارات
www.manaraa.com

Fang, F., Kemp, J.,Jawandha, A.,Juros, J., Long, L, Nanayakkara, S., Stepansky,C., Thompson, B., & Anzia, J. (2007). Encountering patient suicide: A resident's experience. *Academic Psychiatry, 31*(5), 340-344. doi:10.1176/appi.ap.31.5.340

Fauth, J., Gates, S., Vinca, M., Boyles, S., & Hayes, J. (2007). Big ideas for Psychotherapy training. *Psychotherapy: Theory, Research, Practice, Training, 44*(4), 384-391. doi:10.1037/0033-3204.44.4.384

Giordano, F.L., & Briones, D.F. (2003). Assessing residents' competence in psychotherapy. *Academic Psychiatry, 27,* 145-147.

Goldman, W. (2001). Economic grand rounds: Is there a shortage of psychiatrists? *Psychiatric Services, 52*, 1587-1589.

Hilty, D.M., Maynes, S.M., Clark, M.S., Bourgeois, J.A., Servis, M.E., & Kellner, M. (2005). A day in the life of a psychiatry resident: A pilot qualitative analysis. *Academic Psychiatry,29*(4), 405-407. doi:10.1176/appi.ap.29.4.405

Kamenev, M. (2006, October 11). Rating countries for the happiness factor. *Business Week*. Retrieved from http://wwwbusinessweek.com.

Kayes, A.B, Kayes, C.D., & Kolb, D.A. (2005). Experiential learning in teams. *Simulation and Gaming, 36*(3), 330-354.

Khurshid, K., Bennett, J.I., Vicari, S., Lee, M.A., & Broquet, K.E., (2005). Residency programs and psychotherapy competencies: A survey of chief residents. *Academic Psychiatry, 29*(5), 452-458. doi:10.1176/appi.ap.29.5.452

Kirch, D.G. (2006). Financial and organizational turmoil in the academic health center: Is it a crisis or an opportunity for medical education. *Academic Psychiatry, 30*(1), 5-8. doi:10.1176/appi.ap.301.5

المنارة للاستشارات
www.manaraa.com

Kolb, D. (1984). *Experiential learning: Experiences as the source of learning*. Upper Saddle River, NJ: Prentice Hall.

LeCouteur, A., & Delfabbro, P.H. (2001). Repertoires of teaching and learning: A comparison of university teachers and students. *Journal of Higher Education, 42*(2), 205-235.

LeVassear, J.J. (2003). The problem of bracketing in phenomenology. *Qualitative Health Research, 13*(3), 408-420.

Ludmerer, K.M., & Johns, M.E. (2005). Reforming graduate medical education. *Journal of the American Medical Association, 294*(9), 1083-1087.

McCarthy, M.K., Birnbaum, R.J., & Bures, J. (2000). Problem-based learning and psychiatry residency education. *Harvard Review Psychiatry, 7,* 305-308.

Mellman, L., & Beresin, E. (2003). Psychotherapy competencies: Development and implementation. *Academic Psychiatry, 27*(3), 149-153.

Mohl, P.C. (2004). Assessing psychotherapy competence. A*cademic Psychiatry, 28*(3), 251-253.

Mohamed, M., Punwani, M., Clay, M., & Appelbaum, P. (2005). Protecting the residency training environment: A resident's perspective on the ethical boundaries in the faculty-resident relationship. *Academic Psychiatry 29*(4), 368-373. doi:101176/appi.ap.29.4.368

Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks: Sage.

National Institute of Mental Health. (2007). *Transforming the understanding and treatment of mental illness through research.* Retrieved from http://www.nimh.nih.gov/health/statistics/index.shtml.

المنارة للاستشارات
www.manaraa.com

Peshkin, A. (1998). In search of subjectivity: One's own. *Educational Researcher, 17*(7), 17-20.

Pileggi, R., & O'Neill, P.N. (2008). Team-based learning using an audience response system: An innovative method of teaching diagnosis to undergraduate dental students. *Journal of Dental Education*, *20*(10), 1182-1188.

Pratt, M.G., Rockmann, K.W., & Kaufmann, J.B. (2006). Constructing professional identity: Therole of work and identity learning cycles in the customization of identity among medical residents. *Academy of Management Journal, 49*(2), 235-262.

Prochaska, J.J., Fromont, S.C., Banys, P., Eisendrath, S.J., Horowitz, M.J., Jacobs, M.H. & Hall, S. (2007). Addressing nicotine dependence in psychodynamic psychotherapy: Perspective from residency training. *Academic Psychiatry, 31*(1), 8-14. doi:10.1176/appi.ap.31.1.8

Ratanawongsa, N., Wrights, S.M., & Carrese, J.A. (2008). Well-being in residency: Effects on relationships with patients, interactions with colleagues, performance, and motivation. *Patient Education Counseling, 72*(2), 194-200. doi:10.1016/j.pec.2008.04.010

Ronnestad, M.H., & Skovholt, T.M. (2001). Learning arenas for professional development: Retrospective accounts of senior psychotherapists. *Professional Psychology: Research and Practice, 32*(2), 181-187.

Sackett, D.L., Rosenberg, W.C., Gray, J.A., Haynes, B.R., & Richardson, W.S., (1996). Evidence based medicine: what it is and what it isn't: It's about integrating individual Clinical expertise and the best external evidence. *British Medical Journal, 32*(3), 71-74.

المنارة للاستشارات
www.manaraa.com

Samuelowicz, K., & Bain, J.D. (2001). Revisiting academics' beliefs about teaching and learning. *Journal of Higher Education, 41*(3), 299-325.

Schultz-Ross, R.A., & Kline, A.E. (1999). Using problem-based learning to teach forensic psychiatry. *Academic Psychiatry, 23*(1), 37-41.

Schwandt, T.A. (2007). The sage dictionary of qualitative inquiry, third edition. Thousand Oaks: Sage.

Seidman, I. (1998). *Interviewing as qualitative research: A guide for researchers in education and the social sciences.* New York: Teachers College Press.

Serby, M. (2000). Balance in psychiatric education. *Academic Psychiatry, 24*(3), 164-167.

Sharma, B., Dunop, B.W., Ninan, P.T., & Bradley, R. (2007). Use of dialectical behavior therapy in borderline personality disorder: A view from residency. *Academic Psychiatry, 31*(3), 218-224. doi:10.1176/appi.ap.31.3.218

Shaw, B., & Dobson, K.S. (1988). Competency judgments in the training and evaluation of psychotherapists. *Journal of Consulting and Clinical Psychology, 56*(5), 666-672.

Sinai, J., Tiberius, R.G., de Groot, J., Brunet, A., & Voore, P. (2001). Developing a training program to improve supervisor-resident relationships, step 1: Defining the types of issues. *Teaching and Training in Medicine, 13*(2), 80-85.

Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis*, Thousand Oaks: Sage.

Sturm, R. (2001). Are psychiatrists more dissatisfied with their careers than other physicians? *Psychiatric Services, 52*(5), 51-52.

Sudak, D.M., Beck, J., & Gracely, E.J. (2002). Readiness of psychiatry residency training

المنارة للاستشارات
www.manaraa.com

programs to meet the ACGME requirements in cognitive-Behavioral therapy. *Academic Psychiatry, 26*(2), 96-101.

Swick, S., Hall, S., & Beresin, E. (2005). Assessing the ACGME competencies in psychiatry training programs. *Academic Psychiatry, 30*(4), 330-351. doi:10.1176/apppi.ap.30.4.279

Teunissen, P., Boor, K., Scherpbier, A., Van Leuten, C., Van Diemen, Steevoorde, J., Van Luijk, S.J., & Scheele, F. (2007). Attending doctors' perspectives on how residents learn. *Medical Education, 41,* 1050-1058. doi:10.1111/j.13652923.2007.02858.x

Teunissen, P.W., Scheele, F., Scherpbier, A.J., Van Der Vleuten, C.P., Boor, K., & Van Diemen-Steen Voorde, J.A. (2007). How residents learn: Qualitative evidence for the pivotal role of clinical activities. *Medical Education, 41,* 763-770. doi:10.1111/j.1365-2923.2007.02778.x

Thornhill, J.T., & Tong, L. (2006). From yoda to sackett: The future of psychiatry medical

student education. *Academic Psychiatry, 30*(1), 23-28. doi:1176/appi.ap.30.1.23

Timmermans, S., & Angell, A. (2001). Evidence-based medicine, clinical uncertainty, and learning to doctor. *Journal of Health and Social Behavior, 42,* 342-359.

Touchet, B.K., & Coon, K.A. (2005). A pilot use of team-based learning in psychiatry resident psychodynamic psychotherapy education. *Academic Psychiatry, 29*(3), 293-296. doi:10.1176/appi.ap.29.3.293

Tweed, W.A., & Donen, N. (1994). The experiential curriculum: An alternative model for anaesthesia education. *Canadian Journal of Anaethesia, 41*(12), 1227-1233.

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Vakoch, D.A., & Strupp, H.H. (2000). The evaluation of psychotherapy training: Reflections on manual-based learning and future alternatives. *Journal of Clinical Psychology, 56*(3), 309-318.

Weerasekera, P., Martin, M.M, Bellissimo, A., Bieling, P., Shurina-Egan, J., Spencer, A., Whyte, R., & Wolpert-Zur, A. (2003). Competency assessment in the McMaster Psychotherapy Program. *Academic Psychiatry, 27*(3), 166-173.

Welch, G.H., & Lurie, J.D. (2000). Teaching evidence-based medicine: Caveats and challenges. *Academic Medicine, 75*(3), 235-240.

Wertz, F.J. (2005). Phenomenological research methods for counseling psychology. *Journal of Counseling Psychology, 52*(2), 167-177.

Whitman, S.M. (2001). Teaching residents to use supervision effectively. *Academic Psychiatry, 23*(3), 143-147.

World Health Organization. (1999). *Health life expectancy*. Retrieved from http://photius.com/rankings/healthy_life_table2.html.

World Health Organization. (2000). *The World Health Organization's ranking of the world's health systems.* Retrieved from http://photius.com/rankings/healthranks.html.

Yager, J., Kay, J., & Mellman, L. (2003). Assessing psychotherapy competence: A beginning. *Academic Psychiatry, 27*(3), 125-127.

Yalom, I. (1995). *The theory and practice of group psychotherapy,* 4th ed. New York: Basic Books.

Zeddies, T.J. (1999). Becoming a psychotherapist: The personal nature of clinical work, emotional availability and personal allegiances. *Journal of Psychotherapy, 36*(3), 229-235.

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Appendix A: Observation Form

Date

Place

Interviewee

General Description

Position of interviewee

What is their role during this event

Descriptive Notes

Reflective notes

Follow up points

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Appendix B: Participant Release Agreement

I agree to participate in a research study of "What experiences were important and significant during psychiatry education?" The procedure will be a phenomenological research design.

Data will be collected during the academic semester including recorded interviews, researcher observation and focus groups. Participant names will not be associated with the research findings in anyway, and identity as a participant will be known only to the researcher.

I grant permission for the data to be used in the process of completing an EdD. degree, including dissertation and any other future publication.

I understand the purpose and nature of this study and I am participating voluntarily.

____________________________   ____________________________

Research Participant/Date   Primary Researcher/Date

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Health Science Center
Institutional Review Board

February 12, 2010

Jody G Long
College of Medicine
Department of Psychiatry
135 North Pauline

Re: 09-00671-XM: The Development of Psychiatric Residents As Therapeutic Individuals. Qualitative Study. The research purpose is to discover, through qualitative methods, how psychiatric residents experience their development as effective clinicians.

Dear Mr. Long,

The IRB has received your written acceptance of and/or response dated February 12, 2010 to the provisos outlined in our correspondence of February 3, 2010 0concerning the application for the above referenced project.

The Administrative Section of the IRB determined your application to be consistent with the guidelines for **exempt** review under 45 CFR 46.101(b)(2). In accord with 45 CFR 46.116(d), informed consent may be altered, with the cover statement used in lieu of an informed consent interview. The requirement to secure a signed consent form is waived under 45 CFR 46.117(c)(2). Willingness of the subject to participate will constitute adequate documentation of consent.

Therefore your application has been determined to comply with proper consideration for the rights and welfare of human subjects and the regulatory requirements for the protection of human subjects. This letter constitutes full approval of your application, consent cover statement and survey [stamped approved by the IRB on February 12, 2010] for the above referenced study.

This study may not be initiated until you receive approval from the institution(s) where the research is being conducted.

In the event that volunteers are to be recruited using solicitation materials, such as brochures, posters, web-based advertisements, etc., these materials must receive prior approval of the IRB.

Any alterations (**revisions**) in the protocol, consent cover statement, or survey must be promptly submitted to and approved by the Institutional Review Board prior to

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implementation of these revisions. You have individual responsibility for reporting to the Board in the event of unanticipated or serious adverse events and subject deaths.

Sincerely,

Signature applied by Donna L Stallings on 02/12/2010 01:59:58 PM CST
Signature applied by Terrence F Ackerman on 02/12/2010 02:06:35 PM CST
Donna Stallings, CIM Terrence F. Ackerman, Ph.D.
IRB Analyst Chairman

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