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EDITORIAL

What Are Some Stressful Adversities in Psychiatry Residency Training, and How Should They Be Managed Professionally?

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Stress, depression, and burnout are common experiences during residency training [1–3]. Depressive symptoms, for example, increase substantially with the onset of residency training [1]. In conjunction with these concerns, publications have accelerated over time on burnout, well-being, and wellness among medical students, residents, and physicians in the pages of *Academic Psychiatry* [4, 5].

Kannan et al. [6] found a dearth of research in resident populations on the occurrence of posttraumatic stress disorder (PTSD) and on the spectrum of stressors perceived as traumatic. Consequently, they surveyed work-related PTSD symptom profiles among internal medicine residents from three medical schools in the Philadelphia area. With a response rate of close to 70%, they found that the vast majority of resident respondents experienced at least one work-related stressful event and around 5% screened positive for PTSD arising from the most stressful event in training when using a standard cutoff score from the PTSD checklist for the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). In this study, stressful events were most commonly the death of a patient, managing a critically ill patient, verbal abuse from patients or their families, medical error, academic performance, and verbal abuse by colleagues. Physical assault by a patient or a patient's family had the highest relative PTSD symptom trigger rate.

Psychiatry residents likely experience somewhat different stressful adversities than internal medicine residents, although they have some key experiences in common, including verbal abuse from families and patients, medical error, academic performance, and verbal abuse by members of the health care team. One goal for this editorial is to provide some context to the above findings by Kannan et al. [6] by discussing the prevalence of some of the stressful adversities of psychiatry training and their associated psychological consequences. For this purpose, we selected five key stressors: (1) aggression by patients, (2) death of a patient by suicide, (3) mistreatment by colleagues, (4) attendance at disasters, and (5) working with victims of violence. We recognize, though, that other potentially stressful adverse experiences during residency training may include the following:

- death of or occurrence of harm to a colleague [6],
- a patient's life-threatening reaction to psychotropic medications [7],
- a homicide or homicide attempt by a current patient outside of the medical setting [7],
- threats of litigation (e.g., stemming from malpractice or a suicide),
- stressors related to the learning environment (e.g., feeling underequipped and overwhelmed, receiving excessive demands for use of electronic medical record systems, or lacking time) [8],
- educational or emotional neglect by supervisors [9],
- observance of maltreatment of patients by other members of the team [9],
- exam failure [9],
- conflict between attendings [9],
- the inherent uncertainty characteristic of psychiatric patients and their treatment (e.g., treatment of psychotic or patients with addiction), or

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- mandated reporting and potential involvement in filing abuse and neglect reports on parents (sometimes resulting in separation of children from parents).

A second goal for the editorial is to discuss the role of the professional virtues in preventing and managing these adversities, with an emphasis on responses at the level of health care organizations and residency training programs.

Aggression by Patients

Assault by a patient and suicide of a patient have been identified as the two most stressful adversities of training in psychiatry. Violence in healthcare settings appears to be rising [10], and trainees across all of the specialties that have been studied may become a victim of assault by a patient or a patient's family [11]. Aggressive acts may include verbal abuse, a threat or physical intimidation, observing destructive behaviors or physical aggression, sexual harassment or sexual assault, attempted assault, stalking, or being physically assaulted. Estimates of the prevalence of assaults by patients against psychiatry residents range from 25 to 64%, although substantial limitations to the data exist [11]. Few studies compare psychiatry trainees with trainees in different specialties, although those that do suggest that psychiatry residents may be at an elevated risk of experiencing many of these forms of aggressive acts, including assault [12, 13].

Psychologically distressing symptoms can arise from verbal threats and other forms of aggression as well as physical assaults. In one study, for example, the most distressing incident experienced was commonly a verbal threat [13], and in another [14], a greater percentage of respondents reported that verbal abuse impacted their ability to perform duties compared to those who experienced physical abuse. Aggressive acts serve to diminish morale and to increase depressive feelings, difficulty at work, and thoughts of dropping out of residency training [15]. Residents in psychiatry may also report increased vigilance, take greater safety precautions, and avoid certain patient types [16].

Death of a Patient by Suicide

According to one systematically conducted review [17], the prevalence of psychiatry residents' experience of the death of a patient by suicide ranged from 31 to 69%. Notably, only one of the eight cross-sectional studies included in this review was conducted in the USA, and this study had low numbers of psychiatrists and is now dated [18]. One more recently published study found that 8 of 23 residents in one program had experienced the death of a patient by suicide [8]. Variations in study methodologies may have contributed to the discrepancies in estimates of rates [17].

We do not know how often residents in specialties other than psychiatry experience the death of a patient by suicide. Dealing with the suicide of a patient is likely to be emotionally less tolerable than dealing with the death of a patient from cancer, for example [19]. Perhaps the unexpectedness of the death is the most traumatizing feature [20]: some physicians in general medical practice report satisfying experiences when caring for dying patients [21].

Responses of psychiatric residents to suicide can range from a stage of shock or disbelief [22–25] to a sense of exhaustion, turmoil, or demoralization [22]. Residents may experience an ongoing preoccupation with how the suicide could have been prevented or a sense of self-blame, guilt, and anxiety [23, 26, 27]. Some residents experience feelings of avoidance and a loss of confidence in their clinical skills [23], and some withdraw or isolate themselves from colleagues [24]. Attending psychiatrists also can experience low mood, poor sleep, or irritability, and some consider taking an early retirement after the suicide of a patient [28]. Nevertheless, the negative impact may be more severe during training than after graduation [24]. Intense feelings, including a strong sense of foreboding about a patient's risk to commit suicide, can lead to cautious [28], even overly cautious or overly zealous, protection of patients [25, 29] or, alternatively, to avoiding a thorough assessment of suicidal risk and even to avoiding potentially suicidal patients altogether [29]. While the death of a patient by suicide is highly traumatic, suicide attempts are also highly emotionally traumatic, particularly serious attempts and unexpected attempts.

Mistreatment by Colleagues

Residents may become the object of detrimental or derogatory comments by peers, supervisors, ancillary staff members (e.g., nurses, social workers), and physicians from other medical specialties. A persistence of such comments is a form of harassment or bullying. According to one systematic review and meta-analysis, which included 57 cross-sectional and 2 cohort studies, almost 60% of medical students and residents in all training programs had experienced at least one form of harassment or discrimination during their training [30]. Verbal harassment was the most commonly reported form of harassment, with attending physicians as the most commonly cited source [30]. This unfortunately common practice has led the Liaison Committee on Medical Education to require reporting of medical student abuse on a regular basis. Similarly, the Accreditation Council for Graduate Medical Education has required reporting of abuse among residents and fellows.

Information on mistreatment specific to psychiatric trainees is lacking, especially in American settings [31]. Four

noteworthy studies of which we are aware, all of which are now dated, originate from Australia [9], Canada [32], UK [33], and Pakistan [34]. Sizeable minorities of residents had reported being severely criticized or humiliated by an attending or had observed this happening to others [9] or had experienced bullying behaviors in the preceding year [33, 34]. In the Canadian study, the perception of intimidating behaviors, including threats and the abuse of power, was generally low in the working environment [32].

The Australian study [9] provided information on some of the negative consequences of being criticized or humiliated. Residents felt devalued and experienced a reduction in self-confidence or experienced a sense of uselessness, fear, and distress [9]. Mistreatment or bullying has been associated with burnout [35] and posttraumatic symptoms in medical students [36] and surgical residents [37].

We should note that psychiatry as a field is still highly stigmatized in modern medical culture. Many medical students, residents, and fellows experience the devaluation of psychiatry as a bona fide specialty, on par with other medical and surgical specialties. This devaluation, along with low reimbursement rates (another form of devaluation by the field and the insurance industry), is a deterrent for entry into the field and, for those in it, a form of demoralization.

Attendance at Disasters

Two types of disaster are especially relevant as stressful adversities during psychiatric residency training: weather-related events and mass shootings. Weather-related disasters including hurricanes, floods, mudslides, severe droughts, and wildfires are likely to become increasingly prevalent over time [38]. Mass shootings have become commonplace in the USA, and gun violence is an epidemic [39], signifying deeply rooted cultural problems especially when viewed in conjunction with the prevalence of other forms of firearm violence.

Psychiatry residents and especially those working in emergency departments will likely become involved in providing psychological support and counsel to survivors and others affected by disasters. We also know that psychiatrists are often called on to speak to the media about the consequences of what can be done, and what measures can help families and communities. While such involvement is not as intense as being directly at the scenes of disasters, residents who explore the horrors of such events may well experience trauma. We know little about residents' emotional responses, whether positive or negative, in dealing with disasters. Emotional responses of relief workers to hurricanes Katrina and Rita, however, included shock, fatigue, sleep disturbances, anger, and grief [40].

Working with Victims of Violence

Residents will routinely screen for and work with patients (adults and children) who have been verbally, physically, or sexually abused or who are currently in abusive relationships. A trauma curriculum can assist in promoting screening of patients for potential abuse by residents [41]. The #MeToo movement may enable victims to seek psychiatric help more easily and may lead to a surge in the use of services. Other traumatized groups include torture survivors, survivors of trauma associated with refugee or migrant status, veterans of war, and patients who are current or former victims of labor or sex trafficking. The cross-national lifetime prevalence of PTSD, which is one possible psychiatric consequence of violence, was 3.9% in the World Mental Health Surveys [42] and 7.8% in the National Comorbidity Survey [43]. The traumas most commonly associated with PTSD in the latter survey were combat exposure and witnessing of violent acts among men and rape and sexual molestation among women [43].

Vicarious traumatization is a complex phenomenon arising specifically from dealing with victims of violence [44]. McCann and Pearlman [45] described vicarious traumatization as occurring when therapists experience painful images and emotions associated with patients' traumatic memories, and as a result, therapists may find themselves experiencing PTSD symptoms. The closely related concepts of burnout and compassion fatigue differ from vicarious traumatization in that they are not necessarily associated with working with victims of violence, and both are related to the job environment [44].

We are not aware of formal measurements of vicarious traumatization in psychiatry residents, but in one study [46], 26% of medical students reported experiencing vicarious traumatization during their third year of medical school, as defined by a transformation leading to negative changes in the mental health of healthcare workers who encounter individuals who have survived a history of abuse or trauma.

Professional Responses

We chose two adversities in common with the work-related stressful adversities identified in the study by Kannan et al. [6] of internal medicine residents: aggression by patients and mistreatment by colleagues. As we have described, the evidence suggests that psychiatry residents are more likely victims of aggression or violence by patients than are residents in other specialties to which they have been compared [12, 13]. We have also shown how we know little about the prevalence of mistreatment of psychiatry residents by colleagues, and yet, harassment or discrimination in some form or another has been reported by a sizeable proportion of medical students and residents across specialty training areas [30]. However, many are still reluctant to report abuse for fear of

recrimination. When we chose the adversity of death of a patient by suicide, we anticipated that the resulting emotional responses may share some common elements with the death of patients in medical settings by other means, although the potential for severe emotional reactions to the suicide of a patient is high. We should therefore work to optimize psychiatric education related to suicide and suicide attempts [47] and help residents to cope with the death of a patient by suicide [48]. We found little information about how psychiatry residents experience working in the aftermath of disasters, and how they experience working with victims of violence even though psychiatry residents are especially likely to work with these patient populations.

How should the emotional responses to these potential adversities be managed professionally? Some guidance is provided by the professional virtues originating from the scholarly work of John Gregory (1724–1773) and which were more recently brought to light by Laurence McCullough [49, 50]. The four key virtues are integrity (i.e., the pursuit of excellence in the practice of medicine), compassion (i.e., the determination to relieve patients' pain and suffering through identification with their distress), self-effacement (i.e., the putting aside of differences between physicians and patients that should not count as clinically relevant), and self-sacrifice (i.e., a willingness by physicians to take risks in their lives, within limits, in order to protect and promote patients' interests). These virtues serve to put the needs and interests of patients at the forefront of medical practice and to necessarily relegate the interests of physicians and their needs as secondary considerations. Fiduciary obligations are defined in turn by the virtues in conjunction with a commitment to practice according to evidence-based principles. Adherence to these obligations enables patients to trust their physicians intellectually and morally [49–51]. We have utilized this framework in two recent editorials in Academic Psychiatry [52, 53] by describing how the four fundamental virtues inform about the professional obligations of medical students and about the role of maturity in learning medicine.

Physician leaders along with the institutions in which residents train have professional obligations to treat colleagues (and learners) with respect, not simply as a means to achieving the institution's interests [54, 55]. Compassion obligates leaders to be aware of and respond with appropriate support to colleagues' distress [54]. Residency training programs and institutions are professionally obligated to aim to provide safe and supportive environments for trainees. Moreover, as is the case when addressing physician burnout [56, 57], healthcare organizations have an ethical responsibility to prevent adversities when reasonably possible and to implement remedies and promote well-being. However, the implementation of programs for well-being is not a simple task; such programs require funding, time away from clinical and academic duties (or integrated with them), and thus the need for increased coverage.

It follows too that the institutional culture, in support of the clinical learning environment, should readily enable disclosure and discussion of stress or adversities. In psychiatry, it would appear that certain of the adversities presented thus far (aggression by patients, death of a patient by suicide, etc.) would be appropriate to discuss and track in the context of quality and safety forums, morbidity and mortality conferences, or equivalent settings. Moreover, we have a professional obligation to offer treatment for those who are suffering as an outcome of stressful or traumatic professional activities. Mechanisms must be in place that facilitates reporting of occasions of patient aggression against residents and which actively confront a view that aggression is part of the job [58] Mechanisms should also be in place that facilitate the reporting of mistreatment of residents by other professionals. Identification and analysis of problems that contribute to stress are necessary first steps in their remediation. A starting point for approaching colleagues who have acted improperly to other members of the team is to also treat them with compassion on the assumption that they too may be stressed or overwhelmed.

On an individual level, managing potentially suicidal or aggressive patients, uncovering trauma histories, and responding to disasters can evoke powerful emotions in physicians. As we have indicated earlier, these in turn may bias and unhinge clinical judgment and behaviors or lead to an overcautious protection of patients or distancing from patients, even an avoidance of certain types of patients altogether. Self-effacement and self-sacrifice together obligate residents and physicians to tolerate strong feelings when not relevant to the provision of treatment and to deemphasize self-interest when doing so promotes the provision of an excellent standard of care. Strategies that support the provision of excellence in clinical practice include identifying strong feelings and how these may undercut care, leaning on the clinical team for their thoughtful advice and counsel, and utilizing the skills of argument-based ethics and evidence-based medicine. Some methods to manage strong emotions involve ongoing forums for expressing feelings and experiences, such as Balint groups, reflective discussion groups, and meditative practices. These strategies should be taught, modeled, and promoted by healthcare organizations and educational leaders. It should be noted that the very same traumatic experiences are those attendings endure, and the very same practices we are offering for our residents should be offered to faculty. In fact, the modeling of interventions to promote well-being and healing of trauma by faculty will tacitly give permission for residents to accept them. Cultural change cannot occur solely at the resident level but by institutional offerings to residents, faculty, and staff alike.

Our comments have been directed primarily to the professional culture of the practice of psychiatry. Understanding organizational factors that contribute to professional behaviors or their lack is of considerable value [59]. Attention to the

learning and work environment as well as to individual behaviors is also needed in order to promote trainees' wellness and to help those in distress [60]. In doing so, the goal should be to develop nurturing and supportive approaches to teaching and supervision [61].

Prevention of adversities in training is one of the most important tasks we face for the future. Given the recent increased interest in burnout and issues such as mistreatment of residents, some programs and organizations have become proactive. In one psychiatry residency program, for example, leadership convened an "Educational Climate Committee" comprising faculty and residents that were tasked with examining the problem of intimidation of residents and making recommendations for improvements [62]. Faculty should role model professional behaviors for residents in managing the prevention and response to clinical adversities encountered in training. Heathcare organizations should provide peer support to any resident involved in emotionally stressful situations [63]. Indeed, the Charter on Physician Well-Being aims in part to remind physicians of their responsibility to examine the culture of medicine and how it facilitates meaning, fulfillment in practice, and professionalism and to encourage a supportive culture [64]. We also believe that it would be a fruitful investment of teaching psychiatrists' time to serve on hospital committees tasked with preventing and managing aggression and violence in patient care settings.

In conclusion, therefore, the professional virtues inform about the prevention and management of the various adversities that psychiatry residents may encounter in clinical training. Residency training can be emotionally challenging, and emotional responses can subvert the provision of excellent care. Appreciation of the importance of attending to professional culture in the practice of medicine is growing. This attention should occur in concert with supporting residents to develop their maturity and the requisite skills in managing stress and adversities during training. In particular, professional cultures should promote respect, dignity, compassion, and support for trainees and development of the professional virtues in clinical practice.

Compliance with Ethical Standards

Disclosure On behalf of all authors, the corresponding author states that there is no conflict of interest.

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