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The Phenomenon of the Third Year

Jody Long¹ and David Allen¹

Abstract
This article describes the phenomenon of the outpatient year experiences of the PGY (Post Graduate Year)-3 year psychiatry residents using participant interviews, focus groups, and research observation at a university health science center. A qualitative research approach was used to identify and understand psychiatric residents’ experiences of their third year. The research question was, “What are the important and valuable experiences of psychiatry residents and what meaning do they ascribe to these experiences in their acquisition of psychiatric skills?” Four themes emerged from the study: Specialty Choice Was a Momentous Decision, Observation and Reflection Should Be Modeled Prior to Practice, The Value of the Third Year Was the Shift to Psychotherapy Training, and The Importance of Overcoming Hurdles to Acquire Their Psychiatric Skills. This research study revealed that psychiatry residents saw the third year of their psychiatry education as foundational in building their career.

Keywords
psychiatry, residency, qualitative, phenomenology

Introduction
Psychiatry residency education has changed due to new mandates, increased demands on the profession, the dwindling number of psychiatrists in private practice, and the increased numbers of fragile psychiatric populations such as geriatric patients and children (Carlat, 2010). Several major factors have affected psychiatry training in the past two decades including decreased financial resources, the influence of managed care on psychiatrists’ practice styles, and the need to demonstrate accountability in higher education (Ludmerer & Johns, 2005). Identifying important experiences shaping residents’ professional development may help faculty and staff to make better decisions regarding residency teaching (Hilty et al., 2005).

Background
To improve psychiatry education and training, educators and administrators need to know what experiences psychiatric residents believe are important and enhance their educational growth. This study used a phenomenological research design to discover residents’ most valuable educational experiences and their influences on their development as psychiatrists.

As a result of limitations of the lecture format, faculty in residency programs have been shifting toward more vibrant techniques that increase student participation such as team-based learning (TBL), problem-based learning (PBL), evidence-based medicine, and experiential learning (Serby, 2000). With PBL, the residents debate a course of treatment by generating hypotheses to explain the patient’s condition (McCarthy, Birnbaum, & Bures, 2000). TBL divides the class into small groups of students and applies a case-based discussion. All of these can draw on the best evidence, which echoes evidence-based medicine that integrates clinical expertise with the best available external research evidence (Timmermans & Angell, 2001). Kolb’s experiential learning theory has also gained acceptance across higher education and residency training (Ballon, Silver, & Fidler, 2007). Experiential learning theory depends on steps of cognition and understanding that doctors pass through when learning from experience.

Ludmerer and Johns (2005) specified the need to research residents’ perspectives regarding the phenomenon of learning as did Bhugra and Holsgrove (2005) and Hilty et al. (2005). The purpose of this study was to discover, through phenomenological research methods, what psychiatric residents experienced as important and influential as they entered professional practice as psychiatrists. The research question for this study was as follows:

Research Question 1: What are the important and valuable experiences of psychiatry residents and what meaning do they ascribe to these experiences in their acquisition of psychiatric skills?

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Method

Phenomenological research describes the meaning individually ascribed to their lived experiences of a phenomenon and utilizes systemic data analysis procedures to assess the participants’ experiences (Creswell, 2007). The research setting was a university medical school psychiatric department located in a large southeastern city in the United States. Through purposeful sampling, five 3rd-year psychiatric residents who comprised their entire class were interviewed over 1 academic year. Creswell (2007) recommends 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. The participants included four females and one male with three Americans and two foreign residents. Their ages ranged from 28 to 49. One-hour initial interviews were conducted with each of the five residents. They were asked to reconstruct their early experiences in residency that they felt were important and valuable to their career development. Institutional review board approval was received from the university where the research was conducted.

Data Analysis

The study used 15 individual interviews, 5 focus group interviews, and 3 days of observations. The transcribed interviews, focus groups, and observations were analyzed for emergent themes using the Modified Stevick–Colaizzi–Keen Methodology (Creswell, 2007). A list of meaningful, significant and important statements of the residents’ experience was developed, and some statements were combined into superordinate statements. Each statement was granted equal importance and consideration. Verbatim quotes drawn from the interviews and focus groups were used to provide evidence for the statements. The verbatim quotes highlighted common themes. Peer debriefing and member checks were used to add to the reliability of the study. The following themes emerged.

Specialty Choice Was a Momentous Decision

The pressure of matching individual interest to residency specialties is enormous. The residents mentioned ruling out other medical residencies, even ones that paid more.

I never wanted to see the inside of another school once I got out of the 12th grade . . . But it was 1995, I was in an industrial accident at the place where I worked. It was a serious accident with phosgene gas. It made me blind for two days. It was scary. Eventually, I ended going to the Texas Rehabilitation Program and they said we can train you for another job or you can go to school. I was in survival mode as a single mom . . . Then, one day my daughter came home to me and asked something about her going to college. It suddenly dawned on me that my daughter was at the age that actually I didn’t have to be in survival mode anymore. I might have opportunity to dream about what I wanted to do for a change, so I did. I just started various courses at college and found I really liked science . . . A lot of people that I came into contact when I was doing undergraduate biology, they were all going to med school. I started thinking, I could do that, why not? My college counselor said I was too old. Don’t even try. But I thought I’m going to show you. That’s how I ended up getting to med school is the Texas Rehabilitation Program got me started in college. They paid for the first two years of college. But I never thought, I want to be a doctor and work with people . . . but I liked psychology. When I got in medical school, when I actually did my psychiatry rotation I was like, wow, how cool is this. I just felt like this is it. I found what I want . . . 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. There is also such a shortage of psychiatrists. I just couldn’t get away from psychiatry after that. (First Participant)

Contact with psychiatry patients and amicable interactions with departmental faculty and staff during their medical school rotations were decisive factors as they wrestled with their residency choice. Exploring their residency selection was a vital personal and developmental experience resulting in a psychological bond with their specialty choice:

When I got into med school, I found myself kind of captivated 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 it. (Fifth Participant)

Both personal exposures and professional encounters during medical school had an impact on psychiatry as a residency and career. Two participants were influenced by their parents who were also physicians with one resident knowing since she was a child that she wanted to become a psychiatrist. The route to residency may be different for each person; however, some influential factors were common for these five psychiatry residents. These include a strong desire to help people, the recent shortages of psychiatrists, the attraction of healing psychological trauma, and interests in human behavior, family dynamics, and how the brain works.

Observation and Reflection Should Be Modeled Prior to Practice

This theme focused on supervision and lectures. Supervision in psychiatry residency serves several purposes with the foremost being review of patient cases to improve the resident’s skill and patient outcomes. In the midst of a patient crisis, guidance and solace from supervisors were imperative for the less experienced psychiatry residents. Insightful
recommendations and ideas from faculty 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, and encouraging and supporting residents through difficult situations. Each resident in this study reported supervisors who were constructive and helpful.

The staff are very motivating and 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 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. This is a very learning driven program. (Fourth Participant)

Supervision was most crucial in times of crisis. When a resident’s patient committed suicide, residents expressed gratitude that supervisors provided immediate assistance and were accessible and supportive.

Although I can say I have more than ten years’ practice behind my back, I lost one patient for the first time, here [U.S. residency]. One of my patients committed suicide successfully in the hospital [even] with all the possible safety measures. It was bad experience. I had my own personal reaction to this but then had to talk to risk management and the attorneys. It was intimidating. I felt bad for the patient and his family. This was stressful . . . It was difficult to sleep. I kept thinking of different scenarios. I questioned had I missed something. But the director and my supervisor were extremely supportive and helpful . . . I had some immediate support from my supervisor and the faculty. That was valuable. We kind of take that for granted, but I think this is crucial when you really need it. I can really appreciate more that they are accessible and can discuss our problems . . . I was able to move on and let go of my initial reactions. I also learned the importance of treating people not patients. These are people not just another patient. (Third Participant)

Touchet and Coon (2005) reported that resident training has undergone a recent transformation from didactic lectures to include more dynamic learning formats. When observing their professors, the residents found it a most meaningful experience and asked for observation and reflection to be utilized more.

The most valuable experience that I’ve had was the opportunity to watch somebody who’s really good at what they do, just model some of that for us. 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 then I can come up with something else. Some physical exams stuff is all pretty mechanical. 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. 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]. (First Participant)

One resident related feeling lost at times during psychotherapy sessions because of a fear of 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. It really does feel like you a bumbling along and don’t have a clue what you are supposed to do . . . If I don’t see one of the faculty showing us what to do, I’m just kind of guessing. Observing first, probably, that’s been the most helpful thing to me . . . One of my patients, I’ve been lucky was diagnosed as schizophrenic at the hospital. But I began thinking, this needs to be teased out. This lady was 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. With supervision, realizing this is PTSD. Maybe with the translator, I can get to more of the details that I can’t get just from having family members try to talk to me. (Second Participant)

Coupled with their supervision and didactic lectures, observation and reflection increased residents’ abilities, leading to meaningful patient interactions and a feeling of competency. The residents appreciated observing professors’ techniques.

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

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:

We have enough time to see all of our patients for almost an hour if we want to. 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. 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 . . . 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 treatment. I guess seeing somebody [patient] get better makes you feel like, wow, I can actually do this. I thought this whole year is going to be a terribly boring year, it’s not. (Third Participant)

Meaningful patient interactions added to their skill set. Patients were particularly challenging and diagnostically complicated, which enhanced their motivation and skill acquisition:

This patient had AIDS and had picked up secondary infections and depression. Because of my classes and training 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
sombody 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. 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 they [the medical
doctors] 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. 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
sometimes saving somebody is to let them have a natural end to
their life. My training helped my cope with this. 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. (Fifth Participant)

Difficult patients such as terminally ill or psychologically
traumatized patients stimulated the residents’ critical thinking
skills and were described as a foundation for their careers.
Each resident identified a notable patient encounter that
symbolized his or her attainment of competency.

The Importance of Overcoming Hurdles to
Acquire Their Psychiatric Skills

The fourth identified theme was the residents’ desire to be
competent as well as to experience class collegiality. At the
beginning of the academic year, discord plagued this residency
class. One early focus group clearly displayed early conflicts.

Resident A entered the focus group and handed Resident B the
form for her requested vacation time. Resident B responded
the form was incomplete. She bluntly stated the form needed to
have an additional section completed (which was a new
requirement) and that email was sent out 2 weeks ago. She
handed the form back to Resident A. Resident A replied that she
was sorry but she did not receive the email and that her form
should suffice. Resident B repeated that she would not accept
this form until it was completed. It needed another resident’s
signature agreeing to cover for emergency purposes. Resident A
in a heated tone replied “I know what this is all about. We all
know what you’re trying to pull!” After a tension filled moment,
the Resident A took back the form and looked over the
incomplete section. In a direct voice, she asked if Resident
would agree to cover and sign a new form. Resident B promptly
replied no. Resident A, then, turned to another resident and
asked her to cover and sign the form. The other resident stated
that she needed to check her schedule but would get back with
her [Resident A] after the focus group. As the year progressed,
the residency director and supervisors addressed the residents’
discord and reduced their conflicts. Another focus group
depicted this aspect. The Fourth Participant Resident confronted
another resident about hijacking the group topic away from the
topic she had introduced. He, the other resident, simply nodded
and did not become defensive. The Fourth Participant 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.

During a focus group, one resident summarized their
overall development.

Our challenge has been dealing with interpersonal issues
because this year we’ve got our classes all together . . . other
years, we’re all over the place. Now we’re in this environment
where we are all stuck together whether we like it or not. We are
thrown together because of work and learning, not because we
want to be best friends. It [Issues] come out of some
competitiveness between us and feeling like we need to show
something or come across in a certain way. I never really felt
myself in any competition until this year. I think this is the
balance a lot of doctors’ struggle with. Working with them
[third-year residents] can be challenging but now there is some
camaraderie which has kept us together. Working with different
and at times difficult personalitites. (Third Participant)

During formidable educational challenges, the residents
dug in their heels to overcome patient learning obstacles.
When their patients responded poorly, the residents exam-
ined what they could have done better:

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. (Second Participant)

This resident indicated that he thrived by overcoming
obstacles with his learning plans and tasks. During the focus
group, these residents’ abilities to cope with difficulties
matured.

Successful patient outcomes increased the residents’ confi-
dence, self-efficacy, professional composure, motivation,
and skills. Although lectures and supervision were helpful
during the beginning of the third year, the residents felt that
patient interaction was the most influential and meaningful
experience for development of competencies as a
psychiatrist.
Conclusion

The residents in this study experienced their education in diverse ways but identified common themes that connected the important factors of their education. The first theme about residency choice summarized the pressure the residents felt to find a compatible medical residency. Three of these residents suffered hardships along their educational path, which also predisposed their choice of a medical career. This theme was highlighted by the resident whose college was funded by a rehabilitation program. Overall, a fierce determination to enter psychiatry residency was evident.

The second theme was the importance of having models for observation and reflection prior to practice. Guidance and solace from supervisors were important for less experienced psychiatry residents. The residents described supervision as beneficial for their skill acquisition and appreciated the corrective feedback from their supervisors specifically during long frazzled days.

During the start of the third year, residents experience a shift from the controlled environment of inpatient psychiatry to the less predictable nature of outpatient psychiatry. As predicted by Kolb’s experimental learning model, when given the opportunity to observe their professors during patient interactions, residents identified this as the most noteworthy experience. After reflecting on their experiences, they adapted these observations to develop their own style, approach, and skill set. Multiple residents quoted the benefit of observing their supervisors. The importance of implementing experiential learning, team-based, problem-based, and evidence-based formats was supported.

The third theme concerned the shift to psychotherapy training. The third year afforded the residents an opportunity to meet with patients over an extended period of time and consult with expert faculty. These were the types of meaningful clinical encounters advocated by Ludmerer and Johns (2005). This theme was epitomized by the resident meeting with an AIDS patient. Extended patient exposure with such cases provided a foundation for the residents’ careers as evidenced by each resident identifying a notable patient encounter that epitomized their attainment of competency. Although many psychiatry residents dream of affluent practices with upscale patients, the residents in this study preferred meeting with complicated hardship cases. The opportunity to make a positive difference in patients’ lives was highly valued.

The last theme was overcoming hurdles. Success with patient outcomes increased the residents’ confidence, self-efficacy, professional composure, motivation, and skills. Critical incidents during their patient session helped the residents derive meaning from their newly learned psychiatric approaches as evidenced by the resident’s AIDS patient and the conflict among colleagues. This study revealed that patient interaction was the most meaningful experience of training rather than didactic instruction.

Future research implications include the need to further evaluate residents’ experience with competency assessment measures, learner-centered versus teacher-centered approaches, problems encountered with other complex diagnostic disorders, and the experiences of medical school students choosing a specialty and matching with a residency program.

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