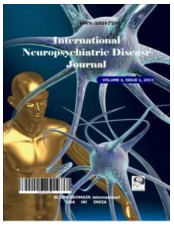

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Do Psychiatry and Family Medicine Residents Differ with Regard to Attitudes towards Treating Substance Use Patients

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Authors' contributions

Authorship credit was given on base on substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data; drafting the article or revising it.

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ABSTRACT

Background and Objective: Substance use disorders are a major health issue affecting many who present for treatment for psychiatric and medical problems. Substance use is associated with employment problems, relational difficulties, child abuse, stress and percentages of untimely deaths. Training and exposure has been shown to lessen negative stigmatizing attitudes towards the treatment of people suffering from substance abuse problems. In the current study, we investigated whether psychiatry and family medicine residents would have different attitudes towards these patients.
Methods: 23 psychiatry residents and 19 family medicine residents consented were asked write about the last substance abuse patient they treated to prime their memory and then complete a self-report that measures clinicians feelings about their patients.
Results: We found no statistical difference between the family medicine and psychiatry residents with regard to their attitudes and feelings toward SUDs patients they treat. Our results also showed that experience or year of training in the residency program was not linked with any significant different in scores on the CTQ scales.

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Conclusion: This result is interesting given that psychiatry residents often have much more training and exposure to this population than their peers in this family medicine residency. But less family medicine departmental hostility towards substance abuse patient as a whole, extra training in the field of addiction for the substance abuse treatment could be possible for this result.

Keywords: Substance use disorders; attitudes; family medicine; psychiatry.

1. INTRODUCTION

Substance use disorders (SUD) are a major health problem. SUDs account for 5.4% of the global burden of disease according to the World Health Organization [1]. Additionally, 4% of deaths are attributed to substance use [2]. Child abuse, family conflicts, stress, and unemployment have all been associated with SUDs [3]. Thirty-one percent of the homeless in America suffer from SUDs [4] and 60% of adults are in the federal prison system for drug related crimes [5] Only 24.1% of people with alcohol dependence ever seek treatment [6] and only 14.7% of people with substance dependence receive professional help [7]. Health professionals play a critical role in the identification of SUDs as many present for health issues other than substance use problems [8,9].

Research has shown that clinicians often harbor stigmatizing attitudes toward SUDs patients [10]. Findings show that clinicians have more negative feelings towards treating substance users then other patient groups such as those diagnosed with depression or diabetes [11]. Clinicians felt most strongly negative towards illicit drug users often feeling unwilling or unable to empathize with these patients [12]. A vignette study by Rao and colleagues [13] showed that more stigmatizing attitudes toward patients who were actively using substances compared to other mental health illnesses.

Familiarity and exposure to the SUDs population has an effect on how clinicians perceive these patients. Physicians who did not work in specialized addiction units showed the most negative feelings for these patients while those who worked on addiction services showed the most positive feelings [11]. Several studies have found that clinicians who have the most contact with the SUDs population reported more positive or different attitudes as compared to those who had little contact [14,15,16,17,18]. May and colleagues [17] found that anesthesiologists with a personal history of addiction also had a more positive attitude towards SUDs patients.

Some explanations for why clinicians on the whole have more negative feelings towards SUDs patients are that clinicians view them as emotionally challenging and potentially unsafe. Clinicians see these patients as violent, manipulative, rude, poorly motivated, and irresponsible [19,20]. One study found that clinicians felt that these dual diagnosis patients were complex and stressful to treat and clinicians felt frustration, resentment and powerlessness [21].

Studies have shown that education and training affect health professionals' attitudes toward SUDs patients [15,22,23,17]. Mental health clinicians reported that the availability and accessibility of supports and clinical supervision as very needed aspects of providing treatment to the SUDs population. Many times the clinician who is on the front line of treatment for these patients are the resident physicians. Shorter and Dermatis [24] found that only 19% of psychiatry residency directors reported that residents were paired with a supervisor for the SUDs patients they treat. In addition, they found that many of the residents were charged with the care of some of the most severe SUDs patients.

The current study looks to investigate if psychiatry residents have less negative reactions to the SUDs patients they treat than a cohort of family medicine residents. Since many patients with substance use disorders also have co-morbid psychiatric problems psychiatry residents should experience more exposure to these patients throughout their training. Family medicine residents often only get a brief rotation treating SUDs patients. We also expect that more senior residents in either psychiatry and family medicine would have less negative feelings about SUDs patients than their less experienced colleagues. Additionally, we also wanted to investigate if personal exposure to psychotherapy and substance abuse problems within their family would affect how they felt about SUDs patients they treated.

2. METHODS

2.1 Participants

Twenty-three Psychiatry residents and Nineteen Family Medicine residents took part in this **Institutional Review Board (IRB**) approved anonymous study. 26 were male with an average age of 33.1. 33.3% were Caucasian, 7.1% African American, 4.8% Hispanic/Latino, 40.5% Other. The breakdown in residents' year in training was as follows: PGY1-23.8%, PGY2-35.7%, PGY3-35.7%, PGY4-4.8%. 45.2% of the sample reported that they had psychotherapy experience. 61.9% were American Medical Graduates, 11.9% American born Foreign Medical Graduates, and 26.2% were Foreign Medical Graduates. All the residents who participated in this study were completing their residency training at Nassau University Medical Center.

2.2 Measures

Countertranference Questionnaire (CTQ; [25]) is a 79-item clinician rated questionnaire designed to provide normed, psychometrically valid assessment of countertransference (feelings the clinician has towards his or her patient). Past research using the CTQ have shown that the measure demonstrates good psychometrics and validity. The CTQ measures a wide range of thoughts, feelings, and behaviors expressed by clinicians toward their patients. The items were derived by reviewing the clinical theoretical and empirical literature on countertransference, related variables, and by soliciting the advice of several experienced clinicians to review the initial set of comprehensiveness and clarity. Items are written in everyday, jargon free language so that the instrument could be used by various clinicians. Through factor analysis, the CTQ was found to contain 8 scales / types of countertransference: *criticized / mistreated*, *helpless / inadequate*, *positive*, *parental / protective*, *overwhelming / disorganized*, *special / over involved*, *sexualized*, and *disengaged*.

2.3 Procedure

All family medicine and psychiatry residents were eligible for participation. The participants who consented to the study were asked to complete a study packet anonymously and leave it in the research box in the main outpatient building. First the participants were asked to think back to the last SUDs patient they treated no matter the setting and to write down the thoughts and feelings they had about this patient and experience. They were instructed not to write down any of the patients personal identifying information and if they had their packet would not be used. No packets were excluded for this reason. The purpose of asking them to recall and write down this information was to make this experience more salient in their memory. Similar procedures have been used in other social psychological research. They then completed the CTQ based on this patient and this experience. Participants also provided demographic information which included their gender, ethnicity, age, year in residency training, whether they were in the family medicine or psychiatry residency, amount of psychotherapy experience (broadly defined for this study-could be as providing psychotherapy or taking part in their own psychotherapy), whether they were foreign born or born in America, whether they attended medical school in America or in another country.

3. RESULTS

Table 1 contains the means and standard deviations of the demographic information and the study measures. To test our hypothesis that psychiatry residents would report less negative reactions to SUDs patients we ran t-tests between the two groups of residents for each of the scales of the CTQ. Table 2 contains the results of these t-tests. Our results showed no difference exists between the two groups. We ran an ANOVA to test whether more senior trainees reported less negative reactions than their less experienced peers. Our results also showed that experience or year of training in the residency program was not linked with any significant different in scores on the CTQ scales.

4. DISCUSSION

The results of our study found that psychiatry and family medicine residents showed no difference in the way in which they react to SUDs patients. This is surprising given that psychiatry residents often have much more training and exposure to this population than their peers in this family medicine residency.

Table 1. Means and standard deviations for study measures

	N	Mean	SD	Range
Years of training in residency	42	2.21	.87	1-4
Age of resident	42	33.14	6.11	26-55
CTQ hostile/mistreated	42	1.79	.21	1.11-2
CTQ helpless/inadequate	42	1.73	.23	1.22-2
CTQ positive/satisfying	42	1.67	.25	1-2
CTQ parental/protective	42	1.74	.26	1-2
CTQ overwhelmed/disorganized	42	1.88	.14	1.44-2
CTQ special/overinvolved	42	1.92	.14	1.4-2
CTQ sexualized	42	1.95	.10	1.6-2
CTQ disengaged	42	1.79	.23	1-2

Table 2. T-test results between psychiatry and family medicine residents on the CTQ

CTQ scales	Score				t
	Psychiatry residents (n = 23)		Family medicine residents (n = 19)		
	M	SD	M	SD	
Hostile/mistreated	1.79	.22	1.79	.21	.01
Helpless/inadequate	1.72	.22	1.74	.23	.39
Positive/satisfying	1.62	.27	1.73	.23	1.44
Parental/protective	1.70	.28	1.79	.21	1.10
Overwhelmed/disorganized	1.88	.14	1.89	.14	.36
Special/overinvolved	1.93	.11	1.91	.17	.58
Sexualized	1.95	.11	1.96	.08	.33
Disengaged	1.82	.22	1.75	.25	.90

Note: N = 183 women and 42 men. Two-tailed t tests were used to assess gender differences.
DO = Destructive overdependence; DD = Dysfunctional detachment; HD = Healthy dependency.
**p< .05*

Psychiatry residents not only complete rotations in substance use treatment units (specifically a detox unit and a 28-day chemical dependency unit) but also are regularly treat psychiatric patients who commonly have co-morbid substance use problems.

Although null results are hard to interpret we identified some possible explanations for our results post hoc. The family medicine residency is chaired by a physician who is also boarded in addiction medicine. Although the residents did not partake in extra training or experiences as a result it could be possible this had an effect. Additionally, research should investigate the difference between psychiatry and internal medicine or emergency medicine which does not specifically get any training in the treatment of SUDs but who assesses and treats many of them. Because the family medicine residents completed a rotation on the chemical dependency unit and also attended trainings during this time might have buffered the residents against having such negative feelings toward SUDs patients.

5. CONCLUSION

The current study contains a small sample of residents from one hospital. Although the residents are diverse in many ways this fact means that our results might not generalize to other locations. Future research should including samples of psychiatry and family medicine residents from a number of hospitals throughout the nation. Another reason that we did not see a difference could be related to the memory task we had the residents complete before completing the CTQ. Future studies should assess residents right after treating a SUDs patient because that is when their emotional reaction is the strongest. Future research should also look to identify the amount of experience and training one needs to have a significant effect on attitudes towards SUDs patients as this would help identify the training needs for these individuals.

ETHICAL APPROVAL

This research study was approved by IRB. I hereby declare that all experiments have been

examined and approved by the appropriate ethics committee.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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