Survey of Psychiatric Treatment Among Psychiatric Residents in Manhattan: Evidence of Stigma

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Objective: Psychiatric trainees seek personal psychiatric treatment for a variety of reasons including educational objectives, symptoms relief, or functional impairment. Data on the rate of psychiatric treatment among residents and the attitudes of residents toward personal treatment are limited. The purpose of this study was to determine the frequency and types of psychiatric treatment among residents and to assess residents' attitudes toward treatment.

Method: A 51-item questionnaire was mailed to all postgraduate year (PGY)-2 through PGY-4 psychiatric residents training in Manhattan in the spring of 2002 (N = 288). Questionnaires were anonymous. Significance was tested using McNemar test of symmetry, dependent-groups t tests, or 2-way contingency table analysis where appropriate. The study was conducted from March 2002 through June 2002.

Results: Forty-eight percent of residents returned the questionnaire. Among respondents, 57% were in individual psychiatric treatment, predominantly individual psychotherapy or psychoanalysis. The rate of medication treatment was 18%, corresponding to a 31% rate of medication use among those in psychotherapy. Residents felt that their training programs explicitly encouraged psychotherapeutic treatment but not medication treatment, and they were more likely to tell other residents and faculty about personal psychotherapy as compared with personal medication use. Residents felt that the use of medication carried "significant" stigma, while personal psychotherapy did not.

Conclusion: In this sample, residents believe there is "significant" stigma associated with the use of psychotropic medication, while psychotherapy is seen as a respected and valued educational and therapeutic experience. These findings deserve the attention of educators and emphasize the need for further research in this area.

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Psychiatric training programs, particularly those that emphasize psychodynamic psychotherapy, have traditionally encouraged residents to engage in psychodynamic psychotherapy because of the belief that personal treatment is a valuable educational experience. A study conducted in 1995 and 1996 that surveyed all psychiatric residencies in the United States (N = 196) had an 86% response rate and reported that 42% of training programs recommend personal psychotherapy for residents.[1] Numerous authors have advocated the educational benefits of personal psychotherapy for clinicians practicing psychodynamic psychotherapy.[2–5] Personal treatment is believed to sensitize the beginning therapist to the interpersonal needs and reactions of patients and also provides a laboratory to observe clinical methods and theory.[6]

However, there may be multiple reasons why a psychiatric resident seeks treatment. Studies suggest that irrespective of specialty, physicians may have higher rates of affective disorder and substance abuse compared with the general population. A review of 9 studies of mental health problems of young physicians[7] reported rates of significant depressive symptoms ranging from 7% to 29%. A survey of 2620 Canadian interns, residents, and fellows[8] assessed depressive symptoms using the Center for Epidemiological Studies-Depression Scale (CES-D). The response rate was 69%, and 23% of respondents had CES-D scores ≥ 16, which is strongly correlated with a diagnosis of major depressive disorder. A smaller study[9,10] used a structured interview by a psychiatrist and Feighner diagnostic criteria to evaluate depression in all first-year resi-

dents at the Barnes Hospital in St. Louis, Mo.; 30% of the sample (16/53) met criteria for major depression.

With respect to behaviors that are associated with depression, a national survey (N = 3000) found that U.S. residents had higher rates of alcohol and benzodiazepine use than age-matched peers.[11] Other studies support the finding of increased rates of alcohol use among residents and older physicians as well.[12–14] There are also data that suicide, an event associated with both affective disorder and substance abuse, is higher among physicians compared with both the general population and other professionals.[15,16]

Studies of the prevalence of psychiatric illness among psychiatrists and psychiatric residents are limited but consistently suggest that psychiatrists have high rates of depression and substance abuse. A national survey of U.S. residents in 11 specialties (N = 1754) found that psychiatric residents had the highest rates of marijuana and benzodiazepine use in the past year and were also more likely to use multiple substances. In addition, psychiatric residents had the second-highest prevalence of daily alcohol use (9.1%).[17] Studies of substance abuse among physicians suggest that psychiatrists may have higher rates of substance use compared with other physicians.[12,14]

With respect to the rate of depression among psychiatric residents in particular, studies are limited. Older studies investigating a range of psychopathology, including depressive symptoms and character pathology, report the rate of "emotional disturbance" among psychiatric residents to be between 4% and 22%, with the lowest estimates coming from research surveying training directors and the highest estimates coming from resident self-report surveys.[18–21] Studies also report higher rates of affective disorder in psychiatrists compared with other physicians, which is consistent with data that the suicide rate of psychiatrists is about twice that of physicians in general.[22,23]

Given the rates of affective disorder and substance abuse, psychiatric residents may seek treatment for relief of symptoms or functional impairment and not simply as an educational endeavor. Of the 5 previous studies that examine personal treatment among psychiatric residents, 2 took place in the 1950s and 1 in 1973: they report rates of personal psychotherapy for residents of 52% to 67%.[24–26] These studies were conducted at a time when the field of psychiatry was dominated by psychodynamic theory and training in psychodynamic psychotherapy was a prominent part of psychiatric residency. Consequently, the studies only assessed rates of psychodynamic psychotherapy. However, 2 recent studies of treatment among psychiatric residents,[27,28] both conducted in 1994, also assessed only personal psychotherapy and did not inquire about other types of treatment. A 1994 study surveyed the 1442 psychiatric residents in the United States but had only a 20% response rate. Of those who responded, 50% of PGY-4 residents were in psychotherapy and 10% were in psychoanalysis.[27] Weintraub et al.[28] surveyed the 3 psychiatric residency programs in Louisville, Ky. Of the 119 residents surveyed, 81% responded; 20% of respondents were in individual psychotherapy, and 78% of those in treatment cited personal reasons rather than educational objectives as the primary reason they started treatment.

These recent studies of treatment among psychiatric residents only assessed personal psychotherapy: no study assessed the use of psychotropic medication among residents. This striking omission may reflect a continuing bias that psychotherapy for residents is seen primarily as an educational endeavor, whereas the use of psychotropic medication signifies psychopathology. Therefore, for residents to report on psychotherapy treatment carries no stigma, whereas any discussion of medication is potentially shameful and stigmatizing.

The purpose of this study was to determine the prevalence and types of psychiatric treatment among residents, including rates of medication use, and to assess differential attitudes toward medication and psychotherapy. Our hypothesis was that the psychiatric resident experiences the personal use of psychotropic medication as shameful and fears that it will lead to stigmatization if revealed to colleagues. In contrast, participation in personal psychotherapy is considered to be a valued part of professional training and, as such, raises little fear of stigmatization.

METHOD

Procedure

A 51-item questionnaire (available from the authors by request) was developed that documented current and past psychiatric treatment, attitudes toward treatment, and reason for starting treatment. Subjects were also asked whether or not personal treatment was encouraged within their training programs and to assess the influence of their personal treatment on their professional role as psychiatrists, e.g., whether their personal treatment experience affected the recommendation of various treatment modalities to patients. Finally, a series of questions was designed to assess attitudes about personal psychiatric treatment, including the use of medication. On a 5-point Likert-type scale, subjects were asked to rate the presence or absence of stigma with respect to psychotherapy and psychotropic medication use both within their training programs specifically and within the field of psychiatry in general. A "1" on the scale indicated little or no stigma, and a "5" indicated "significant" stigma. Likewise, subjects were asked to rate if there was any positive regard toward psychotherapy or medication use within their training programs using a similar 5-point scale on which a rating of "1" represented little or no positive regard and a "5" represented "significant" positive regard. Subjects were also asked about their willingness to discuss their personal treatment with 6 different categories of people

within their training program, e.g., residency training director, supervisor, other resident. The survey instrument takes 15 to 20 minutes to complete.

Participants

Given the sensitivity of the information asked in this survey, it was necessary to balance the desire to acquire demographic information about participants with the desire to insure confidentiality. We were concerned that asking for demographic data would increase residents' concerns about confidentiality, especially since some programs have small numbers of residents. Therefore, to maximize response rate, the only demographic data collected were training program and postgraduate year (PGY).

The decision to initially study only residents in Manhattan was made to increase the feasibility of completing the project with a reasonable response rate. Residency directors and chief residents at each program received an introductory letter explaining the purpose and design of the study as well as a follow-up phone call to answer questions and enlist cooperation with the survey. Lists of residents (N = 288), along with their mailing addresses, were obtained directly from the administrator or training director of each program.

The study sample consisted of all PGY-2 through PGY-4 psychiatric residents training in a program in Manhattan during the spring of 2002. Child psychiatry and other trainees were not included in the sample. Subjects received an introductory letter explaining the purpose of the project and clarifying that participation was anonymous and voluntary. Subjects were then sent the survey instrument with a return stamped envelope addressed to the research assistant at the Columbia Psychoanalytic Center. This study was approved by the Institutional Review Board (IRB) at the New York State Psychiatric Institute (IRB protocol #4340). The study was conducted from March 2002 through June 2002.

Statistical Analysis

Our central hypothesis was that psychiatric residents would experience the personal use of psychotropic medication as shameful and therefore would be inclined to tell fewer people about medication use. At the same time, we expected that psychiatric residents would not experience their participation in personal psychotherapy as shameful and would be willing to tell more people about their experience. To test this hypothesis, we first classified participants according to the way they responded on the 5-point Likert-type scale measuring the perception of stigma associated with either medication use or psychotherapy. We classified respondents as reporting little or no stigma (a 1 or 2 on the scale) or as experiencing stigma (a 3 or more). We then tested disagreement among these 2 dichotomous variables (medication stigma and psychotherapy stigma) using McNemar test of symmetry, which tests whether there is a significant discrepancy in how respondents were classified with respect to stigma for either psychotherapy or psychotropic medication use. The test statistic is a χ^2 with 1 degree of freedom. Analyses for positive regard toward psychotherapy or psychotropic medication use were conducted similarly. To test whether psychiatry residents would tell more people about their participation in psychotherapy versus the use of psychotropic medication, we used a paired-samples or dependent-groups t test. All other analyses (e.g., tests of association between 2 categorical variables) were conducted using 2-way contingency table analysis (χ^2 test of independence). For all rates, percentages were rounded to the nearest whole number.

Table 1. Response Rate by Program in a Survey of Psychiatric Treatment Among Psychiatric Residents in Manhattan

Program No.	No. of Surveys Received/ Residents in Program, N	Response Rate, %
1	5/32	16
2	4/14	29
3	4/13	31
4	6/18	33
5	13/39	33
6	14/31	45
7	25/51	49
8	7/14	50
9	22/32	69
10	9/12	75
11	28/32	88

RESULTS

The questionnaire was sent to 288 residents (108 PGY-2s, 101 PGY-3s, and 79 PGY-4s) distributed across the 11 psychiatric training programs in Manhattan.

Response Rate

The overall response rate was 137/288 (48%), and the response rate by postgraduate year was 55/108 (51%), PGY-2; 51/101 (50%), PGY-3; and 30/79 (38%), PGY-4. One respondent did not indicate program year. There was no statistically significant relationship between program year and response rate ($\chi^2 = 3.74$, df = 2, $p < .2$). Response rates across the 11 training programs were not uniform, as shown in Table 1. Three programs, numbers 7, 9, and 11, contributed a disproportionately high number of respondents. These 3 programs made up 115/288 participants (40%) invited to take part in the study, but they comprised 75/137 respondents (55%) ($\chi^2 = 23.9$, df = 1, $p < .001$). This differential response rate warranted attention in order to detect possible differences between these 3 programs and the rest of the sample, particularly because programs 7, 9, and 11 are each formally affiliated with a university-based psychoanalytic institute and, as

Table 2. Rates of Medication Use by Medication Type Among Psychiatric Residents in Manhattan

Medication Type	Total N[a]	Percentage Using Medication
Antidepressant	19	76
Hypnotic	6	24
Anxiolytic	5	20
Stimulant	2	8
Antipsychotic	1	4
Mood stabilizer	1	4

[a]Four subjects (16%) reported taking 2 medications; 3 subjects (12%) reported taking 3 medications; 1 subject (4%) did not indicate the type of medication.

such, might have different educational foci and quite possibly include more exposure to psychodynamic and psychoanalytic concepts. The other programs in the sample do not have formal affiliations with psychoanalytic institutes. For this reason, certain survey items were subjected to additional analysis to assess possible differences in response patterns for respondents from programs 7, 9, and 11.

Current Treatment

Overall, 78/137 respondents (57%) were currently in treatment. Of those in treatment, 53 reported that their treatment was psychotherapy only, 24 reported combination treatment with psychotherapy and psychotropic medication, and 1 reported psychopharmacologic treatment alone. Overall, 25/137 respondents (18%) reported psychotropic medication use (Table 2), corresponding to a 31% (24/77) rate of medication use among those residents in individual psychotherapy. Respondents from programs 7, 9, and 11 reported higher rates of treatment (59/75 [79%]), when compared with the rest of the sample (19/62 [31%]). The association between being a resident from program 7, 9, or 11 and being in treatment was statistically significant ($\chi^2 = 31.92$, df = 1, $p < .001$).

Of the residents in treatment, 58/78 (74%) began their treatment during residency and 20/78 (26%) began treatment before residency. There were no statistically significant relationships between program year and rate of treatment, with 30/55 PGY-2s (55%), 33/51 PGY-3s (65%), and 14/30 PGY-4s (47%) in treatment ($\chi^2 = 2.664$, df = 2, $p < .26$).

Characteristics of Psychiatric Treatment

Forty-seven of 78 respondents (60%) indicated that "personal issues" were their primary motivation for treatment, and 17/78 (22%) indicated that "educational value" was their motivation for treatment. Although the question was presented as a forced-choice item, 14/78 (18%) indicated that they entered treatment for both personal issues and educational value. There was no statistically significant association between being a respondent from program 7, 9, or 11 and the primary motivation for treatment ($\chi^2 = 3.299$, df = 2, $p < .192$).

Fifty-nine of 77 residents (77%) in individual psychotherapy reported being in psychodynamic psychotherapy, 10/77 (13%) in psychoanalysis, and 1 (1%) in supportive psychotherapy; 7/77 (9%) indicated that their treatment was eclectic, with psychodynamic, supportive, and cognitive-behavioral elements. No resident reported being in a psychotherapy that was primarily cognitive-behavioral or interpersonal. Three of 137 (2%) were in couples/marital therapy, and 1/137 (< 1%) reported attending a 12-step program. There were no residents in group psychotherapy.

Prior Treatment

Sixty-five of 137 respondents (47%) reported being in psychiatric treatment that terminated prior to the study or prior to their current treatment. In terms of lifetime rates of treatment, 97/137 (71%) reported some form of psychiatric treatment during their lives, with 96/137 (70%) having been in psychotherapy and 37/137 (27%) reporting psychotropic medication use; 36/96 residents (38%) who had been in psychotherapy were also prescribed a psychotropic medication at some point during the course of psychotherapy.

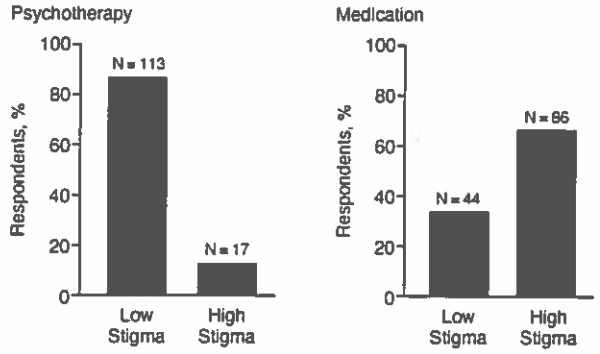
Perceptions of Whether Treatment Was Overtly Encouraged Within the Training Program

One hundred twelve of 137 respondents (82%) reported that their program encouraged residents to seek psychotherapeutic treatment, while 38/137 respondents (28%) reported that their program encouraged medication treatment if indicated. Respondents from programs 7, 9, and 11 were more likely to report that their program encouraged personal psychotherapy, and this association was statistically significant ($\chi^2 = 11.667$, df = 1, $p < .001$). There was no statistically significant relationship between a respondent being from program 7, 9, or 11 and his or her report of whether psychotropic medication treatment was encouraged ($\chi^2 = .006$, df = 1, $p < .940$).

Attitudes and Perceptions About Treatment Within the Subjects' Training Program

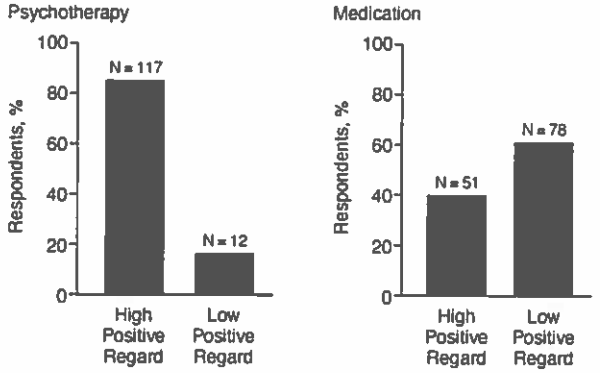
Seven respondents did not completely answer the item in which participants were asked to rate their perception of stigma within their training program with regard to personal psychotherapy versus personal psychotropic medications use. Of the 130 respondents who answered the question completely, 113 (87%) felt that personal psychotherapy held little or no stigma (a 1 or 2 on the 5-point scale), while only 44/130 (34%) reported that psychotropic medication use held little or no stigma (Figure 1). Of those who felt personal psychotherapy held little or no stigma, 70/113 (62%) felt that psychotropic medication use held moderate to significant stigma (3 or more on the 5-point scale). Conversely, 86/130 respondents (66%) felt that psychotropic medication use held moderate to

Figure 1. Ratings of Stigma Within Psychiatric Residency Program: Psychotherapy Versus Medication (N = 130)[a]



[a]Significant difference in ratings ($\chi^2 = 6.830$, df = 1, $p < .009$).

Figure 2. Ratings of Positive Regard Within Psychiatric Residency Program: Psychotherapy Versus Medication (N = 129)[a]



[a]Significant difference in ratings ($\chi^2 = 8.651$, df = 1, $p < .003$).

"significant" stigma, but the majority of those (70/86 [81%]) felt that psychotherapy held little or no stigma. The tendency to rate psychotropic medication use as having moderate to "significant" stigma while rating psychotherapy as having little or no stigma was statistically significant ($\chi^2 = 6.830$, df = 1, $p < .009$). Similarly, as seen in Figure 2, respondents were more likely to rate personal psychotherapy as having positive regard within the training program, while psychotropic medication did not. This association was statistically significant ($\chi^2 = 8.651$, df = 1, $p < .003$).

The stigma ratings of those currently in treatment were analyzed separately to detect any associations between the type of current treatment and stigma rating. This was done by separately analyzing the stigma ratings for the 53 residents in psychotherapy only and the 25 residents taking medication. With regard to the 53 residents in psychotherapy alone, there was no statistically significant relationship between a report of psychotherapy treatment and stigma ratings for either psychotherapy or psychotropic medication use ($\chi^2 = 0.250$, df = 1, $p < .617$ and $\chi^2 = 0.737$, df = 1, $p < .391$, respectively). Similarly, for the 25 respondents who reported psychotropic medication use, there was no statistically significant relationship between medication use and stigma ratings for either psychotherapy or psychotropic medication use ($\chi^2 = 0.035$, df = 1, $p < .852$ and $\chi^2 = 0.348$, df = 1, $p < .555$, respectively).

Table 3. Number of Residents Willing to Reveal Use of Psychotherapy or Medication to People Typically Found Within a Residency Training Program[a]

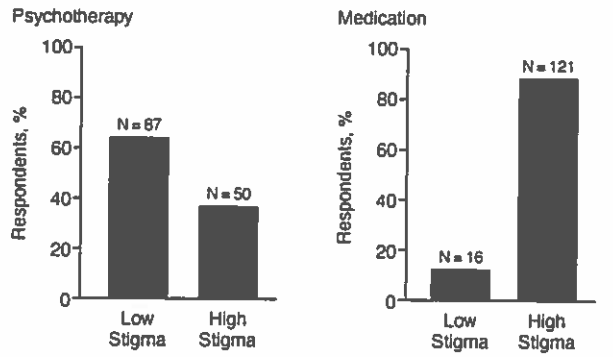
Person Within Residency Program, by Category	Would Tell That Person About Personal Psychotherapy, N	Would Tell That Person About Personal Medication Use, N
Residency training director	113	31
Course director	83	6
Psychotherapy supervisor	122	20
Unit attending	82	6
Any resident	80	3
Other faculty	56	5

[a]All differences statistically significant with $p < .0001$ (McNemar test).

Ratings of stigma and positive regard were also analyzed for respondents from programs 7, 9, and 11. There was a statistically significant relationship between being a resident from 1 of these 3 programs and rating psychotherapy as having little or no stigma ($\chi^2 = 8.847$, df = 1, $p < .003$). There was no statistically significant relationship between being a resident from 1 of these programs and the stigma rating for medication use ($\chi^2 = 2.571$, df = 1, p = NS). Respondents from programs 7, 9, and 11 were more likely to rate psychotherapy as having positive regard within their training program, with 75/75 (100%) reporting that personal psychotherapy held positive regard, compared with 49/61 (80%) of the respondents from the rest of the sample (1 person did not answer the question). This association was statistically significant ($\chi^2 = 16.182$, df = 1, $p < .0001$). There was no statistically significant relationship between being from programs 7, 9, or 11 and the positive regard rating for medication use, with residents uniformly reporting that psychotropic medication use held little positive regard ($\chi^2 = .457$, df = 1, $p < .499$).

From a list of 6 people typically found within a training program, respondents reported that they would tell more of those people about personal psychotherapy as opposed to personal pharmacotherapy (Table 3). From the 6 categories of people presented on the survey instrument, respondents indicated that they would tell a mean of 3.91 (SD = 2.07) people about personal psychotherapy and would tell a mean of 0.52 (SD = 1.10) people about personal pharmacotherapy. This difference was statistically

Figure 3. Ratings of Stigma Within the Field of U.S. Psychiatry: Psychotherapy Versus Medication (N = 137)[a]



[a]Significant difference in ratings ($\chi^2 = 7.151$, df = 1, $p < .007$).

significant ($t = 17.863$, df = 136, $p < .0001$). In order to assess if those respondents currently taking medication would answer the question differently, we separately analyzed the responses of those respondents currently taking medication (N = 25). A similar result was found. Those taking medication would tell a mean of 4.44 (SD = 1.92) people about personal psychotherapy and a mean of 0.68 (SD = 1.41) people about personal pharmacotherapy ($t = 8.605$, df = 24, $p < .0001$).

Residents' Beliefs About U.S. Psychiatrists' Attitudes Toward Treatment

When asked to rate their perceptions of stigma within the field of U.S. psychiatry as a whole, 87/137 (64%) of respondents felt that psychotherapy held little or no stigma, while only 16/137 (12%) felt that medication use carried little or no stigma (Figure 3). Of the 87 people who felt that psychotherapy carried little or no stigma, 72/87 (83%) felt that medication use carried "significant" stigma. The tendency to rate medication use as having more stigma than psychotherapy was statistically significant ($\chi^2 = 7.151$, df = 1, $p < .007$). Results were similar for respondents from programs 7, 9, and 11. Unlike the within-program stigma ratings, there was no relationship between being a respondent from 1 of these 3 programs and stigma ratings for psychotherapy ($\chi^2 = .239$, df = 1, $p < .625$). Similarly, there was no relationship between being a respondent from 1 of these 3 programs and stigma ratings for medication use ($\chi^2 = .165$, df = 1, $p < .685$).

Influence of Personal Treatment on Professional Practice

Of those in current or prior psychotherapy, 91/96 (95%) reported that their treatment was a valuable educational experience, and 91/96 (95%) felt their own psychotherapy served as a positive model for how they conducted psychotherapy with their own patients. Sixty-four of 96 (67%) reported that personal psychotherapy made them more likely to recommend psychotherapy for patients.

Of those who had taken medication, 14/37 (38%) reported that personal pharmacotherapy had made them more likely to prescribe medication for patients. Twenty-three of 37 (62%) reported that personal medication use influenced their choice of medication for a patient on at least 1 occasion.

DISCUSSION

To our knowledge, this is the first study to examine the rate of both psychotherapy and psychotropic medication treatment among residents. In this sample, 56% of respondents were in psychotherapy, and 31% of residents in psychotherapy were prescribed psychotropic medication. Overall, there was an 18% rate of psychotropic medication use among all respondents, and the vast majority (96%) of those taking medication were also in psychotherapy. The rate of psychotherapy in this sample is higher than that found by Weintraub et al. among residents in Louisville, Ky., (20% rate of personal psychotherapy) but is consistent with previous studies showing rates of personal treatment among residents between 52% and 67%.[24–26,28] The rates of medication use among those in psychotherapy are comparable to rates of psychotropic medication use found in samples of patients in psychoanalysis.[29,30]

A striking finding was that residents in this sample believe that there is significant stigma associated with the use of medication. In comparison, psychotherapy is seen as a valued and educational therapeutic experience without stigma. Residents felt this to be true not only within their own programs but within the field as a whole. Residents were less willing to reveal the use of psychotropic medication compared with personal psychotherapy, and this bias was even more pronounced among the residents currently taking medication. This strongly suggests that the experience of taking psychiatric medication does little to relieve concerns about stigma.

Numerous authors, particularly those with a psychodynamic orientation, have argued the educational benefits of personal psychotherapy, including the idea that personal psychotherapy allows clinicians to develop conviction about the validity and efficacy of psychotherapy.[6] Residents in this survey supported this assertion, with the majority of respondents (67%) who had been in psychotherapy reporting that they were more likely to recommend psychotherapy to patients as a result of their own experience. However, a focus on psychotherapy as "educational" may hinder an open acknowledgment of the need for treatment among residents and may exacerbate a dichotomy in which psychotherapy is seen as a useful part of training, whereas medication use is viewed as a marker

of psychopathology. This may be particularly problematic given that research strongly suggests that psychiatric residents have rates of certain psychiatric disorders that are comparable to, if not higher than, the general population. In fact, the majority of respondents in this sample began treatment for noneducational reasons. This finding is similar to the results found by Weintraub et al., in which 78% of residents in their sample entered treatment for personal reasons.[28]

The lack of data about psychotropic medication use among psychiatric residents may itself be an indication that, as a field, we do not acknowledge psychiatric illness in ourselves or our colleagues. Furthermore, the labeling of certain treatments, such as psychotherapy, as primarily educational may reflect the same unwillingness to openly acknowledge need for treatment. There may, indeed, be an educational benefit to personal psychotherapy for psychiatrists and other mental health professionals, but to continue to promote psychotherapy, a treatment utilized for a range of Axis I and II disorders, as primarily educational may be perpetuating the stigma associated with psychiatric illness. This study suggests that psychiatric residents may have the same negative attitudes about psychiatric illness found in the general population, specifically that a need for psychotropic medication defines someone as "really" sick and perhaps unreliable, and consequently, that individual is vulnerable to social repercussions. At the very least, residents taking psychotropic medication fear that they will be seen negatively by others.

This study has some significant methodological limitations. Most notably, a 48% response rate necessitates caution in the confidence and interpretation of these results. Furthermore, the nature of the resident sample raises questions about the generalizability of the results. Manhattan contains a number of residency programs that emphasize psychodynamic training, and thus may be different from training programs in the rest of the country. In addition, in this sample, there was a higher response rate from programs that were associated with psychoanalytic institutes, programs that may have a stronger psychodynamic emphasis than the other programs in the sample. Finally, the culture of New York City is often portrayed in films, literature, and cartoons as promoting psychotherapy, and this culture may have impacted these results in a way that further impacts generalizability.

Nonetheless, the results of this study deserve the attention of psychiatric educators. It may be that educators could do more to help identify and dispel negative attitudes about psychiatric illness and treatment. In much the same way that celebrities and public figures have helped to dispel myths about psychiatric illness and make treatment more acceptable in the general public, similar strategies might be attempted within academic departments. If senior, respected members of departments were willing to share their experiences with psychiatric illness and treatment, it may help challenge possible implicit beliefs that psychiatric treatment, particularly medication use, is shameful and something to be hidden. There is a difference between privacy and secrets. Although personal medical information is not often shared in a public or an educational setting, it may be that discussing a personal medical illness might hold less stigma than admitting to psychiatric illness. Unfortunately, we did not test this hypothesis, and this issue would be an important consideration for future research.

The disheartening finding that residents associate stigma with the use of psychotropic medication may have profound implications for residents' personal psychiatric treatment as well as their treatment of patients. Although this study documents only the attitudes of psychiatric residents, it is probable that the stigma associated with psychotropic medication use extends beyond residency and is prevalent in the field as a whole. Educators, administrators, and clinicians must consider their role in the genesis and perpetuation of these attitudes.

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