likely than anxiety disorder patients to have experienced severe sexual abuse.

No relationship was found between sexual abuse and PTSD severity scores. The reason may be that patients were allowed to rate PTSD symptoms in relation to the traumatic event that had the most profound impact on their life, which was sometimes unrelated to sexual abuse.

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Medication Backup: Attitudes and Practices of Psychiatrists and Residents

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Twelve residents and 12 attending psychiatrists in the adult division of a university-based department of psychiatry responded to a 20-item questionnaire about medication backup, or the provision of psychotropic medications for a patient treated in psychotherapy by another clinician. The attending psychiatrists and residents did not differ significantly in their attitudes about and practices of medication backup. Results of this preliminary study indicated that about half of both groups saw between one and five patients a month for this purpose. All except one respondent believed that medication backup may have a detrimental effect on treatment. (*Psychiatric Services* 48:536–538, 1997)

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Medication backup is the provision of psychotropic medications for a patient treated in psychotherapy by another clinician (1). Although the literature on this topic is scant, medication backup is a growing treatment modality. Of great concern is that little or no consensus exists about the ethical and clinical appropriateness of medication backup, the optimal management of this treatment format, the delineation of responsibility between the treating clinicians, the training necessary to effectively participate in this type of care, which diagnostic groups of patients would most or least benefit from a medication backup arrangement, or the effects of this treatment format on clinical outcome.

The development of medication backup predates the extensive use of psychotropic medications. In 1947 Fromm-Reichmann (2) suggested that in a psychoanalytic hospital, one clinician should assume the role of "manager" and one should function as the psychotherapist. Psychiatrists continued to participate in interdisciplinary treatment as the community mental health movement unfolded. Many

psychiatrists found working in community mental health centers to be very unsatisfying, often because they were relegated to providing medication backup for large numbers of patients (3).

In 1973 the American Psychiatric Association published a series of guidelines for the standard of care for psychiatrists involved in interdisciplinary treatment (4). The document emphasized respect for other disciplines and the right of each to set its own training and practice standards. The guidelines stated clearly that the psychiatrist must always retain primary responsibility for the overall care of the patient whether in medical or nonmedical settings.

In 1980 the American Psychiatric Association again published guidelines for concurrent care with other clinicians in an attempt to resolve questions that had arisen since the 1973 position paper (5). A new conceptual model was offered. The nature of the relationship between the psychiatrist and the psychotherapist could be described as consultative, supervisory, or collaborative.

The foregoing were recommendations and statements of policy. Little empirical work had been done to assess the prevalence of medication backup. Beitman and colleagues (6) conducted a survey of psychiatrists and psychologists in the state of Washington to determine the prevalence of medication backup and to examine differences between clinicians who participated in this treatment format and those who did not. They found that 63 percent of the psychiatrists saw at least one patient for medication backup in the month before the survey and that most saw two or three such patients.

A study by Goldberg and associates (7) gathered data on psychiatrists' attitudes toward medication backup. One shortcoming of this work was that only the prescribing psychiatrist's attitudes were studied, leaving the attitudes of the psychotherapist unexplored.

The studies described above applied largely to fully trained clinicians in an outpatient setting. Vasile and Gutheil (8) wrote about the difficulties experienced by trainees in providing medication backup in a hospital setting. They discussed both the practical and the emotional problems that arose and distinguished between factors related to the patient, resident, psychotherapist, and milieu. Patient factors included "splitting" and valuing one clinician over the other.

McNutt and colleagues (9) addressed the dilemmas faced by residents providing medication backup for more seasoned psychotherapists in an outpatient setting. They discussed the self-confidence problems the residents reported when working with an experienced psychotherapist whose relationship with the patient is often better developed.

Riba and associates (10) surveyed directors of psychiatric residency training across the United States about the prevalence of formal training for psychiatric residents in medication backup, the requirement of residents to provide this service, and attitudes about the importance of medication backup. Eighty-five percent of the responding programs required residents to provide this service. These findings represent the context for the study reported here, which explored differences between attending psychiatrists and residents in practices of medication backup and attitudes toward it.

Table 1

Practice patterns and attitudes of 12 attending psychiatrists and 12 psychiatric residents surveyed about medication backup

Survey item	Attending psychiatrists		Residents	
	N	%	N	%
Practice patterns				
See one to five patients per month in medication backup	5	41	6	50
See each medication backup patient monthly	6	50	10	83
Have monthly contact with the collaborating therapist	3	25	6	50
Believe medication backup is a growing part of my practice	4	33	8	66
Attitudes				
Think medication backup may create additional obligations for the psychiatrist	5	41	10	83
Think medication backup may have a detrimental effect on treatment	11	92	12	100
Feel satisfied with my current participation in medication backup	11	92	7	58

Methods

Our survey instrument consisted of a six-page, 20-item self-report questionnaire that relied entirely on closed-ended questions. The survey was mailed to all attending psychiatrists (N=24) and psychiatric residents in postgraduate years 2 through 4 (N=22) employed by the department of psychiatry of the University of Michigan in the adult clinical division. No follow-up was done, either by letter or telephone call.

Because the data consisted of categorical frequency information, we used a chi square test to assess whether the differences between the practices and attitudes of residents and attending psychiatrists approached statistical significance.

Results

Forty-six surveys were mailed to faculty and residents, and 24 were returned, for a total response rate of 52 percent. Twelve of the 24 attending psychiatrists (50 percent) and 12 of the residents (56 percent) responded. Table 1 shows the differences between attending psychiatrists and residents in practice patterns and at-

titudes. No significant differences between the two groups were found.

Discussion and conclusions

This study was of limited scope. Our sample was a very small group of residents and faculty in a single university medical center. We did not send a follow-up survey asking nonrespondents why they did not return the survey. Our total response rate was only 52 percent, and our statistical analysis indicated no significant differences between attending psychiatrists and residents in practices and attitudes related to medication backup. The lack of statistical significance is likely a function of small sample size. Therefore, the results of this modest study are presented to add to the limited literature on the topic of medication backup.

In our study, the responding residents and attending psychiatrists saw comparable numbers of patients in medication backup arrangements; about half of each group saw between one and five patients a month. Residents were as likely as attending psychiatrists to believe that further obligations for the psychiatrist are created by these arrangements. They agreed that medication backup could create treatment problems.

Residents were not as likely as attending psychiatrists to feel satisfied with their current participation in medication backup, but the difference was not significant. Satisfaction was presented as a unitary concept, and it was not clear if dissatisfied clinicians would wish to participate to a greater or lesser extent in medication backup or what changes would make them feel more satisfied. The issue of satisfaction may also have had an impact on whether or not medication backup was viewed by both groups as a growing part of their practices.

At the time of the study, no additional training in the practice of medication backup was given to our residents. We have since added a series of core didactic sessions on this subject in the third and fourth postgraduate years. In the curriculum we have begun to emphasize the role definitions and explicit responsibilities of residents who are providing medication backup and the need for clear communication between the psychiatrist and the therapist. Finally, in both psychopharmacology and psychotherapy supervision, residents with faculty supervisors are now asked to review their practice patterns and attitudes toward medication backup and their possible impact on patient care. Future studies should systematically explore such curricular and clinical supervisory needs and determine the impact of these changes on patient care, outcome, and training. ♦

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