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Reflective Team Supervision After a Frightening Event on a Psychiatric Crisis Service

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Objective: *The authors demonstrate the value of reflective team supervision as part of the informal curriculum in an emergency psychiatry setting after a potentially traumatizing adverse event.*

Method: *The article gives a case presentation of a violent adolescent who eloped from his hospital Emergency Department and provides a description of team supervision sessions that facilitated informal learning for residents and medical students after this event.*

Results: *Reflective team supervision sessions after this event resulted both in improved resident well-being and learning opportunities, as well as hospital quality improvement designed to prevent future elopements.*

Conclusions: *Reflective team supervision can be an essential component of trainee education to enhance residents' well-being and to promote both systems-based practice and practice-based learning. This can be an excellent forum to explore themes of humility, self-reflection, and professional growth.*

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Emergency psychiatry work, especially dealing with suicidal or homicidal patients, can be emotionally distressing for mental health workers. In a phenomenological study of young physicians' response to suicidal patients, Hoifodt et al. found that physicians report "pain, anger, and annoyance" when confronted with patients' suicidal behavior and they felt "sadness and guilt" in the aftermath of a suicide (1). Similarly, other publications have noted high rates of stress and burnout in crisis mental health clinicians (2–4).

The need for trainee supervision in emergency psychiatry is magnified after frightening adverse events, when trainees may experience stress, trauma, or self-blame. After such events, the role of the supervisor extends beyond teaching and evaluating, to include being a stabilizing figure and modeling appropriate reactions—functions that constitute part of what have been described as the informal or "hidden" curriculum in medicine. The goal of this article is to demonstrate the value of informal, reflective team supervision in crisis/emergency psychiatry in ensuring high-quality patient care as well as promoting trainee well-being.

Case Report

A 17-year-old boy was brought to the pediatric emergency department (PED) by the police on a 72-hour psychiatric hold for being a "danger to others." The previous day, he had reportedly told a teacher at his high school that he wished to have the police kill him, and that he wanted to stab a police officer, take away his firearm, and start shooting at people. The patient was allowed to return home that day. However, the next day, the school contacted the police, who then transported him to the hospital. According to the police, "improvised weapons" were found in his backpack, along with "anti-government journal entries." The patient was assigned a "sitter" aide in the PED and two

members of the child and adolescent psychiatry team—a medical student and a fourth-year general psychiatry resident—arrived to evaluate him.

During this initial evaluation, the patient appeared guarded and refused to answer most questions. He was observed to be well-groomed, with long hair in a pony-tail, wearing a hospital gown, and occasionally making darting glances around the room. He took long pauses before answering questions, and he seemed irritated. When asked about his mood, he simply shrugged his shoulders. He became visibly more agitated when asked about his family, and suddenly stood up, removed his gown, and, after quickly putting his clothes on, stated “I’m getting the f*** out of here.” He ran out, and a Psychiatric Code was called. The patient managed to run out of the hospital into the street. A police officer stopped his car to apprehend him, but the patient grabbed the officer’s gun and threatened him with it. The officer was able to subdue him only with the assistance of a passer-by. The patient was brought back to the hospital in handcuffs.

At this time, he was evaluated, cuffed to a bed, by the attending child and adolescent psychiatrist while other members of the Child Crisis Team watched. The patient revealed that he had been depressed and angry for “a long time,” and that both of his parents had died when he was 14. His father died in front of him, and he expressed feeling guilty for not having been able to prevent it. Because no relatives would take them in, the patient was living with his 23-year-old brother, a musician struggling with obsessive-compulsive disorder (OCD). They had been threatened with eviction and had few resources. The patient had no past psychiatric history, and denied medical problems. Family psychiatric history was significant only for his brother’s OCD.

He reported his mood as “indifferent;” however he appeared sad and distrustful, and his affect was intense, with full range. There was no evidence of thought disorder, and he denied suicidal or homicidal thoughts. He explained that his elopement and scuffle with the police had been part of a plan to go on a shooting rampage that would make him famous, but lead, eventually to his own death. However, when he was asked what he would desire if he had “three wishes,” he stated that he wished “that this didn’t happen.” Drug screening and urinalysis were both negative.

Discussion

Throughout the week after this event, the Child Crisis Team (CCT)—an attending child psychiatrist, two medical

students, two child psychiatry fellows, and one fourth-year general-psychiatry resident—held a series of meetings reviewing the details of the case to acknowledge its emotional impact and to identify and begin to address systemic problems.

Emotional Impact on Crisis Team Members

This case weighed heavily on members of the CCT because the traumatic events were not just reported to them, but unfolded before them in the PED and right outside the hospital. Several team members expressed dread at the thought of what might have happened had the youth successfully commandeered the police car and gone on his intended rampage. To ensure the team that it would be safe to reveal their personal reactions, the attending psychiatrist reported his own trauma-related nightmare and asked for other personal reactions (5). Team members expressed preoccupation with this case when at home: the medical student who had initially interviewed the patient also reported having nightmares, and others had awakened in the middle of the night thinking about the case, mentally re-enacted the scenario, or considered what might have been done differently. The medical student and the general-psychiatry resident who first interviewed the patient appeared the most emotionally affected. All team members expressed relief at having the opportunity to express their thoughts and feelings, and recognizing that their experience was shared, and not pathological.

All members of the CCT felt that acknowledging and exploring vicarious trauma in this case was therapeutic. In an ethnographic study of an internal medicine Morbidity and Mortality Rounds program over the course of 4 months, Kuper et al. concluded that these sessions served as a modality by which attending physicians can model professionalism and teach trainees how to take responsibility for their mistakes, while dealing with the emotional impact of events such as patient deaths (6). In a similar manner, reflective team supervision can help residents understand that introspection is a fundamental skill for therapists. That is, by reflecting on their own experience, they can better understand the complex and sometimes frightening experience of their patients. A key element in acquiring skills is modeling, which not only serves as instruction, but also a means to reinforce values. In our case, trainees felt that, during the discussion sessions, the attending psychiatrist modeled the importance and appropriateness of acknowledging the emotional impact of a frightening event. The intimacy of the group setting facilitated personal reflection and disclosure. This was essentially an exercise in

mindfulness—of acknowledging the importance of the “here and now” experience—which has been linked to improvements in physician well-being and attitudes toward patient-centered care (7).

Differences in processing seemed to follow level of training: medical students and general-psychiatry resident talked about their fear and sense of having only narrowly avoided disaster, whereas the child psychiatry fellows were more intellectualized about their experience but were more able to use this experience to address the system problems identified by this case.

Addressing the emotional impact first allowed the team to identify two systemic concerns, without feeling personally “at fault” for the near-disastrous outcome.

#1: Lack of a Safe Evaluation Area

The lack of an adequate holding area for evaluation of aggressive or unstable adolescent patients enabled this patient to elope from care. To separate minors from adults in the psychiatric emergency room, minors are evaluated in an unlocked, unguarded room in the Pediatric Emergency Room. Our patient, like all minors brought to the PED on a 72-hour hold, was automatically assigned a sitter for observation, but this precaution alone was ineffective in preventing his elopement: he was not handcuffed, and the PED has no guard. As a result of this case, hospital administrators decided that law-enforcement officers bringing in patients on psychiatric holds will remain with the patient in handcuffs until the psychiatry service arrives. This is particularly important, given the limited evidence that sitters reduce the incidence of elopement or episodes of violence (8). A plan was made to set aside one room in the PED to serve as a seclusion room for potentially violent or agitated patients.

#2: Assessment of Violence Risk

In this case, the written hold gave specific warnings indicating that the patient was possibly dangerous, might be carrying weapons, and had been having thoughts of “killing a cop.” At the time this case presented to the hospital, the CCT was informed that three other youths had arrived simultaneously to the PED for evaluation, and so the team split up to see these cases. Unfortunately, because of this pressure, no one read the 72-hour hold until after the patient interview started. Had this document been read beforehand, we would have been more cautious in our approach and perhaps might have notified other PED staff of the risks this patient posed.

During the brief initial interview, the patient displayed signs of agitation and paranoia that have been noted in the

literature to be potential warning signs of imminent violent behavior (9). Our patient exhibited tense posture, scanned the room, muttered to himself, and clenched his fists. In spite of these early signs, no efforts were made to communicate his possible impulsivity and aggression. Assessment of known predictors of violence, such as history of substance abuse, acute psychosis, history of previous violence, or history of antisocial personality disorder (10), was also not obtained in this case. Opportunities to gather this history before the elopement, however, were limited.

On a systemic level, this case prompted meetings with the county police assigned to the hospital to review and discuss the protocol for evaluating potentially violent minors in the PED. From an educational standpoint, the training of residents in violence-prevention was reviewed. Many psychiatric residents report inadequate training in dealing with violent patients (11). McNiel et al. demonstrated that clinicians who participated in a systemic training program in evidenced-based violence risk-assessment showed improvements in clinical documentation of violence risk-assessment (12). In our training program, the decision was made to incorporate a review of assessing violence risk in the orientation to all new CCT members on their first day, with special attention to medical students, who, with the least experience, are the least prepared to detect and react to violent patients.

Reflective Supervision as Informal Curriculum

In their 2009 paper, Wear and Skillicorn define the informal curriculum in medical education as “the opportunistic, idiosyncratic, pop-up, and often unplanned instruction that takes place between anyone who is teaching (attendings, residents, other healthcare professionals), and trainees (13).” It is notable that the general and child psychiatry residents on this team had substantial formal didactic instruction and clinical experience in settings with potentially assaultive patients. However, this formal curriculum did not leave them feeling prepared for this event. Often, it seems, it is through actual experience with a patient, followed by thorough processing afterward, that residents are able to access and integrate what was contained in those initial lectures and apply what they learned in earlier clinical experiences to the new clinical situation.

The reflective team supervision described in this paper was an informal learning activity; it was not planned, not a requirement, and the instructor did not conduct the sessions with LCME or ACGME competencies in mind. Wear and Skillicorn report in their study that attending physicians, residents, and medical students all identified attending role-modeling as the most powerful element of the

informal curriculum. Also, they emphasize that faculty attending physicians communicate to their trainees what they think is important by modeling which activities are worthy of the team's time. Through reflective supervision and self-disclosure, the attending in this case modeled the value of introspection, reflection, and mindfulness. These sessions conveyed the importance the attending places on supporting the emotional health of trainees and in examining how the team members could improve their skills in violence assessment.

Psychiatry and other specialties have reflective activity built into the formal curriculum: process groups, mindfulness, and narrative medicine groups. The purpose of reflection is to nurture and maintain compassion and empathy in trainees, qualities that have been shown to diminish during the rigors of medical training (14). Treadway and Chatterjee describe an effort at Harvard Medical School to encourage trainee reflection through biweekly meetings, the goal of which is "the creation of a 'safe space' for reflection and discussion...allowing both positive and negative experiences to be used to reinforce behaviors conducive to the development of compassionate, emotionally engaged physicians." (15) There is, however, a limited extent to which reflective activities can be efficaciously incorporated into a formal curriculum, as some of what is learned occurs spontaneously and "in the moment," and is dependent on the behaviors that trainees witness in their seniors and attending physicians. In other words, if self-reflection modeled in a process group is not also modeled in the clinical setting, the potential benefits may be lessened for trainees.

As the accreditation process has grown progressively more bureaucratic and detail-oriented, it may have moved many program directors to place heavier emphasis on formal learning activities at the expense of informal ones, such as supervision that is reflective and open to the needs of trainees in the moment. The pressures on faculty to be increasingly more productive and justify their salaries through clinical billing and grant funding has also directed the attention of faculty members away from this sort of reflective supervision. This would be an unfortunate and negative consequence, given the evidence that the informal curriculum is a powerful mechanism of transmitting skills, knowledge, and attitudes to trainees.

Conclusion

This case demonstrates how reflective team supervision after a frightening psychiatric emergency event can address

the event's emotional impact and lead to improvements in both resident competencies and patient care. By addressing both the real and imagined consequences of an event, team supervision can serve as a forum for self-reflection and, by exploring themes of vulnerability and humility, can foster professional growth. This type of supervision forms an essential component of the "informal curriculum" in psychiatric medical education. In this case, team supervision also proved constructive in identifying and addressing systemic problems at our institution. These included specific improvements to patient and trainee safety in the emergency setting. This model of team supervision may help meet the requirement that program directors monitor and promote the well-being of residents. This includes their level of fatigue, stress, and distress during emotionally difficult work. Although these goals may be partially met through formal learning activities, nothing shapes trainees' behavior and experience as powerfully as role-modeling in the informal curriculum. Its reflective and open nature, as well as the increased frequency of team supervisory sessions after this frightening adverse event, allowed team members to explore their own emotional reactions, thus promoting their well-being and enhancing their learning.

The authors report no conflicts of interest.

References

1. Høifødt TS, Talseth AG: Dealing with suicidal patients: a challenging task: a qualitative study of young physicians' experiences. *BMC Med Educ* 2006; 6:44
2. Carson J, Fagin L: Stress in mental health professionals: a cause for concern or an inevitable part of the job? *Int J Soc Psychiatry* 1996; 42:79-81
3. Priebe S, Fakhoury WK, Hoffmann K, et al: Morale and job perception of community mental health professionals in Berlin and London. *Soc Psychiatry Psychiatr Epidemiol* 2005; 40: 223-232
4. Fothergill A, Edwards D, Burnard P: Stress, burnout, coping, and stress management in psychiatrists: findings from a systematic review. *Int J Soc Psychiatry* 2004; 50:54-65
5. Knox S, Hill CE: Therapist self-disclosure: research-based suggestions for practitioners. *J Clin Psychol* 2003; 59:529-539
6. Kuper A, Nedden NZ, Etchells E, et al: Teaching and learning in Morbidity and Mortality Rounds: an ethnographic study. *Med Educ* 2010; 44:559-569
7. Krasner MS, Epstein RM, Beckman H, et al: Association of an educational program in mindful communication with burnout, empathy, and attitudes among primary care physicians. *JAMA* 2009; 302:1284-1293

8. Harding AD: Observation assistants: sitter effectiveness and industry measures. *Nurs Econ* 2010; 28:330–336
9. Blanchard JC, Curtis KM: Violence in the emergency department. *Emerg Med Clin North Am* 1999; 17:717–731, viii
10. Antonius D, Fuchs L, Herbert F, et al: Psychiatric assessment of aggressive patients: a violent attack on a resident. *Am J Psychiatry* 2010; 167:253–259
11. Schwartz TL, Park TL: Assaults by patients on psychiatric residents: a survey and training recommendations. *Psychiatr Serv* 1999; 50:381–383
12. McNiel DE, Chamberlain JR, Weaver CM, et al: Impact of clinical training on violence risk assessment. *Am J Psychiatry* 2008; 165:195–200
13. Wear D, Skillicorn J: Hidden in plain sight: the formal, informal, and hidden curricula of a psychiatry clerkship. *Acad Med* 2009; 84:451–458
14. Newton BW, Barber L, Clardy J, et al: Is there hardening of the heart during medical school? *Acad Med* 2008; 83:244–249
15. Treadway K, Chatterjee N: Into the water: the clinical clerkships. *N Engl J Med* 2011; 364:1190–1193

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