Resident Perceptions of Disorder-Specific Competency in Psychiatry Residency Training

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Background

- Little is known about the perceptions of psychiatry residents with regard to their knowledge, training, or skills/readiness for managing the DSM-5 major mental disorders
- This is significant for conditions such as obsessive-compulsive disorder where up to 90% of patients do not seek treatment, up to 92% do not receive treatment, and there can be a lag of 17 years from diagnosis to treatment[1]
- Half of psychiatry residents and staff may miss the diagnosis of OCD[2]
- Such missed diagnoses can lead to iatrogenic harm such as incorrect medication recommendations, involuntary admissions, and inappropriate CAS reports[2,3]
- These issues may reflect limited exposure during residency[4]
- Addressing shortcomings in expertise is necessary to improve patient outcomes, reduce stigma, and remove barriers to care[4]

Objective

- To assess Canadian psychiatry residents' perceptions of competency across the DSM-5 major mental disorders
- We hypothesized that residents would perceive deficits in their knowledge, training, and skills/readiness for OCD relative to the other major mental disorders

Methods

- We designed a 21-question survey assessing resident perceptions of disorder-specific competency along dimensions of knowledge, training, and skills/readiness
- Questions are formatted as five-point Likert scales and open-ended short answer questions
- We collected 66 responses from PGY1 – PGY5 as well as fellows, representing the 14 English-speaking programs
- We performed descriptive analysis, ANOVAs, and Bonferroni-corrected head-to-head comparisons
- Additional pending analyses include MANOVAs of perceived competency for major mental disorders comparing junior to senior residents and comparing CBD to non-CBD trainees

Results

Table 1. Mean scores for self-rated perception of **knowledge** regarding the DSM-5 major mental disorders. Disorders have been ranked according to means (1 = Intervention; 2 = Direction; 3 = Support; 4 = Competent; 5 = Proficient). In all tables, disorders are ranked in ascending order relative to the disorder in the first row of each column and differences in all tables are relative to the disorder in the first row of each column and are statistically significant at the $p < 0.001$ level.

SSRD (3.41)						
< OCRD (3.74)						
< TSRD (3.83)						
< NCOG (3.83)						
< ADHD (3.90)						
< PERS (3.96)	OCRD (3.74)					
< SUBS (4.03)	< SUBS (4.03)	ADHD (3.90)	NCOG (3.83)	TSRD (3.83)		
< BPRD (4.21)	< BPRD (4.21)	< BPRD (4.21)	< BPRD (4.21)	< BPRD (4.21)	PERS (3.96)	
< ANX (4.27)	< ANX (4.27)	< ANX (4.27)	< ANX (4.27)	< ANX (4.27)	< ANX (4.27)	
< SCZ (4.30)	< SCZ (4.30)	< SCZ (4.30)	< SCZ (4.30)	< SCZ (4.30)	< SCZ (4.30)	SUBS (4.03)
< DEP (4.38)	< DEP (4.38)	< DEP (4.38)	< DEP (4.38)	< DEP (4.38)	< DEP (4.38)	< DEP (4.38)

Table 2. Mean scores for self-rated perception of adequacy of **training** regarding the DSM-5 major mental disorders. Disorders have been ranked according to their means (1 = Strongly disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; 5 = Strongly agree).

SSRD (2.88)							
< OCRD (3.38)							
< ADHD (3.42)							
< TSRD (3.44)							
< NCOG (3.57)	OCRD (3.38)						
< PERS (3.75)	< PERS (3.75)						
< SUBS (3.77)	< SUBS (3.77)	ADHD (3.42)	NCOG (3.57)	TSRD (3.44)			
< BPRD (4.01)	< BPRD (4.01)	< BPRD (4.01)	< BPRD (4.01)	< BPRD (4.01)	PERS (3.75)	SUBS (3.77)	
< SCZ (4.10)	< SCZ (4.10)	< SCZ (4.10)	< SCZ (4.10)	< SCZ (4.10)	< ANX (4.28)	< ANX (4.28)	BPRD (4.01)
< ANX (4.28)	< ANX (4.28)	< ANX (4.28)	< ANX (4.28)	< ANX (4.28)	< DEP (4.40)	< DEP (4.40)	< DEP (4.40)
< DEP (4.40)	< DEP (4.40)	< DEP (4.40)	< DEP (4.40)	< DEP (4.40)			

Table 3. Mean scores for self-rated perception of **skills/readiness** regarding the DSM-5 major mental disorders. Disorders have been ranked according to their means (1 = Strongly disagree; 2 = Disagree; 3 = Neutral; 4 = Agree; 5 = Strongly agree).

SSRD (2.77)						
< ADHD (3.41)						
< SUBS (3.47)						
< NCOG (3.56)						
< PERS (3.58)	OCRD (3.26)	ADHD (3.41)	NCOG (3.56)	TSRD (3.21)	SUBS (3.47)	
< BPRD (4.13)	< BPRD (4.13)	< BPRD (4.13)	< BPRD (4.13)	< BPRD (4.13)	< BPRD (4.13)	
< ANX (4.13)	< ANX (4.13)	< ANX (4.13)	< ANX (4.13)	< ANX (4.13)	< ANX (4.13)	PERS (3.58)
< SCZ (4.23)	< SCZ (4.23)	< SCZ (4.23)	< SCZ (4.23)	< SCZ (4.23)	< SCZ (4.23)	< SCZ (4.23)
< DEP (4.30)	< DEP (4.30)	< DEP (4.30)	< DEP (4.30)	< DEP (4.30)	< DEP (4.30)	< DEP (4.30)

Legend: SSRD (Somatic symptom and related disorders); ADHD (Attention-deficit/hyperactivity disorder); ANX (Anxiety disorders); BPRD (Bipolar and related disorders); DEP (Depressive disorders); SCZ (Schizophrenia spectrum and other psychotic disorders); NCOG (Neurocognitive disorders); OCRD (Obsessive-compulsive and related disorders); PERS (Personality disorders); SUBS (Substance-related and addictive disorders); TSRD (Trauma- and stressor-related disorders)

Discussion

- Somatic symptom and related disorders had the lowest scores for perceived competency relative to most other major mental disorders
- Perceived weakness is also apparent among obsessive-compulsive and related disorders, neurocognitive disorders, ADHD, trauma- and stressor-related disorders, personality disorders, and substance-related and addictive disorders
- The findings of this study provide a helpful benchmark and could function as a periodic measure of progress in improving targeted areas of weakness in national curricula
- The accuracy of self-reported competency will require validation to ensure correlation between perceived and actual competence
- Future studies may include case vignettes evaluating diagnosis and treatment recommendations for disorders to assess actual vs. perceived competency
- Illumination of perceived weaknesses can be leveraged to create and pilot targeted interventions including podcasts, modules, and other scalable online interventions

References

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