

Nonacademic Assistance Programs by Robert E. Levey and Jo Ann Cornelius

INTRODUCTION

The fact that stress is typical during the residency training period has been well documented in the professional literature.¹ Common issues described include anxiety,² depression,^{3,4} hostile working environments,⁵ anger and irritability,⁶ alcohol and substance abuse,⁷⁻⁹ gender issues,^{10,11} marital and family problems¹²⁻¹⁴ and a variety of situational, professional, and personal problems including heavy work load, sleep deprivation, difficult patients, poor learning environments, financial stresses, relocation issues, isolation and social problems, information overload, and career planning issues.¹⁵ It should be pointed out that international medical graduates often face a variety of additional stressors.¹⁶

A discussion of these stress issues will illuminate and clarify the scope of the problem. Then a description of resident assistance program objectives and program elements will be enumerated.

Stress

Stress is a normal part of life and of professional training. Stress may help build confidence, ambiguity tolerance, and maturity, as well as foster the acquisition of knowledge and skills. Girard, et al^{17,18} found a predictable sequence of anxiety and depression to occur in first year residents. Toews et al¹⁹ found residents had slightly elevated scores in comparison to a norm group on stress, with female residents scoring significantly higher than their male counterparts on anxiety, somatization, and depression. The gender differences, however, may be indicative of females being more open to acknowledging psychological symptoms than males. When normal stress shifts into impairment, more serious issues like severe depression, suicide, and substance abuse may result.

Depression

Depression is reportedly as common in the physician population as it is in the general population.³ A study of more than 1,300 male medical graduates from Johns Hopkins found a lifetime prevalence of 12.8% for major depression,²⁰ which is almost identical to the 12% prevalence found among US males ages 45-54 in a nationally representative sample.²¹ The only difference was later onsets reported in physicians. Lifetime prevalence in self-identified female

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