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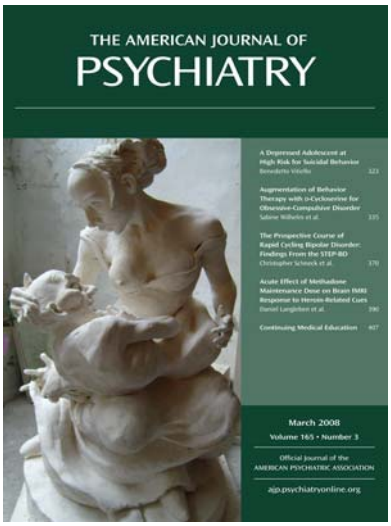

The following is an interview with Amy E. Wallace, M.D., M.P.H., on "Managing a Family and an Academic Career," conducted by Jennifer McLaren, M.D. Dr. Wallace is an HSR&D Advanced Career Development Awardee at the White River Junction VA and an Associate Professor of Psychiatry at Dartmouth Medical School who has managed to combine raising six children with an academic career in psychiatry. Dr. McLaren is a third year psychiatry resident at Dartmouth Hitchcock Medical Center and the Resident Editor for this issue.

Dr. McLaren: **What were your goals early in your career? How did you visualize your career progressing?**

Dr. Wallace: I wanted to combine a family and a full-time academic career. I knew I wanted six children and I knew it would be a challenge to balance that with my career. I became interested in research during residency; whenever I came up with questions for my supervisors, they would say, "why don't you look into that?" I started out working on my own small projects. Initially, I did a small clinical trial examining the use of methylphenidate in depressed medically ill patients. I have since learned to take things by the moment and to take advantage of things as they come. I have never spent too much time visualizing the progression of my career; I take it one day at a time.

Dr. McLaren: **As a woman, what challenges or obstacles have you faced while balancing an academic medical career and a family?**

Dr. Wallace: When I was a resident we didn't have residency hour restrictions and we worked long hours. I remember being pregnant during residency and being sleep deprived. Getting enough sleep was a real challenge. I had four of my children during residency and fellowship. During my pregnancies, I always tried to be loyal to my co-residents and would take all of my calls prior to maternity leave, which left me exhausted. The residency work hour restrictions are a positive change which make it a bit easier for medical professionals to balance a career and a family. Also, I could not have managed without my great day care provider. Having a child care provider that you really trust is important. This made it easier for me to leave my children and return to work quickly.

Dr. McLaren: **Do you think male and female physicians are treated differently?**

Dr. Wallace: While I would like to say that there are no differences, my husband and I have done research on income disparities between male and female physicians. Across the board in every medical specialty, including psychiatry, women make less than men even after adjusting for hours worked, time in profession, board certification, and other factors that might explain the difference. If female physicians are working just as hard, have similar credentials and experience, and yet are earning less money than their male counterparts, then certainly, we women still have some obstacles to overcome.

Dr. McLaren: **Has it been difficult to find women mentors in academic medicine?**

Dr. Wallace: I have had both male and female mentors, all of whom have been extremely helpful. If there are no mentors in your facility, you can find a mentor elsewhere. You can communicate with mentors by phone and e-mail. People in academic professions are usually more than willing to be mentors. It is about taking initiative and finding yourself a mentor. It can be as easy as going on MEDLINE and looking up what you are interested in and contacting an expert in that field that you would like to be your mentor.

Dr. McLaren: **What is the best advice that you have received regarding balancing medicine and family?**

Dr. Wallace: Balancing a career and a family is about making the most of every stretch of time. You can do a lot in only 15 minutes, so use it. When trying to balance a career and a family, it is all about using your time well.

Dr. McLaren: **What advice do you have for residents trying to manage a medical career and a family?**

Dr. Wallace: Managing an academic career and a big family is like an endurance race. For 99% of the race you cannot see the finish line, but you can visualize it in your mind. You have to enjoy the process. I really enjoy working on my research. I also love parenting my children. If you enjoy the process, it doesn't seem like work.

I also think it is important to make your situation as easy as possible on yourself. I live close to my children's school. I have a child care provider I trust. I have a lot of other people in my network who help, including my husband and neighbors. I am not doing it alone, I have a team.

The Great Balancing Act: Pregnancy During Residency

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The number of women in medicine continues to increase, with women accounting for 49.1% of all medical school graduates in 2007 (1). In 2006, 54.4% of psychiatry residents were female (2). The increasing number of female residents undoubtedly leads to an increase in the number of pregnancies that occur during residency. A 1998 study found that nearly 50% of all married female residents become pregnant during their residency training (3).

Residency is a challenging time in a physician's career due to the long work hours, the academic demands, and the psychological stress. It can be difficult to balance pregnancy and the rigors of residency. This article reviews some of the challenges commonly encountered by residents who become pregnant.

Challenge #1: Balancing sleep, relaxation, and work. While it is important for any resident to take care of their health, it is especially important for a resident who is pregnant to take care of her health. Residency work hours are long and the stress can be severe, and these factors can lead to detrimental effects on pregnancy (4). Several studies have found an increased risk of adverse pregnancy outcomes among residents. These studies found that residents had higher rates of preterm labor, preterm delivery, preeclampsia, low birth weight, intrauterine growth retardation, and abruptio placentae compared with nonresidents (4–8). One study compared the pregnancy outcomes of a physician group versus a nonphysician group and found that the physician group had almost twice the risk of an adverse event during pregnancy. The physician group had a fourfold increase in risk of preterm labor and more than a twofold increase in risk of preterm delivery (8). These are concerning findings for the resident who is pregnant; however, the majority of these studies are retrospective, using data obtained from self-reported questionnaires. This type of study design can lead to some methodological flaws. These studies suggest that the rigors of residency adversely affect both the fetus and mother. One may hope that if these studies were repeated in the era of work hour restrictions, we would see a decrease in stress level among residents and thus decreased rates of complications during pregnancy. Certainly, it is important for physicians and residents who are pregnant to find the proper balance for themselves in terms of sleep, relaxation, and work.

Challenge # 2: When to fit in breastfeeding? One study examined breastfeeding among residents and found that 80% of female residents were breastfeeding while on maternity leave; however, half of these women stopped breastfeeding upon their return to work. Only 15% of residents continued to breastfeed at 6 months after birth. Among this population, long work hours was the leading reason for cessation of breastfeeding (9). There are several challenges residents face when trying to breastfeed upon returning to work after maternity leave. Carving out the time and place to pump breast milk is a challenge. However, if one chooses to breastfeed, there are undeniable benefits to the child (10). Taking a proactive mindset toward breastfeeding may help residents continue to breastfeed when returning to work. It may be appropriate to discuss the logistics of pumping while at work with your program director or other supervisor.

Challenge #3: Conflict among residents. When a resident is on maternity leave, the burden of her workload is shared by her co-residents. At times, a resident's pregnancy can lead to conflict among her co-residents (11–13). Conflict can occur when co-residents feel that residents who are pregnant receive preferential treatment (11). Tinsley suggests that residents who become pregnant should "notify colleagues of her pregnancy as early as possible to allow for ample time for rescheduling to be arranged and be openly appreciative of those who help to cover during her absence" (13). Planning early and being proactive in terms of the work schedule and being on call can mitigate the burden your pregnancy places on your peers.

Challenge # 4: Patient reaction to a psychiatrist's pregnancy. A psychiatrist's pregnancy stirs a wide range of reactions in patients. Patients may experience unexpected emotions that they have a difficult time understanding and expressing. These feelings can include anger, rejection, and abandonment. It is important for the psychiatrist to be aware that her pregnancy may illicit strong reactions from her patients and that it can affect the therapeutic relationship (14). Being mindful of patient reaction to your pregnancy may allow for more nuanced interpretations of patient interaction.

Certainly, these are only some of the challenges related to having a child during residency. Many of these challenges are not limited to one's residency but carry throughout a physician's career. However, the vast majority of women feel the joys of having a child are worth these challenges.

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The Unexpected Impact of Pregnancy: One Psychiatry Resident's Experience

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I knew that having a baby would change my life, but I never imagined the impact it would have on my career. As my patients seemed to pay little attention to my expanding abdomen, I was convinced my pregnancy was not really affecting them.

Eight months into my pregnancy, I began to alert my psychopharmacology patients of my impending maternity leave. While I do not know exactly what reaction I expected from my patients, I was surprised by the barrage of personal questions that followed. I was happy to share every detail of my pregnancy with the cashier at the grocery store. However, I was not accustomed to sharing personal information with my patients and was often flustered by their inquiries. I found myself constantly struggling to redirect conversation back to the patient and away from my personal issues.

My experiences in the psychopharmacology clinic helped me to be mindful of the impact my pregnancy could have on my psychotherapy patients. My supervisor predicted the news would bring a wealth of material into therapy, but I was still skeptical. Initially, my therapy patient was intrigued. She offered her congratulations and asked the perfunctory questions about pregnancy. I navigated questions about my due date and the baby's gender with ease. Over time, the discussion intensified and she began to show a myriad of emotions. She was frustrated and disappointed, feeling I was abandoning her. She was scared and worried, wondering if she would still be a priority. She was fearful and uneasy, feeling that she should no longer "burden" me with her problems. After slowly working through all of these emotions, she began to share memories of her own pregnancy, which included the pain of her spouse's infidelity. Just as my supervisor predicted, my pregnancy elucidated some very key therapeutic developments.

As I tidied up all of my patients' issues and my delivery date approached, I continued to struggle with ambivalence about the length of my maternity leave. Initially, I wanted to return to work as soon as possible to minimize the impact of my absence on both my patients and my colleagues. However, I also wanted to immerse myself in motherhood, spending every possible moment at home with my family. It seemed no decision was without negative consequences and I found myself stuck with a tough decision. Staying home meant feeling guilty about missing work. Going back to work meant feeling guilty about leaving my new baby.

Upon returning to work, I had to make decisions about how to handle questions about the baby. Would I put up pictures? What about a screensaver? What questions would I answer? How would I handle questions I didn't want to answer? A huge event had happened in my life and I could have filled hours of conversation with baby stories, but I knew it was in not in my patients' best interests to fill my clinic hours with discussions about myself. While it would require significant effort, I was determined to maintain appropriately firm boundaries.

The experience of pregnancy is personal and each woman has to make decisions about how to best balance a professional career and an expanding family. Though there is some literature about how pregnancy affects both psychiatrists and patients, it can still be very difficult to manage all of the issues that come with pregnancy in a therapeutically appropriate manner. With much supervision and significant thought, I chose to take an extended maternity leave and upon my return to work, adopted a conservative approach to patient care–no pictures, no screen savers, and minimal information. Navigating through personal questions was awkward at times. But with diligence and continued practice, it became more natural and I was finally able to develop a sense of comfort in managing my career and motherhood.

2008 APA Annual Meeting

We would like to invite all residents to participate in a focus group taking place at the 2008 APA Annual Meeting in Washington, D.C. Editor-in-Chief Robert Freedman, M.D., along with select Deputy Editors and editorial staff, will solicit thoughts on the Residents' Journal and ideas on how the *American Journal of Psychiatry* can be of further use to residents. The meeting is scheduled for Tuesday, May 6, 2008, at 3:00 to 5:00 p.m. in the Grand Hyatt Washington, Burnham Room, Constitution Level. For further information please contact ajp@psych.org.

For information on the 2008 APA Annual Meeting, including registration and housing, please visit http://www.psych.org/MainMenu/EducationCareerDevelopment/Meetings/AnnualMeeting.aspx.

What's Your Opinion? Let us know what you think about any of the content in this month's issue of The Residents' Journal. Send your brief comments to ldevine@psych.org by March 24, 2008. A selection of comments will be published in the next issue in the "Second Opinion" section.

Want More? In addition to the online portion of the Residents' Journal, there is an e-mail supplement delivered each month. This month's e-mail highlights rapid-cycling bipolar disorder and treatment of a depressed adolescent at high suicide risk. To subscribe, simply e-mail Lisa Devine, Editor of the Residents' Journal at ajp@psych.org.