troubling and challenging for young psychiatrists.[2] To address and prevent the negative effects of patient suicide on psychiatrists, we should consider how early exposure affects young psychiatrists in their personal and professional identities.

In a survey of 764 French psychiatrists,[3] we reported that nearly 90% were first exposed to patient suicide during their early careers. Moreover, compared with exposure among more seasoned psychiatrists, exposure during the early career phase was more strongly associated with negative emotional states, including guilt, sadness, and shock, and with greater feelings of responsibility. Nearly one in four (23%) early career psychiatrists considered changing their career path in the aftermath of the exposure. Early career psychiatrists can indeed experience strong and profound feelings of incompetence and question their professional abilities and skills as competent psychiatrists. Furthermore, education programmes that do not discuss patient suicide or how to deal with its repercussions were found to be a prominent risk factor for the tridimensional (ie, traumatic, emotional, and professional) effect.

Therefore, recognising that early career psychiatrists are more likely to be first exposed to patient suicide than later in their career, and are therefore more vulnerable to the repercussions of patient suicide, must be the first step in initiating structural, academic, and cultural change in prevention strategies aimed at buffering the effect of patient suicide on psychiatrists.

First, educational programmes aimed at preparing psychiatric trainees for patient suicide should be urgently implemented.[4] Learning how to deal with the emotional and professional issues related to patient suicide should be one of the key components of psychiatric training and professional identity.

Second, support from senior psychiatrists must be seen not as simply kind and friendly companionship, but rather as a commitment of psychiatric institutions and medical schools to offer an institutionalised space for affected young psychiatrists through comprehensive understanding of their needs and emotions when confronted with patient suicide.

Third, we strongly agree with the editors that psychiatric facilities are workplaces that must value everyone's mental health and thus must focus on the mental health of early career psychiatrists by implementing dedicated programmes aimed at offering them institutional support in the aftermath of patient suicide.

EO reports personal fees from Janssen Cilag, Otsuka, AstraZeneca, all outside the submitted work. GV reports personal fees from Janssen, outside the submitted work. EL has no competing interests.

*Edouard Leaune, Emilie Olié, Guillaume Vaiva
edouard.leaune@ch-le-vinatier.fr

Center for Suicide Prevention, Centre Hospitalier le Vinatier, Bron, F-69500, France (EL); PSYR2 Team, Lyon Neuroscience Research Center, Lyon, France (EL); Neuropsychiatrie: Recherche Epidémiologique et Clinique, Université de Montpellier, Montpellier, France (EO); Lille Neuroscience & Cognition, Université de Lille, Lille, France (GV); and Centre National de Ressources & Résilience pour les psychotraumatismes, F-59000 Lille, France (GV)

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A recurring reproduction error in the administration of the Generalized Anxiety Disorder scale

The 7-item Generalized Anxiety Disorder scale (GAD-7) is a brief, easy-to-administer measure of general anxiety that has good psychometric properties in primary care settings[1] and in the general population.[2] As such, the GAD-7 is a widely used screening tool, with over 9200 citations by late December, 2020.

The GAD-7 assesses how frequently a respondent has experienced each of seven core anxiety symptoms during the preceding 2 weeks. The response options are: not at all (scored as 0), on several days (scored as 1), on more than half of the days (scored as 2), and nearly every day (scored as 3).

We have discovered a recurring error in the clinical literature regarding the use of the GAD-7. In some studies, the lowest response option, "not at all", was erroneously reproduced as "not at all sure". This typographical error has the potential to alter the meaning of this response option. In the altered form, a respondent selecting the lowest option is not reporting the absence of symptoms, but rather uncertainty as to the presence of symptoms.

The number of published studies that report findings incorporating this error is small but non-negligible. Through a literature review,[3] we have confirmed the occurrence of this error in 147 articles and theses, the first of which appeared in April, 2012. Insofar that not all papers explicitly report the possible response options when using the GAD-7 (in an independent sample of 119 publications since 2018,[3] only 44 papers [37%] reported the response options), we suspect this result underestimates the prevalence of this error in clinical research. Worryingly, more than half of the reports that included the error (77 [52%] of 147) were published since 2019, suggesting that the rate at which this error is reproduced is increasing.

Crucially, the modified response scale violates the ordinality of the responses, potentially altering the psychometric properties of the GAD-7. Moreover, changing the interpretation of the lowest response option might bias responses towards increased selection

of the score 0 response option. Although this bias would probably have only a minor effect on individual scores and scale means, the effect of the error on the sensitivity of the scale in detecting clinical anxiety is unknown. Additional research would be needed to understand how this alteration affects the measurement properties of the GAD-7 and, in turn, how this might have affected the findings of previous studies that made this error.

We highlight this error as it is imperative for researchers in the future to ensure that the contents of the scales they use match those described in the original investigations (or clearly report when an alteration is made, and why), rather than use unverified online sources that can potentially include errors, as is likely to have happened in these identified papers.

We declare no competing interests.

*Samuel Zorowitz, Daniel Bennett, Gina Choe, Yael Niv
zorowitz@princeton.edu

Princeton Neuroscience Institute (SZ, DB, GC, YN) and Department of Psychology (YN), Princeton University, Princeton, NJ 08540, USA; Department of Psychiatry, Monash University, Melbourne, VIC, Australia (DB)

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An evidence-based path forward for diversity training in medicine

On Sept 22, 2020, President Trump signed Executive Order 13950, banning US diversity and inclusion trainings that contain "divisive concepts".[1] Banned materials included trainings with unconscious or implicit bias, or anything that described the USA as "fundamentally racist or sexist", which was deemed to be "offensive", "anti-American", and "destructive ideology".[1] Moreover, Executive Order 13950 contained a mandatory review of all diversity and inclusion training materials supported by federal taxpayer dollars and a mechanism for reporting non-compliance. Although the long-term effect of this order is unknown, many private and public agencies cancelled or delayed diversity trainings, fearing the loss of federal funding.[2]

The executive order ignored established evidence supporting the important role that diversity and inclusion trainings play in health-care education, workforce retention, and the fight against health disparities.[3–5] Even a temporary cessation in diversity and inclusion curricula could create dangerous blind spots for a cohort of health-care trainees who will go on to provide medical care to culturally and racially diverse communities throughout the country.

Additionally, the executive order's use of obstructive censorship based on revisionist history and the vilification of counternarratives (eg, critical race theory) represented a form of gaslighting, a strategy used to gain and maintain power by manipulating others to question their memory, perception, or judgment through the induction of alternative beliefs or denial of reality. Executive Order 13950 obfuscated facts and presented a false rationale for imposing restrictions on diversity and inclusion trainings. In fact, its narrative was a quintessential example of racial gaslighting: the phenomenon of perpetuating white supremacist ideology by promoting narratives that obscure or minimise racism and silence the viewpoints of those it affects.[6] The executive order subverted the realities of racial and gender oppression in favour of a mythological presentation of the USA as unbiased and equally accessible to all, and it inaccurately claimed that anti-racism and anti-sexism efforts themselves produce racism and sexism.

The executive order came amid a national reckoning on racism and racial health inequities, accentuated by the COVID-19 pandemic. During this crucial moment, more effort is needed to confront systemic racism, reduce health disparities, and mitigate implicit bias, not less. We urge health-care agencies not to yield to pressure to postpone or halt diversity and inclusion trainings, but instead to take a principled, evidence-informed stand to enhance educational programmes by incorporating effective elements of diversity and inclusion trainings into medical education curricula. More information on the evidence-based components of diversity training are in the appendix. Diversity education must continue with integrity and fidelity. At this key point in history, health-care trainees are learning from the actions and responses of mentors and leaders. Silence is complicity. Our responsibility to educate means

See Online for appendix

***Panel:* Recommendations in response to Executive Order 13950**

1 We urge the Biden administration to take a stronger stand than the recent revocation, which is limited to encouraging agencies to "consider suspending, revising, or rescinding" actions that they took based on Executive Order 13950.[7] We recommend not only removing the ban, but also taking the affirmative step of using scientific evidence to guide the development of policy and legislation that advance education in these critical areas.
2 We encourage affected agencies and health-care systems to reinstate or continue to provide diversity and inclusion training, as supported by scientific evidence.
3 We recommend that agency leaders and administrators support and stand behind employees and trainees who continue to teach, lead, or participate in diversity and inclusion trainings.
4 We encourage all health-care educators to request formally that diversity and inclusion training proceed as planned before Executive Order 13950.
5 We implore our colleagues in the medical community and professional health-care organisations across various disciplines to speak out against this and future efforts to suppress diverse voices or trainings on diversity and inclusion.
6 We invite researchers to expand the study of the importance, effect, and efficacy of diversity and inclusion training and the concepts threatened by Executive Order 13950.