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Education and training

A survey of psychotherapy experience among psychiatric registrars

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Psychotherapy is recognised as an integral part of general psychiatric education at the level of preparation for the membership exam. Guidelines were first published over 20 years ago by the Royal Medico-Psychological Association (RMPA, 1971). In 1986 these guidelines were reviewed and clarified amid some pessimism about how widely the previous recommendations were being met (Royal College of Psychiatrists, 1986). The shortage of consultant psychotherapists and the competing demands of other service and training commitments were suggested as explanations for this.

The guidelines divide training into essential experience in individual psychotherapies, namely dynamic, behavioural and supportive. Optional experience is suggested in other therapies, e.g. group, family, marital, counselling and crisis intervention. For the essential areas of training at least two cases should be undertaken. It is suggested that of the optional experience, there should be "substantial initiation" in at least one.

Supervision is recommended for dynamic and behavioural therapy in small groups and also as support in the management of psychotherapeutic problems arising in any interactions with patients either in a general psychotherapeutic or psychiatric context.

The object of our survey was to compare current training received with these 1986 College guidelines.

The study

A confidential postal questionnaire was sent to all known psychiatric registrars in the South West region. Twenty-five posts were identified. We asked for years of qualification, passing MRCPsych Part I and Part II, date of first appointment as a registrar, which specialty posts they had occupied at registrar level and if a psychotherapy post was available in their scheme.

We asked the following questions.

(a) Have you received practical training in the assessment of patients for psychotherapy?
(b) Have you treated patients in the following way (with appropriate supervision)
  (i) individual dynamic psychotherapy
  (ii) behaviourial psychotherapy?
(c) Have you received basic training in the following types of therapy
  (i) group
  (ii) family and marital
  (iii) counselling and crisis intervention?
(d) Are supervision seminar groups available in your training scheme?
(e) Are you expected to present full case reports on patients you have treated with psychotherapy?
(f) Do you feel there is enough psychotherapy training and experience available in your local psychiatric rotation?
(g) Have you sought psychotherapy training outside your training scheme?

Findings

Out of 25 registrars posts, 23 were occupied; 22 trainees responded. All had qualified in medicine between 1982 and 1990. Thirteen had passed the MRCPsych examination and the mean time in post as a registrar was two years. Two respondents had worked in a full-time psychotherapy post and six trainees in total had access to such a post (see also Table I).

These findings demonstrate that the majority of junior career psychiatrists in our survey do not receive psychotherapy training and supervision as recommended by the Royal College of Psychiatrists.

Comment

This is the first survey report, to our knowledge, on training in psychotherapy at registrar level. The

TABLE I

Proportion of registrars receiving recommended training in psychotherapy (total number of registrars in region = 23)

Training in assessment for psychotherapy	11 (50%)
Treated individual patients with dynamic psychotherapy	18 (82%) 10 seeing three or more cases
Treated individual patients with behavioural therapy	4 (18%) most seeing one case only
Experience in group therapy	2 (9%)
Experience in family therapy	10 (45%)
Experience in counselling and crisis intervention	12 (55%)
Supervision groups available	15 (73%)
Written case reports performed	7 (32%)
Dissatisfied with training in psychotherapy	17 (74%)
Sought psychotherapy training outside NHS rotation	9 (40%)

survey was performed, for practical reasons, in only one region but a high response rate was achieved (96%). Despite this being a cross-sectional survey, the average experience of two years per registrar implies an adequate temporal exposure to local training and we consider this to be a representative study. There could be several reasons for the failure to achieve even the essential targets in training.

Looking at the characteristics of the respondents, most had been in post as registrars some time, had full membership of the College and would therefore have been well established in their local psychiatric training, yet most had been involved in limited training in psychotherapy. Registrars were obviously aware of the deficiencies in training and by the comments offered on the returned questionnaires concerned to the extent that many had sought extra psychotherapy training outside their National Health Service scheme. In fact only six registrars had access to a psychotherapy post on their scheme, and these trainees worked in a scheme with a full-time consultant psychotherapist as a trainer.

Another possible reason is that psychotherapy training is obviously affected by the availability of senior psychiatrists experienced in the specialty and in our region there is only one full-time consultant psychotherapist and three consultant psychiatrists with special responsibility. This compares poorly with other regions in a recent survey by the specialist section of the Royal College of Psychiatrists (1991), e.g. North East Thames has 27 such consultants and the four Thames regions combined have a total of 77 posts out of a national total in England and Wales of 122 (full-time, part-time and special responsibility posts included). One obvious explanation for failure to achieve these training targets is inadequate human resources and it would seem that most NHS regions lack the consultant psychotherapists without whom these guidelines are not achievable. Consultant psychotherapy posts and training opportunities are concentrated in the greater London area for historical reasons and it would be interesting to compare psychotherapy training received by registrars in these regions. There is no higher professional training in psychotherapy locally and this may have an adverse effect on the experience in psychotherapy of future consultant psychiatrists as well as influencing entry into psychotherapy as a career, perpetuating a lack of psychotherapy experience in the profession.

The importance of these findings is manifold. Psychotherapy skills are commonly regarded as central to all areas of psychiatric practice and such an obvious lack of organised training in them is possibly more widespread and is of serious concern. With a move towards community orientated treatment the College has stated the need for psychotherapeutic techniques (Royal College of Psychiatrists, 1990); these may be difficult to achieve if adequate training is not available. Patients have increasing expectations of psychiatric services including access to psychotherapeutic treatments in which the general psychiatrist must be grounded. Psychiatrists as leaders of multidisciplinary teams need a broad base of expertise if they are to have the confidence of non-medical team members who themselves may have had a formal psychotherapeutic training. A particularly deficient area shown in our survey was that of the behaviourial therapies and a recent article (Stern, 1993) had highlighted a perceived need for an increase in consultant posts in this developing field. The effective management of very challenging patients, such as those with severe personality disorder and long-term mental health problems, requires psychotherapeutic approaches that are only learnt by practical experience.

This study poses various questions: are these guidelines practical, and if such experience is to be regarded as fundamental, should these guidelines become obligatory for entry to the MRCPsych Part II examination? Should experience be gained in each type of psychotherapy or would more in depth training in a chosen approach be more practicable and useful? We do not believe that the deficiencies in training we have identified are confined to our region alone and like the specialist psychotherapy section of the College fear that this is a national problem in psychiatry training.

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A self-help group for women drinkers – a trainee's perspective

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While working as a registrar on a Regional Alcoholism Treatment Unit (ATU), I took part in a weekly support group for women. This afforded a valuable insight into the way in which alcoholism affects women, and showed how a group could be used by its members in a variety of ways. It was an important and valuable learning experience which is not commonly available to trainees in psychiatry.

The unit is based in a teaching hospital and run by a multidisciplinary team. There are facilities for in-patient and out-patient detoxification, and longer term rehabilitation, including individual counselling and group support. The unit encourages clients to develop an individual support network which best suits their own needs.

Background to the group

The unit recognised early in its development the increasing number of women alcoholics being referred to services, and established a Women's Group to meet their needs. Initially the group had only a few regular attenders, but has expanded so that two groups are now held weekly, each attended by 25 to 30 clients.

A social worker and a member of the nursing staff facilitate the group. There is no set agenda and the participants can raise any issue they wish. It is an open group; some women have individual counselling prior to attendance, but this is not a prerequisite.

Ages range from the late teens to over 70 years. A broad spectrum of backgrounds are represented. Many women use other services including individual therapy and Alcoholics Anonymous. Some have had many years of sobriety (15 years or more) while others might have only a couple of days, and attend after starting on a detoxification programme. Between these two extremes, a wide range exists. Most of the women live independently, some in dry-houses, others in hostels. Several travel 30 miles or more to attend the group.

Content of the discussions

There was frequent talk about drinking, always in an air of openness and honesty, and frequently tinged with shame and guilt. Women would admit if they had relapsed into drinking and talk about the circumstances surrounding their doing so, always acknowledging their own responsibility. The focus was not so much on past drinking but more on coping with the present. Advice given and comments made were pragmatic and supportive. There was never any sense of disapproval towards those who were currently drinking. Instead, each looked for what could be learnt from the current relapse, and how that could help in the future.