Training Psychiatrists in Behavioural Psychotherapy—Dispelling Myths

ROGER FARMER, Lecturer in Psychiatry; DAVID MILLER, Clinical Psychologist; JOHN GREEN, Acting District Psychologist and JOE HERZBERG, Senior Registrar, Department of Psychiatry, St Mary's Hospital, Praed Street, London

Behavioural psychotherapy is probably now the preferred treatment in as many as 25% of neurotic patients or 12% of adult psychiatric outpatients.[1] It is, of course, part of some psychiatrists' therapeutic repertoire already. However, more widespread use of behavioural methods by psychiatrists would seem to be desirable and this is particularly so as clinical psychologists remain thin on the ground in many places. Indeed clinical psychology remains one of the smallest health-service professions. In 1981 there were 1,105.7 qualified clinical psychologists (whole time equivalents) in England.[2] Moreover this overall figure conceals enormous disparities between Health Authorities, some of which provide good psychological services while others provide virtually nothing. In recognition of the importance of behavioural techniques, the Royal College of Psychiatrists has recommended that experience of them should be an integral part of any psychiatrist's training.[3]

Given the importance of behavioural psychotherapy as a therapeutic tool, why do many psychiatrists not use it? Obviously where there is ready access to clinical psychology services psychiatrists may understandably believe there is no need for them personally to employ behavioural techniques. Lack of teaching and adequate supervision are almost certainly other factors but probably only partially account for the failure of many psychiatrists to use behavioural methods. Other reasons, while related to these, may, however, be more subtle. Marks[1] has suggested that the reluctance of some is based on certain prevalent but false attitudes towards behavioural psychotherapy. These include beliefs that: (1) The indications for its use are few and concern only focal phobias. (2) It is necessarily very time-consuming. (3) It is superficial and mechanistic in its approach, and inattentive to the patient's emotions. (4) A detailed knowledge of learning theory is an essential prerequisite to its practice.

During two training courses run by the authors for staff, particularly trainee psychiatrists, at St Mary's Hospital, we attempted to dispel myths such as these. We think our experience may be of interest to others and is particularly relevant at this time as an updated set of guidelines for the training of general psychiatrists in psychotherapy is currently being prepared by the Royal College of Psychiatrists.

The courses

Much of the present teaching of behavioural psychotherapy tends to be wholly didactic and divorced from actual clinical cases. It was thought that any misconceptions about behavioural psychotherapy or a reluctance to use it could best be overcome by frequent reference to patients and encouragement of first-hand clinical experience. Also while emphasising the empirical and scientific basis of behavioural psychotherapy with its requirements of testability, repeatability and objectivity,[4] we hoped that the concern of behavioural psychotherapists with a patient's inner world of feelings and attitudes, as well as their perceptable behaviour, would become evident. Indeed the term 'behavioural psychotherapy' was chosen for the training courses, rather than 'behaviour therapy', to emphasise this holistic awareness.

Two courses have been run over the last year. Each comprised 10 weekly sessions lasting up to 60 minutes each. A different topic was covered each week; characteristics of behavioural psychotherapy; anxiety management; phobic disorders; eating disorders; depression; obsessive-compulsive disorder; marital therapy; ward-based programmes (including token economy); psychosexual dysfunction; social skills training. A more didactic presentation during the first half of each seminar was followed by case presentations—where possible of patients currently under treatment. This procedure allowed discussion of any clinical difficulties which had arisen as well as emphasising the clinical relevance of the session. Altogether 12 psychiatric SHO's or registrars attended the two courses as well as one research psychologist, five nurses and two occupational therapists. Where behavioural treatment of a patient was undertaken by a course participant one of the authors provided supervision, the extent of which varied according to the experience of the therapist and the complexity of the case. In certain cases a course participant and a 'teacher' acted as co-therapists. Suitable patients had either recently been seen by a trainee psychiatrist or were drawn from the pool of referrals to the clinical psychology department.

For the purposes of this article we shall concentrate on the 12 junior psychiatrists who participated. Only four had themselves previously used behavioural techniques and for two this experience had been minimal (less than three cases treated). While the courses were running, eight of the junior psychiatrists took on cases treating in all 10 patients (five agoraphobics, two depressives, one obsessional neurotic, one patient with an anxiety state and another with vaginismus). Six of these eight trainees had had no previous first-hand experience of using behavioural methods. In addition most of the others who did not actually treat a patient with behavioural methods during their course have done so subsequently.

Evaluation

At the end of each course the participants' views were obtained by means of a questionnaire which could be anonymous. In response to a question asking the trainees who had personally employed behavioural treatment during the course if it had been effective in their opinion, six said yes, one felt that while the psychological treatment had been beneficial it was best employed in conjunction with medication, and one was equivocal. Although, in general, positive attitudes were expressed about the course, one participant found the structure too 'fragmented' with insufficient 'flow' from one week's topic to the next. Another advocated the inclusion of 'practical treatment demonstrations', and complained that the sessions were not long enough. One appreciated the use of role play in the marital therapy seminar and thought this technique should have been more widely exploited. Distribution of handouts well in advance of seminars was suggested by another, and to show it is difficult to please all of the people all of the time one said the sessions should be more 'didactic and directive'. All except one stated that they were more likely to use behavioural psychotherapy in the future. The exception (who intends to work ultimately as a psychoanalyst) said he was more likely as a result of the course to refer certain patients to clinical psychologists for behavioural treatment.

The non-medical participants

Of the five nurses, four had direct involvement in supervising ward-based programmes during the course. Also two assisted in the treatment of agoraphobic patients and one in treating a patient with obsessional thoughts. Both occupational therapists acted as co-therapists in social skills training groups. The research psychologist had much more previous experience than the other participants and provided usefully informed input during sessions.

All the non-medics commented positively on the course and several thought increased interdisciplinary understanding had resulted. The nurses particularly appreciated a discussion of operant conditioning as a theoretical rationale for ward-based programmes while the occupational therapists thought that social skills training should be an important aspect of their work.

Comment

Having received feedback from participants on other courses we have run in this department, it was evident that this course was particularly well received. Further twice-yearly courses are planned incorporating where possible suggestions from previous participants. For instance there will be more emphasis on the use of behavioural psychotherapy in combination with drug treatment. Also we hope to make greater use of videotaped recordings to illustrate teaching points and to enable more direct feedback on the treatment of patients.

Our impression is that certain popular misconceptions about behavioural treatment can be dispelled during courses of this kind and first-hand experience of using behavioural methods seems important for this. Certainly, personal involvement in the treatment of patients by all participants while the course is running will be our aim in the future.

Clearly, systematic assessment of courses of this kind is necessary. As well as attitude change and the extent of any subsequent use of behavioural methods, the appropriateness of referrals to the clinical psychology department for treatment is an outcome variable we intend to look at.

REFERENCES

[1]MARKS, I. M. (1981) Psychiatry and behavioural psychotherapy. *British Journal of Psychiatry*, **139**, 74–78.

[2]WATTS, F. N. (1985) Clinical psychology. *Health Trends*, **17**, 28–30.

[3]THE ROYAL COLLEGE OF PSYCHIATRISTS (1971) Guidelines for the training of general psychiatrists in psychotherapy. *British Journal of Psychiatry*, **119**, 555–557.

[4]MARKS, I. M. (1982) Toward an empirical clinical science: behavioural psychotherapy in the 1980s. *Behaviour Therapy*, **13**, 63–81.

The Mental Health Act 1983 Draft Code of Practice
Mental Health Act Commission's Discussion Paper on Consent to Treatment

LORD COLVILLE, Chairman, Mental Health Act Commission

Professor Bluglass[1] has recently written in the *Bulletin* on this subject. Articles have also appeared in the *British Medical Journal* by Dr Hamilton[2] and Professor Kendell.[3] Comments were invited on both documents: to the DHSS on the Code and to MHAC on their paper. To judge by the articles referred to, clarification of the background to and function of both documents is urgently needed.

Neither the Royal College of Psychiatrists nor any other professional body has, to date, produced a Code of Practice for those concerned with mental health. Parliament required that a Code should be written. Presented with this task the Commission considered what should be done. A brief statement of uncontentious principles, susceptible of no disagreement, seems to be that for which some are now