Trainees' experience and attitudes to behavioural–cognitive psychotherapy training

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We performed a survey to examine the behavioural–cognitive psychotherapy teaching and experience of trainee psychiatrists in the South Thames (West) Region. Sixty-four per cent of the whole sample who responded to the survey, including 90% of the registrars who responded, had treated at least one patient using behavioural–cognitive methods. Few trainees reported no experience of behavioural–cognitive psychotherapy with almost all attending some form of teaching. Trainees generally reported that they valued this experience.

Previous surveys of junior doctors' experience of behavioural–cognitive psychotherapy in the South West Thames Region found that the introduction of monthly visits by a peripatetic senior lecturer in behavioural psychotherapy led to a significant ($P<0.001$) increase in the number of trainees gaining behavioural and cognitive experience (Drummond & Bhat, 1987, 1989). The proportion of trainees who gained experience of treating at least one case under supervision increased from 17% to 42% in the time between these two surveys.

In 1987 a working party was convened to establish the educational goals, content and processes for the learning of communication skills and psychotherapy by doctors in the South West Thames Region training in psychiatry (Crisp *et al*, 1987). The working party recommended that all trainees should have experience of treating at least five patients using behavioural–cognitive psychotherapy. As there were at that time 43 senior house officers (SHOs) and 76 registrars (119 trainees) in psychiatry in the Region, it was not possible for the senior lecturer to provide each of them with regular supervision. Instead, one consultant psychiatrist in each teaching hospital was appointed to spend a session a week as a local behavioural psychotherapy supervisor (Drummond, 1992). Subsequently, a diploma in behavioural cognitive psychotherapy was introduced by the Academic Department of Mental Health Sciences at St George's Hospital Medical School in 1993. This diploma required both theoretical and practical behavioural–cognitive experience and was planned primarily for trainee psychiatrists.

The Royal College of Psychiatrists (1993) has since produced new guidelines for psychotherapy training for psychiatric trainees. For the first time they require experience in behavioural–cognitive psychotherapy treating one intensive case and several time-limited cases.

We report a further survey to see how many trainee psychiatrists currently working in the South Thames (West) Region had gained such experience.

The study

All SHOs and registrars employed in the Region between September 1994 and February 1995 were issued with a questionnaire. This asked about psychiatric training, behavioural–cognitive clinical experience and the quality of training.

Trainees received the questionnaire when they attended behavioural–cognitive psychotherapy teaching or the Region's weekly MRCPsych Part II course. Non-responders were sent another copy by post, and if necessary were telephoned and prompted to complete it.

Findings

One hundred of the 137 trainees (73%) in the Region returned the questionnaire. Of these, 50 were registrars (total number of registrars in region=58; response rate=86%) and 50 were SHOs (total SHOs=79; response rate=63%). Vocational general practitioner (GP) trainees working in psychiatry accounted for ten questionnaires returned by the SHOs.

The trainees had been qualified for an average of 6.6 years (range=2–27 years, s.d.=4.4) and had spent an average of 3.5 years (range=1–6 years, s.d.=1.6) in psychiatry. Sixty-four had clinical experience in behavioural–cognitive psychotherapy. If it is assumed that those trainees who did not return the questionnaire had no such experience, 47% of junior psychiatrists had some

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clinical experience. Forty-five (90%) of the 50 registrars who responded (78% of the total number of registrars in the region) had clinical experience. Details of the conditions treated and the treatments used are given in Table 1. Eighty-five of the responders had attended lectures or tutorials on behavioural–cognitive psychotherapy. Sixty-three reported under 12 hours of supervision and teaching while 12 had had 12–24 hours, and 10 over 24 hours. Seventy had experienced all the behavioural–cognitive psychotherapy supervision working in the South Thames (West) Region, with 15 receiving some supervision elsewhere. Trainees had been supervised by a range of professionals including a consultant psychiatrist (54), a psychologist (29), a consultant psychotherapist (23), a nurse behaviour therapist (17) and a senior registrar (7). Sixty-two had experienced group supervision, and 27 individual supervision. Forty-six reported their group having five or fewer trainees, and 16 trainees had been in larger groups. Twenty-six trainees reported fortnightly supervision, 16 weekly supervision, 19 monthly and 7 less than monthly.

The trainees rated how useful, interesting, relevant to clinical practice and relevant to the MRCPsych examination the sessions had been on a nine-point scale (0=low – 8=high). Overall, trainees rated the behavioural–cognitive psychotherapy seminars and supervision as useful (mean=5.5, range=1–8, s.d.=1.8); interesting (mean=5.6, range=1.8, s.d.=0.2); relevant to clinical practice (mean=6.0, range=0.8, s.d.=1.9) and relevant to the MRCPsych examination (mean=5.2, range=0.8, s.d.=1.9).

Not surprisingly, registrars were much more likely to have treated a patient using behavioural–cognitive psychotherapy. Forty-five of the 50 registrars had treated at least one patient, while 20 had treated more than five patients and 18 had treated between two and four. Comparing registrars with SHOs there was a significant increase in clinical experience (χ^2=30.3, d.f.=1, P<0.001) and in the number of cases treated (Mann–Whitney U test, P<0.05).

Similarly, GP vocational trainees were less likely than other trainees to have had any clinical experience (χ^2=64.0, d.f.=1, P<0.0001).

Table 1. Junior doctors' clinical experience of behavioural–cognitive psychotherapy

Any behavioural–cognitive clinical experience	**64**
Diagnoses of patients	
Obsessive–compulsive disorder	35
Agoraphobia	35
Generalised anxiety/panic (cognitive therapy)	28
Depression (cognitive therapy)	27
Social phobia	22
Specific animal phobia	16
Social skills deficit	9
Other phobic condition	16
Sexual dysfunction	6
Sexual deviation	5
Treatments used	
Exposure *in vivo*	50
Exposure in fantasy	34
Self-imposed response prevention	34
Cognitive therapy for anxiety	28
Cognitive therapy for depression	27
Thought stopping	19
Habituation training (for obsessional thoughts)	11
Sexual skills training	10
Social skills training	7
Other types of therapy	6
Total number of patients treated by 64 trainees	199

Comment

This study demonstrates that a large percentage of trainees in our Region treat at least one patient with behavioural–cognitive psychotherapy. This finding is similar to the results of the 1989 survey (Drummond & Bhat, 1989). Since the last survey there have been several changes in the provision of behavioural–cognitive psychotherapy teaching as mentioned in the introduction which might have been expected to increase trainees' motivation to undertake this training. However, these changes may have had a greater impact than demonstrated in our survey. Since 1989, there has been a reduction in registrar posts and an increase in SHO posts which means that there is currently a relatively high proportion of trainees new to psychiatry. Also there are more SHOs in the Region who do not intend to become career psychiatrists. It is encouraging that 90% of registrars who responded to the survey (78% of total sample) had gained behavioural–cognitive clinical experience.

Of concern are the five registrars who reported they had had no experience of behavioural–cognitive psychotherapy and the nine registrars who did not return the questionnaire. A number of these trainees may have only recently started in the Region and may have previously worked in Regions where behavioural–cognitive psychotherapy supervision was not generally available, and some may have been on short-term contracts as locums. However, the findings indicate that even in a registrar rotation with psychotherapy tutors, one whole time equivalent peripatetic senior lecturer in behavioural–cognitive psychotherapy and good support from local behavioural psychotherapy supervisors, some trainees do still

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avoid such experience. Observations over several years lead us to suspect that some trainees gain extensive psychodynamic and behavioural–cognitive psychotherapy experience and also engage in research whereas a small minority do not engage in any of these activities.

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