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Psychiatric Bulletin (2007), **31**, 394–396. doi: 10.1192/pb.bp.106.013227

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Psychotherapy requirements as recommended by the College: awareness and achievement by senior house officers

AIMS AND METHOD

We questioned 141 senior house officers (SHOs) across three training schemes in order to ascertain the awareness and achievement of psychotherapy requirements as recommended by the College. A structured questionnaire was used and administered either in person or over the telephone to all SHOs. Of all the trainees surveyed, 32 were eligible for MRCPsych part II.

RESULTS

Only 9% of the SHOs eligible for MRCPsych part II were able to meet the requirements. Less than a third of all trainees were aware of the College guidelines.

CLINICAL IMPLICATIONS

Trainees face a number of practical problems in meeting the College guidelines. Psychotherapy training for basic specialist trainees is in need of urgent review and steps need to be taken to ensure that SHOs are gaining basic psychotherapeutic skills.

Psychotherapy training is an essential component of basic specialist training in psychiatry. The Royal College of Psychiatrists produced guidelines in 1993 and again in 2001 outlining the training requirements for basic specialist trainees to have experience in several forms of psychotherapy (Royal College of Psychiatrists, 1993, 2001). There are five basic requirements:

- development of interview skills
- psychotherapeutic formulation of psychiatric disorder
- a minimum of three short-term cases (12–16 sessions), each using a different psychotherapeutic model
- one long-term individual case (12–18 months) – any model
- some experience of either group psychotherapy or couple, family or systemic therapy.

Although it is mandatory to fulfil these requirements in order to enter for the MRCPsych part II examination, there is evidence from existing literature that senior house officers (SHOs) have often been unable to meet them (McCrindle *et al*, 2001; Pretorius & Goldbeck, 2006).

The aim of this study was to explore the extent to which SHOs were meeting the College psychotherapy requirements. To our knowledge this is the only such study across three different deaneries.

Method

At the time of the study there were 203 SHOs across three training schemes: groups 1, 2 and 3 (Leeds and Wakefield, Leicester, and Merseyside). Excluding trust doctors, locum SHOs, foundation year 2 and general practitioner trainees, 161 of these 203 SHOs were eligible for this survey. A questionnaire was designed to assess the awareness of psychotherapy training requirements and the achievement of these requirements by SHOs. The questionnaire was in a tick-box format and covered questions on awareness of College psychotherapy guidelines, previous psychiatric experience and experience of various forms of psychotherapy. Respondents were considered aware of the College guidelines if they could list all the College psychotherapy requirements. If they were aware of more than one but not all of the guidelines they were considered partially aware. This questionnaire was administered either in person or over the telephone to the eligible SHOs over a 7-month period between 1 January and 31 July 2006. (A copy of the questionnaire is available from S.A. on request.)

Results

We questioned 141 out of 161 eligible SHOs giving a response rate of 88%. Of these, 20% (n=28) were in the first year of training, 42% (n=60) were in the second year of training and 38% (n=53) had done more than 2 years

of training. Those trainees who have completed 2.5 years of training, and are therefore eligible for MRCPsych part II, should according to the College guidelines have met the psychotherapy training requirements before taking the examination (Royal College of Psychiatrists, 2001).

Of all the respondents, 30% (n=42) were fully aware of the College guidelines, 47% (n=66) knew some of the requirements and 23% (n=33) knew none of the requirements.

Of the respondents eligible for MRCPsych part II (n=32), 95% reported attending a Balint group, 38% had either completed or were involved in a long case, 9% had completed three short cases in different modalities, and 50% had experience of attending group, couple, family or systemic therapy.

All the long cases attempted were in the psychodynamic modality. Cognitive–behavioural therapy (CBT) was used in 76% of the short-term cases, cognitive–analytic therapy (CAT) was used in 19% and supportive psychotherapy in 5%. Only 9% of those eligible for MRCPsych part II met all College guidelines, and these were all in group 3.

Discussion

The main finding of our study was that 91% of the respondents were not able to meet the College psychotherapy guidelines by the time they were eligible for the MRCPsych part II examination. This is in line with existing literature (Hwang & Drummond, 1996; McCrindle *et al*, 2001; Pretorius & Goldbeck, 2006). The other finding was that 23% of the trainees knew none of the psychotherapy requirements.

Anecdotal evidence suggests that the most common difficulty faced by trainees in meeting the College guidelines is lack of suitable training cases. These training cases can be difficult to provide as it requires 9–12 h of assessment time by psychotherapy consultants to yield one patient suitable for psychodynamic psychotherapy (Janmohamed *et al*, 2004). However, there is evidence to suggest that SHOs can be effective therapists (Mace *et al*, 2006) and can also have an important impact on service, leading to a reduction in waiting times for treatment (Janmohamed *et al*, 2004).

There are several other practical hurdles that trainees face that can limit their access to psychotherapy. For example, the therapist is expected to see a client for long-term psychotherapy at the same place and same time for at least 12–18 months. With the changes in working patterns, introduction of partial shift system, job changes every 6 months (often over a wide geographical area), patients frequently defaulting and pressure of the MRCPsych examination, this can often be an impossible task for trainees (Kolawole *et al*, 2006). In training schemes which implement half-day protected time for psychotherapy training, more SHOs are able to take up cases for psychotherapy (Wildgoose *et al*, 2002; Janmohamed *et al*, 2004). This is not the case across all training schemes, giving rise to widespread variation in training opportunities.

In this study, 95% of the trainees were attending or had attended only a Balint-type group in the first year of their training, which is also evident in other schemes (Das *et al*, 2003; Duddu & Brown, 2004). This leaves them with only 2 years to meet the other four psychotherapy requirements. We suggest that if suitable training cases were allocated in the first year, trainees would not only find it easier to meet College guidelines but would also develop useful skills that could help in their everyday practice.

It is also evident from this study that few SHOs are using psychotherapeutic modalities other than CBT for the short-term cases. Specialist services like the eating disorder service and personality disorder network exist across the training schemes in this survey; they use other psychotherapeutic models such as dialectical behaviour therapy, interpersonal therapy and CAT. These are underutilised by SHOs as access to them is limited to trainees placed there. It is imperative that the therapies provided by specialist services are integrated into general psychotherapy training so that trainees get a greater variation of experience.

Some of the previous studies (Podlejska-Eyres & Stern, 2003; Carley & Mitchison, 2006) carried out in other regions have reported a greater proportion of SHOs meeting the psychotherapy requirements compared with our sample. This shows that there are disparities in psychotherapy training opportunities across different regions. It may be worthwhile to undertake a survey of all basic specialist trainees in psychiatry under the auspices of the College to identify regions where deficiencies exist in psychotherapy training. From the trainee perspective, we value the psychotherapy training we are given, and we hope that psychotherapy training will be fully integrated into the new system so that all trainees will have the opportunity to develop basic psychotherapeutic skills essential for any competent psychiatrist.

There are several limitations to this study. In our sample SHOs were at different stages of their training, and those on the scheme for only a short time may not be expected to be aware of all the training requirements. However, making the SHOs aware of the guidelines by introducing them at induction may motivate them to seek psychotherapy training. In addition, we did not look at whether SHOs who have passed MRCPsych part II examination met the psychotherapy requirements. This could be addressed in future studies by surveying those who have passed MRCPsych part II.

Declaration of interest

None.

Acknowledgements

We thank Drs Emad Salib and Ihsan Kader for their supervision and Dr Anne Worrall-Davies for reviewing the manuscript.

https://doi.org/10.1192/pb.bp.106.013227 Published online by Cambridge University Press

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https://doi.org/10.1192/pb.bp.106.013227 Published online by Cambridge University Press