Psychotherapy training and experience of successful candidates in the MRCPsych examinations

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We conducted a survey of the psychotherapy training of a national sample of successful MRCPsych candidates to discover the extent of their psychotherapy training and their opinion about its adequacy. Ninety doctors answered the survey. Overall 71% of trainees had clinical experience in behavioural–cognitive psychotherapy and 78% in psychodynamic psychotherapy with fewer gaining experience in group and family psychotherapies. The majority of trainees were dissatisfied with the extent of their behavioural–cognitive psychotherapy training (82%) and psychodynamic training (50%). Trainees felt that their psychotherapy training was an important component of their psychiatric training.

In June 1993, the Royal College of Psychiatrists published new guidelines for psychotherapy training for junior psychiatric trainees. For the first time psychotherapy training was made compulsory for general professional training (RCP, 1986, 1993). This change coincided with changes to the MRCPsych Part II examination where candidates could be tested on their ability to give psychodynamic and cognitive–behavioural formulations based on a patient's case history.

There has, however, been continuing disquiet among both trainees and trainers about these changes and their abilities to achieve the targets set out in the guidelines. Some of these concerns such as the deficits in training in behavioural–cognitive psychotherapy and family therapy were highlighted in the recent paper by the Collegiate Trainees' Committee (Castle *et al*, 1994).

In the light of the concern we decided to establish the extent of psychotherapy training in successful MRCPsych Part II examination candidates. This group was chosen on the basis that they had just completed their general professional training in psychiatry. The study was designed to identify regional differences and candidates' own views on the importance they attach to psychotherapy experience.

The study

In the Spring 1994 MRCPsych Part II Examinations, there was a total of 291 candidates of which 144 (49.5%) were successful. These successful doctors were sent a questionnaire enclosed with their results from the Royal College of Psychiatrists.

The questionnaire asked candidates to report their experience in behavioural–cognitive psychotherapy, individual dynamic psychotherapy, group therapy, family therapy, personal and other psychotherapies. In addition, candidates were asked their opinion on the adequacy and relevance of psychotherapy experience in their training.

Findings

Ninety (62.5% of total sample) replies were received and although the option of anonymity was offered, only 15 chose not to identify themselves.

Candidates' background

United Kingdom graduates comprised almost three-quarters of the respondents (England 60%, Scotland 4%, Wales 7%, Northern Ireland 3%). Only four qualified from Eire. Among overseas graduates, over a third were from the Indian subcontinent.

The doctors had qualified an average of 7.6 years previously (range=14; s.d. 2.92; mode=5 years). Three-quarters had been working in psychiatry for less than five years but seven trainees had been in the field for longer than eight years. Most trainees (88%) were registrars but there were four senior house officers, two staff psychiatrists and two senior registrars.

Three quarters of the respondents had been in a psychiatric rotational training scheme linked to a university hospital/medical school.

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Candidates' psychotherapy experience

Most trainees reported attending lectures in behavioural–cognitive psychotherapy (90%) and dynamic psychotherapy (94%). The majority of trainees (78%; 70) had experience of individual dynamic psychotherapy. Most trainees who had this experience (69%; 48) had been in psychiatry for less than five years. Dynamic psychotherapy experience was lacking in the three trainees from Northern Ireland and was uncommon for trainees from Wales, the West Midlands and Eire. Most of the trainees (71%; 50) who had experience of individual dynamic psychotherapy had treated two or more cases.

In contrast to the situation with behavioural–cognitive psychotherapy, only one trainee was not supervised. Consultant psychotherapists provided the supervision for most trainees (69%; 48).

Fifty-eight per cent had experience of group psychotherapy. Much of this experience was unsupervised. Just over half (56%; 50) of the trainees had experience of family/marital therapy. Family therapy experience was more frequent in trainees from Northern & Yorkshire, South Thames and Special Health Authority in London. Only 6% (3) of the trainees were not supervised. Most (60%; 30) were supervised by consultant psychiatrists.

About a third (26) of respondents reported other psychotherapy experiences. Cognitive analytic therapy and supportive psychotherapy were most commonly mentioned. Others that were highlighted included psychodrama, music therapy, art therapy, hypnotherapy and participation in staff support groups.

A third (28) of trainees had undergone personal psychotherapy. The majority of them 71% (20) experienced individual therapy. Group experience accounted for just over a fifth (21%). Over a third (36%) of those with personal experience had duration extending beyond 18 months while slightly less than a third (32%) spent less than six months in personal psychotherapy.

The majority (82%; 74) of respondents indicated that they did not have enough training in behavioural–cognitive psychotherapy. Even among those who had gained behavioural–cognitive clinical experience, a majority (47 out of the 63) felt that they would have benefited from more training. Fewer trainees (57%; 51) indicated that they did not have enough training in dynamic psychotherapy.

The doctors were asked to rate the importance of the various aspects of psychotherapy training using a four point scale with 1=unimportant and 4=extremely important. The mean score on this scale was 3.44 (s.d.=0.76; range=1–4) with over half (56%) indicating that psychotherapy experience was extremely important in relation to their psychiatric training.

Comment

The response rate for the study was good. The willingness of the great majority not to remain

Table 1. Details of the trainees' clinical experience

	Behavioural–cognitive psychotherapy	Individual dynamic psychotherapy	Group therapy	Family therapy
Percentage with experience	71%	78%	58%	56%
Number of cases treated/ groups led	⩾5 40%	⩾5 33%	⩾5 2%	⩾5 43%
		⩾2 71%	⩾3 12%	1 25%
			2 26%	
			1 48%	
Treatment sessions	–	<20 sessions 17%	<20 sessions 53%	<20 sessions 52%
		>50 sessions 50%	>50 sessions 16%	>50 sessions 8%
Duration of experience	–	<12 months 53%	<6 months 60%	<6 months 56%
		>18 months 36%	>12 months 19%	>12 months 10%
Candidates supervised	86%	97%	80%	94%
Supervisors				
Consultant Psychotherapist	11%	69%	29%	18%
Consultant Psychiatrist	65%	29%	26%	60%
Psychologist	40%	16%	–	10%
Nurse Therapist	19%	–	10%	14%
Senior Registrar	–	16%	–	–
Form of supervision				
Individual	60%	17%		
Group	19%	49%		
Both	16%	33%		

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anonymous made possible regional differences in the various aspects of training to be identified. It is understandable that regional variations in psychotherapy training are inevitable in the present context of inadequate resources and supervisory manpower. However, the dearth of group and family therapy in entire regions is worrying.

In general, there was a high reported rate of attendance at both behavioural–cognitive and dynamic psychotherapy theoretical teaching. Greater exposure to behavioural–cognitive psychotherapy lectures and seminars was associated with greater exposure to psychodynamic theoretical teaching.

It is encouraging to note that contrary to expectation, almost three-quarters of the respondents had experience of treating patients using behavioural–cognitive techniques. However, the overall view remains that there is insufficient training in this field of psychotherapy. This was consistent with the recent findings of the Collegiate Training Committee (Castle *et al*, 1994). It appears that even in respondents who have treated five or more cases, the level of dissatisfaction remained high with this aspect of their psychotherapy training. This problem may be as much to do with the quality of training and supervision currently available, as the need to widen the availability of behavioural–cognitive psychotherapy to these regions which have little access to this training. It is significant to note that consultant psychotherapists only supervised a tenth of trainees treating patients using behavioural–cognitive techniques.

Individual dynamic psychotherapy is generally considered a crucial experience of training in psychotherapy with important implications in all other psychiatric work. It is alarming that almost a quarter of the trainees who have completed their general professional training have no experience in this aspect of psychotherapy training. The problem arose from a small number of regions which lack facilities for psychodynamic psychotherapy training. Another problem with psychodynamic training is that trainees often need to move base, which leads to difficulties in longer term therapies. From our survey, approximately half of the trainees with experience of individual dynamic psychotherapy had therapy extending over a year. The availability and frequency of dynamic psychotherapy supervision appears satisfactory in most regions.

The eclectic experience recommended for psychotherapy training is clearly difficult to achieve as only seven of the respondents indicated experience in all six categories. The latest set of guidelines from the College has attempted to be more specific in its targets and recommendations.

There are clear areas of deficits and difficulties in psychotherapy training for general professional psychiatric training. The increasing emphasis and input by the College in attempting to rectify the current less than satisfactory situation is to be lauded.

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