in all specialities, except possibly with respect to a fear of isolation. Because of the replacement of long-stay hospitals with community-based services, isolation has become a particular problem for consultants in the psychiatry of learning disability. This was further highlighted by the fact that 71% would be cautious about choosing a consultant post where there were no consultant colleagues. This factor may discriminate against certain types of post, for example those in rural locations or in small trusts.

Planned mergers of many small NHS trusts in the near future may contribute to an improvement in this aspect. Another possible remedy might be to encourage the development of trusts more specialised in learning disability work, providing both in-patient and community services. By serving a larger population base on a sub-regional basis, more consultants would be working together under the same employer, facilitating support and communication. It would also allow better continuity of care and further specialisation of service development (e.g. providing tertiary 'centres of excellence' in autism/epilepsy, or mentally disordered offenders).

Despite the various concerns it was reassuring to see that the majority of respondents (94%) were pleased with their choice of learning disability as a career. The results indicated that important factors were the clinical challenge and the interesting client group, with only 14% being influenced by salary enticements. The high number of questionnaires returned also indicated a keen interest by trainees in their training and future.

It would seem that trainees welcome regular annual conferences, such as those offered by the Faculty, but that these should also address training issues and provide regular advice such as how to find the right consultant post. We hope that the recent College Council directive will improve recruitment into the Faculty.

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Psychotherapy experience in Ireland

Siobhan Rooney and Gabrielle Kelly

Aims and method A questionnaire was sent to members of the Psychotherapy Section of the Irish Division of the Royal College of Psychiatrists to assess psychotherapy training.

Results Members from Northern Ireland, compared with those from the Republic, had more mandatory psychotherapy experience in a variety of psychotherapies, had attended more lectures on the theories of the psychotherapies, had cases longer in analysis and were more satisfied with their level of supervision. Few non-consultant hospital doctors had obtained mandatory psychotherapy training as outlined by the

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College guidelines and they were also generally dissatisfied with their basic training in psychotherapy.
Implications Although there were clear qualitative differences in psychotherapy training between Northern Ireland and the Republic, 100% of members believed there should be improvements in the training of psychotherapy in Ireland. If the Royal College guidelines are to be adhered to, these results would imply that changes in the structure of psychotherapy training in Ireland particularly for non-consultant hospital doctors are required.

The Royal College of Psychiatrists has outlined the importance of psychotherapy training as being an integral part of general professional psychiatric training (Grant *et al*, 1993). The objectives being to improve interview and communication skills, to understand and practise the principles of supportive counselling, to explore the dynamics of the doctor–patient relationship and to know the basic principles of cognitive–behavioural and dynamic psychotherapy, such learning being obtained through a small group format with general practitioner trainees and psychiatric senior house officers. The College guidelines (Grant *et al*, 1993) have detailed a core level of psychotherapeutic experience that is mandatory and emphasises the need for regular supervision of cases in psychotherapy throughout training. Previous studies (Hamilton & Tracey, 1996; Hwang & Drummond, 1996; Byrne & Meagher, 1997) have assessed the extent of psychotherapy training and clinical psychotherapeutic experience of trainees in psychiatry and have found that training falls short of the guidelines outlined by the College, with trainees in eastern Ireland having particularly higher levels of dissatisfaction and a substantial proportion having lower levels of training than previous studies (Byrne & Meagher, 1997).

The function of this study was to assess the extent of mandatory psychotherapy training and experience of non-consultant hospital doctors who are registered members of the Psychotherapy Section of the Irish Division of the College and to also compare regional differences between members' training from Northern Ireland and the Republic of Ireland. Although there is one Psychotherapy Section of the Irish Division of the College, Northern Ireland and the Republic are different countries with two different health services and appear to have different emphases on psychotherapy training and the format it should take. This study assesses the quantitative and qualitative differences in psychotherapy training between Northern Ireland and the Republic and determines if training is in accordance with the College guidelines.

The study

Following a meeting of the Psychotherapy Section of the Irish Division of the College in 1996, an attempt was made to increase the membership of the section and to encourage trainees in psychiatry who were interested in psychotherapy to become members of the Psychotherapy Section. A circular was sent through the Irish Division of the College inviting membership.

A questionnaire was formulated and circulated to the registered members of the Irish Psychotherapy Section. The questionnaire primarily assessed the level of mandatory psychotherapeutic experience obtained by members as outlined by the College guidelines, their experience of supervision in their training, levels of satisfaction with training and supervision and what suggested changes were necessary to improve the training of psychotherapy in Ireland. Results were compared between Northern Ireland and the Republic of Ireland and the experience and training in psychotherapy of non-consultant hospital doctors was highlighted.

Findings

The response rate was 46% (*n*=46). A total of 23.9% (*n*=11) answered the questionnaire from Northern Ireland and 76.1% (*n*=35) answered from the Republic of Ireland. Of the non-consultant hospital doctors, 14.3% (*n*=3) were from The North and 85.7% (*n*=18) were from the Republic. From the total sample, 46.7% (*n*=21) were non-consultant hospital doctors, and of these 10.9% (*n*=5) were senior registrars/specialist registrar, 28.3% (*n*=13) were registrars and 6.5% (*n*=3) were senior house officers in psychiatry. The median number of years in psychiatry for those in Northern Ireland was 16 years and the median number of years in psychotherapy was three years. The median number of years in psychiatry for members from the Republic was eight years and the median number of years in psychotherapy was four years.

With regard to mandatory psychotherapy experience as outlined by the College guidelines, 14 (31.8%) of the total sample had attended an interview methods course or doctor–patient relationship seminar along 'Balint' lines in their first year of training, 40% (*n*=4) from Northern Ireland and 29.4% (*n*=10) from the Republic of Ireland. Mandatory psychoanalytical psychotherapy experience was obtained by 63.6% (*n*=7) of members in Northern Ireland compared with 51.4% (*n*=18) of members in the Republic. More doctors in the Republic had obtained mandatory psychotherapy experience in cognitive–behavioural

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psychotherapy, 47.1% (*n*=16) compared with 36.4% (*n*=4) in Northern Ireland. Two (10.5%) non-consultant hospital doctors had experience of Balint groups and 28.6% (*n*=6) had obtained mandatory experience in psychoanalytical psychotherapy (Table 1).

Proportionally more doctors from Northern Ireland had attended lectures in psychoanalytical psychotherapy, 100% (*n*=11), family psychotherapy, 81.8% (*n*=9) and group psychotherapy, 72.7% (*n*=8) compared to doctors from the Republic. More members from the Republic had attended lectures in cognitive-behavioural psychotherapy, 82.9% (*n*=29). Non-consultant hospital doctors most commonly attended lectures on the theories of cognitive-behavioural psychotherapy (Table 2).

The average duration of cases in psychotherapy are outlined in Table 3. Members from Northern Ireland saw cases longer with 60% (*n*=6) seeing clients for an average of two years or more compared to 20% (*n*=7) in the Republic. The majority of non-consultant hospital doctors, 66.7% (*n*=14), saw clients in psychotherapy for six months or less.

There were no significant differences in the amount of supervision in each psychotherapy depending on whether one was from Northern Ireland or the Republic of Ireland. However, over 50% of members from Northern Ireland and the Republic had received one hour or less supervision per month in cognitive-behavioural family, group and brief focus psychotherapy. The majority of non-consultant hospital doctors, 61.9% (*n*=13), had supervision for one hour or less per month with 9.6% (*n*=2) having had supervision for four hours or more per month (Table 4).

Supervisors were most commonly a consultant psychiatrist in 56.6% (*n*=26) of cases and a consultant psychotherapist in 48% (*n*=22) of cases, with only one (2.2%) supervisor being a senior or specialist registrar; 81.8% (*n*=27) of supervisors were psychoanalytically trained and 24.2% (*n*=8) were cognitive-behaviourally trained.

Significantly more doctors from Northern Ireland, 54.55% (*n*=6), rated their supervision as 'excellent' compared to 22.9% (*n*=8) in the Republic, whereas 17.1% (*n*=6) from the Republic and 0% from Northern Ireland rated their super-

Table 1. Mandatory psychotherapy experience

	Total sample *n*=46	**Northern Ireland**	**Southern Ireland**	**Non-consultant hospital doctors**
Balint group	14 (31.8%)	4 (40.0%)	10 (29.4%)	2 (10.5%)
Psychoanalytical psychotherapy	25 (54.3%)	7 (63.6%)	18 (51.4%)	6 (28.6%)
Cognitive-behavioural psychotherapy	20 (44.4%)	4 (36.4%)	16 (47.1%)	7 (35.0%)
Family psychotherapy	25 (54.3%)	7 (63.6%)	18 (51.4%)	7 (33.3%)
Group psychotherapy	18 (39.1%)	7 (63.6%)	11 (31.4%)	4 (19.0%)
Brief focus psychotherapy	19 (42.2%)	5 (45.4%)	14 (41.2%)	7 (33.3%)

Table 2. Attendance at lectures

	Northern Ireland	**Southern Ireland**	**Non-consultant hospital doctors**
Psychoanalytical psychotherapy	11 (100.0%)	25 (71.4%)	12 (57.1%)
Cognitive-behavioural psychotherapy	8 (72.7%)	29 (82.9%)	15 (71.4%)
Family psychotherapy	9 (81.8%)	22 (62.9%)	11 (52.4%)
Group psychotherapy	8 (72.7%)	20 (57.1%)	8 (38.1%)
Brief focus psychotherapy	5 (45.4%)	19 (54.3%)	8 (38.1%)

Table 3. Average duration of cases in psychotherapy

	Northern Ireland[1] (*n*=10)	**Southern Ireland**	**Non-consultant hospital doctors**
Six months or less	3 (30%)	15 (42.9%)	14 (66.7%)
One year	0 (0%)	8 (22.9%)	4 (19.0%)
18 months	1 (10%)	5 (14.3%)	0 (0%)
Two years	4 (40%)	5 (14.3%)	1 (4.8%)
More than two years	2 (20%)	2 (5.7%)	2 (9.5%)

1. One missing case.

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Table 4. Frequency of supervision

	Frequency per month	Northern Ireland	Southern Ireland (n=33)	Non-consultant hospital doctors
Psychoanalytical psychotherapy	One hour or less	3 (27.3%)	12 (37.5%)	13 (61.9%)
	Four hours or more	6 (54.5%)	11 (34.4%)	2 (9.6%)
Cognitive-behavioural psychotherapy	One hour or less	8 (72.7%)	21 (63.6%)	14 (66.7%)
	Four hours or more	0 (0%)	4 (12.2%)	2 (9.6%)
Family psychotherapy	One hour or less	7 (63.6%)	19 (57.5%)	13 (61.9%)
	Four hours or more	1 (9.1%)	8 (24.2%)	4 (19.0%)
Group psychotherapy	One hour or less	8 (72.7%)	28 (84.9%)	18 (85.7%)
Brief focus psychotherapy	One hour or less	10 (90.9%)	22 (66.6%)	16 (76.2%)

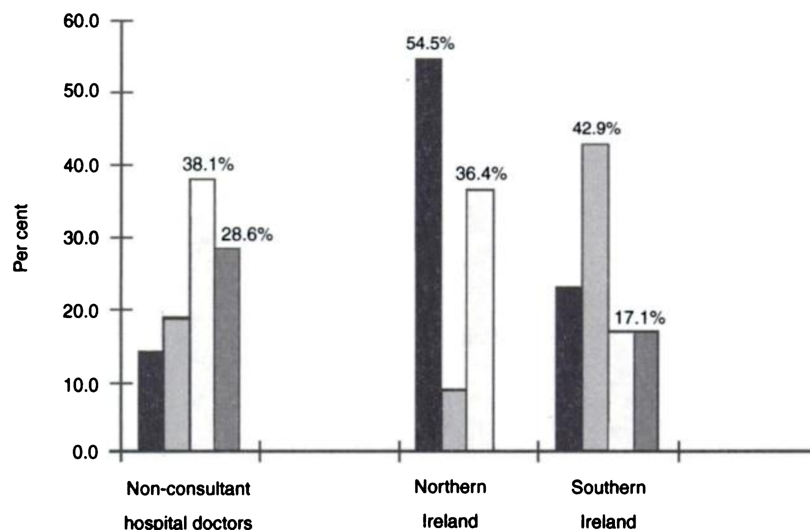

Fig. 1. Rates of satisfaction to supervision. ■, excellent; ■, good; □, adequate; ■, poor.

vision as 'poor' (P=0.03). Of the non-consultant hospital doctors, 28.6% (n=6) rated their supervision as being 'poor' (Fig. 1).

There were no significant differences in the levels of satisfaction to basic training in psychotherapy between Northern Ireland and the Republic of Ireland. Five (45.5%) from Northern Ireland and 14 (40%) from the Republic rated their training as excellent/good, 3 (27.3%) from Northern Ireland and 10 (28.6%) from the Republic rated it as very poor/poor and the remaining described their training as adequate. Non-consultant hospital doctors' level of satisfaction with their training indicated that, 9.5% (n=2) described it as good, 42.9% (n=9) described it as adequate and 47.6% (n=10) described it as being poor/very poor.

More doctors from the Republic felt they needed more training in all the psychotherapies but significantly cognitive-behavioural psychotherapy, 62.9% (n=22) (P=0.004), and group psychotherapy, 60% (n=21) (P=0.035). The majority of non-consultant hospital doctors felt they needed further training in all the psychotherapies (Table 5).

One hundred per cent of the sample believed that there should be improvements in the training of psychotherapy in Ireland. The most popular suggestions for improving psychotherapy training included: more supervision of cases in psychotherapy; increased availability of trained supervisors; increased availability of training schemes in psychotherapy; and the use of small group meetings for case presentations (Fig. 2). One hundred per cent of non-consultant hospital doctors supported the use of log-books to document their training in psychotherapy.

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Table 5. Percentages of doctors who felt they needed further training

	Northern Ireland	Southern Ireland	Non-consultant hospital doctors
Psychoanalytical psychotherapy	3 (27.3%)	16 (45.7%)	14 (66.7%)
Cognitive-behavioural psychotherapy	1 (9.1%)	22 (62.9%)*	17 (80.9%)
Family psychotherapy	3 (27.3%)	20 (57.1%)	16 (66.7%)
Group psychotherapy	2 (18.2%)	21 (60.0%)*	16 (76.2%)
Brief focus psychotherapy	2 (18.2%)	13 (37.1%)	13 (61.9%)

*$P<0.05$

Comment

The response rate in the study was low, with more consultants answering the questionnaire. Consultants may have been more willing to answer the questionnaire because they were significantly more satisfied with their training and had more psychotherapy experience. The low response rate may reflect a reluctance to answer any questionnaire but it may also represent an apathy towards psychotherapy training in Ireland. The results can only be interpreted in a limited capacity in view of this low response rate.

Of those who did answer the questionnaire, it emerged that more doctors in Northern Ireland had gained mandatory psychotherapy experience of Balint groups, psychoanalytical, family and group psychotherapy as outlined by the guidelines of the College. They had attended more lectures on the theories of these psychotherapies, had more frequent supervision in psychoanalytical psychotherapy and had cases for longer in psychotherapy. In the Republic more doctors had obtained mandatory psychotherapy experience in cognitive-behavioural psychotherapy and more had attended lectures in cognitive-behavioural psychotherapy. More members from the Republic felt they needed further training in all the psychotherapies, but specifically cognitive-behavioural and group psychotherapy. It is clear that members in Northern Ireland have a broader and have more mandatory experience of a range of psychotherapies, whereas in the Republic there appears to be more emphasis and a greater interest in obtaining psychotherapy training in cognitive-behavioural psychotherapy.

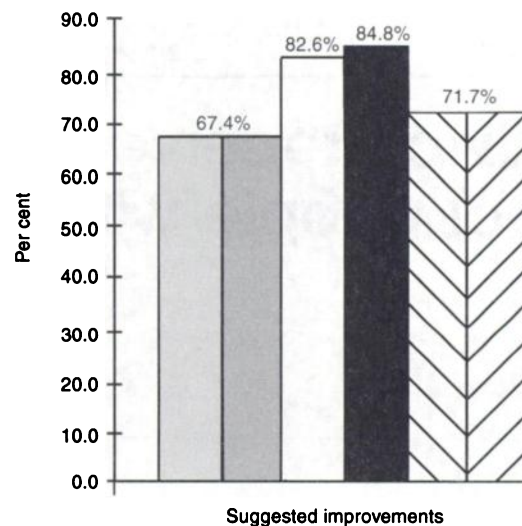

Fig. 2. Suggestions for improving psychotherapy training. ▣*, reading groups;* ■*, more lectures;* □*, more trained supervisors;* ■*, more supervision;* ▧*, training schemes;* ▨*, small group meetings*

In comparison, relatively few non-consultant hospital doctors had obtained mandatory psychotherapy training as outlined in the guidelines of the College. The majority rated their satisfaction to training in psychotherapy as being poor/ very poor and identified a need for further training in psychoanalytical, cognitive-behavioural, group and brief focus psychotherapy.

Members from Northern Ireland were significantly more satisfied with the standard of their supervision during their psychotherapy training. Possible reasons include a greater availability of supervisors, more frequent supervision, cases in psychotherapy longer or that members have access to a broader range of training in a variety of psychotherapies compared to members in the Republic. However, there remains a large proportion of doctors in Northern Ireland and the Republic who have one hour or less supervision per month in cognitive-behavioural, family, group and brief focus psychotherapy and are therefore not receiving adequate psychotherapy supervision. The majority of non-consultant hospital doctors have one hour or less supervision per month in all psychotherapies. This lack of psychotherapy supervision, may explain why non-consultant hospital doctors generally have cases in psychotherapy for six months or less.

In this study, only eight (24.2%) of supervisors were cognitive-behaviourally trained despite there being an obvious need from non-consultant hospital doctors and doctors from the

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Republic for further training in cognitive–behavioural psychotherapy. Previous studies (Stern, 1993; Castle *et al*, 1994) drew attention to the specific deficits of training in cognitive–behavioural psychotherapy and supported the advice that there should be an increase of senior registrar posts in this speciality, so that future consultants will have some experience of cognitive–behavioural psychotherapy.

One hundred per cent of the sample recognised a need for improving psychotherapy training in Ireland. Some individual suggestions included a need to formalise a structured national training programme in psychotherapy, appointments of consultant psychotherapists in the Republic and support from the Irish Division of the College to promote psychotherapy training in psychiatry.

For a more structured and continuous means of assessing training in psychotherapy and ensuring that all non-consultant hospital doctors have adequate supervised training in all psychotherapies, previous papers have advocated the use of log-books (Royal College of Psychiatrists, 1995; Hamilton & Tracy, 1996; Sullivan *et al*, 1997). In this study 100% of non-consultant hospital doctors and 87% of consultants supported the use of log-books for documenting psychotherapy training.

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Information and advice received by carers of younger people with dementia

Hilary J. Husband and Meera N. Shah

Aims and method Retrospective information on advice and information received post-diagnosis was obtained from 40 carers of younger people with dementia, using a semi-structured interview.

Results Twelve carers received services from old age psychiatry, the remaining 28 from predominantly adult psychiatry or neurology. Those in receipt of old age services reported greater adequacy of diagnostic information, higher levels of advice giving and more frequent referral to social services.

Clinical Implications While old age services were more successful on the parameters examined, the gradually

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