

A Regional Survey of the Training of Junior Psychiatrists in Behavioural Psychotherapy

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It is 16 years since the Royal College of Psychiatrists published its recommendations for the training of psychiatrists.¹ The guidelines for the training of general psychiatrists in psychotherapy have recently been reviewed and, once again, experience in behavioural psychotherapy was an integral part of such training.²

The efficacy of teaching behavioural psychotherapy techniques to various professional and non-professional groups has been extensively researched. However, there have been few reports on the efficacy of teaching behavioural psychotherapy to junior psychiatrists. Previous reports have been on small numbers of interested junior doctors.^{3,4}

Large surveys of doctors have either examined the overall experience of psychiatrists of general professional training⁵ or have examined experience in psychotherapy in general, which includes behavioural psychotherapy.^{6,7} In addition these reports have depended on self-report of experience without the use of objective measurement of the efficacy of training.

The present study aimed to evaluate the effect of three teaching sessions on the behavioural experience and knowledge of junior psychiatric trainees in the South West Thames Region.

Method

The sample

The South West Thames Region and its psychiatric hospitals have been described previously.^{8,9} All clinical tutors in the Region were contacted and arrangements made for monthly teaching sessions to be held in their own hospitals.

There are 11 postgraduate psychiatric teaching rotations in the Region and of these 10 clinical tutors agreed to the monthly meetings. One clinical tutor declined the offer as he believed his trainees were already receiving adequate behavioural psychotherapy training.

The present survey excludes the information obtained from trainees working in the Wandsworth District, which is served by St George's Hospital Medical School, as these trainees had greater access to behavioural psychotherapy teaching with sessions held at weekly intervals. The nine rotations included in the survey consisted of 68 trainees who were based at 27 different psychiatric institutions. The questionnaire information was obtained from 61 of these trainees.

Timing of the survey

The survey was conducted shortly after the appointment of a new peripatetic senior lecturer (Dr Lynne M. Drummond). Prior to this appointment there had been

no regular senior lecturer teaching in behavioural psychotherapy in the region for at least one year.

The questionnaire information was obtained during the initial three sessions at each hospital base, i.e. January–March 1986. However, two of the hospitals were unable to commence the sessions until later in the year and the survey was thus delayed by two months at these sites.

Teaching sessions

The teaching sessions were a minimum of two hours in length and contained four elements:

- (1) Lectures on an aspect of behavioural psychotherapy—30 minutes each. The topics covered were: (a) anxiety and phobic disorders; (b) obsessive-compulsive disorders; (c) application and use of behavioural psychotherapy.
- (2) Video demonstrators of a behavioural treatment session—30 minutes each (in sessions 1 and 2 only).
- (3) Questions and discussion (all sessions).
- (4) Supervision of trainees' clinical cases. This was performed using role play and a portable video camera for feedback to trainees (all sessions).

Questionnaires

Each trainee psychiatrist who attended a behavioural psychotherapy teaching session during the period of the survey was issued with a personal identification number (PIN). This number was unknown to the senior lecturer or other trainees and was used by the trainee on all questionnaires during the survey. The purpose of the PIN was to ensure confidentiality and to encourage trainees to give accurate feedback on how valuable they found the sessions.

Four questionnaires were administered during the survey:

- (1) **Background information questionnaire** (Session 1).
- (2) **Multiple choice questionnaire** (Sessions 1 and 3). 50 True–False questions about behavioural psychotherapy. In order to test its validity, it was also administered to behavioural nurse therapists who were at the end of their training for the ENB650 Course at the Maudsley Hospital.¹⁰ They had a mean score of 78% with a range of 70–92%.
- (3) **Evaluation of session** (Sessions 1, 2 and 3). Visual analogue scales recording how useful—useless; boring—interesting; relevant to clinical practice—not relevant to clinical practice; relevant to MRCPsych—not relevant to MRCPsych, each session and its various components were felt to be.

(4) Final questionnaire (Session 3).

Visual analogue scales were used as before but recording overall assessment of initial three sessions. Trainees asked whether they had been prompted to read further about behavioural psychotherapy, had used techniques in clinical practice and if they intended to continue attending.

Results*Attendance*

Of the 68 trainees who could have attended the sessions, 61 (89.8%) attended at least one behavioural psychotherapy teaching session during the period of the survey. However, the attendance reduced at each teaching session during the survey: 50 trainees (73.5%) attended session 1, 38 (55.9%) attended session 2 and only 28 (41.2%) attended session 3. Interestingly, the attendance increased in the sessions following the survey and 38 (55.9%) attended session 6.

Subjects

Sixty-one trainees attended at least one of the teaching sessions during the survey. Of these, 25 (41%) were employed as senior house officers (SHO) and 36 (59%) as registrars. Sixteen (26.2%) had spent less than six months in psychiatry, 23 (37.7%) between six months and three years and 22 (36.1%) more than three years.

The majority of trainees reported that they had received little previous teaching in behavioural psychotherapy. Thirty-three (54.1%) reported that they had not previously attended any lecturers on behavioural topics and only six (9.8%) trainees reported that they had received more than 12 hours didactic behavioural teaching.

The majority of trainees, 43, (70.5%) reported no previous behavioural psychotherapy supervision. The trainees who did report previous supervision were ten (16.4%) who had received between 0–6 hours, five (8.2%) 6–12 hours and only three (4.9%) more than 12 hours. In view of this it is not surprising that most trainees had little or no clinical experience in behavioural techniques. Eleven trainees (18.0%) reported that they had treated an agoraphobic patient, eight (13.1%) an obsessive compulsive patient, six (9.8%) sexual dysfunction, five (8.8%) social skills deficits and an even smaller number specific phobia or sexual deviations. The most frequent behavioural technique used was exposure *in vivo* used by 13 trainees. Eight trainees reported they had used response prevention and an identical number of trainees exposure in fantasy. Six trainees claimed to have used cognitive therapy for depression and two trainees for anxiety but with the lack of previous behavioural supervision, it was unclear as to how this was defined by trainees.

Multiple choice paper

The initial mean score for all subjects ($n=61$) was 60.4%. The trainees who attended more than one session and completed two MCQ papers ($n=28$) had an initial mean MCQ score of 62.7%.

The mean score on the repeat MCQ paper at the third session was 72% ($n=28$). This improvement in the MCQ score was significant at <0.01 (paired t-test).

The relationship between a number of factors and the initial MCQ score was examined using an analysis of variance if the factor was categorical and correlational analysis if continuous. No significant difference was found between the length of time trainees had been in psychiatry and their initial MCQ scores. Trainees who had previously attended lectures in behavioural psychotherapy scored a mean of 9% higher on the initial MCQ paper ($P<0.001$). Previous supervision in behavioural psychotherapy was also reflected in a higher initial MCQ score ($P<0.001$).

Evaluation of sessions

Overall the trainees reported that they valued the sessions. Visual analogue scores showed that trainees found the sessions useful, interesting, relevant to clinical practice and to MRCPsych.

The final questionnaire was completed by 28 trainees. Of these, 20 (69%) reported that the sessions had prompted them to read about behavioural psychotherapy and 26 (89.7%) said that they intended to continue attending the sessions. However, only six (20.7%) had used any of the techniques they had learned in clinical practice at this early stage.

Drop-outs

The drop-out rate was high from the sessions. Whether the trainees who failed to continue attending the sessions differed from those who continued to attend any of the measures recorded was examined using analysis of variance. No significant difference was found in the general psychiatric experience, behavioural psychotherapy experience, initial MCQ scores of the evaluation of the sessions.

Discussion

This paper demonstrates that behavioural psychotherapy teaching is welcomed by junior hospital doctors who find it relevant to their clinical practice as well as to the MRCPsych examination. This finding is similar to that of other workers.^{3,4} However, the number of registrars who reported that they used the skills learned in the sessions in their clinical work was disappointingly low. Although the timing of the survey was limited and it was performed at the commencement of formal behavioural psychotherapy supervision, whereas more registrars have subsequently used the skills, it does emphasise the need for encouragement from teachers for practical experience to be obtained. Trainees themselves have frequently reported that their consultants have been unwilling to allow them to treat patients behaviourally, preferring them to refer patients to clinical psychologists. If this is the case then further education of many consultants to the Royal College's Recommendations for Behavioural Psychotherapy Training is needed in the Region.

Another disturbing finding is the high drop-out rate of trainees during the survey. No predicting factors for drop-outs were found and these trainees valued the teaching sessions as much as the attenders. Clearly holidays, study leave, MRCPsych examinations and changeover of jobs has an effect on the attendance but this would not appear to be the whole answer. Again, a few trainees reported that they were being actively discouraged from attending the sessions by some consultant psychiatrists. This lack of enthusiasm for psychological treatments by consultant psychiatrists has been reported by other workers.^{6,7} Despite this attitude of senior medical staff it is encouraging that over 50% of the trainees have continued to attend the sessions in the post-survey period. Evaluation of the sessions did mean that major changes were not made to the teaching programme in response to the drop-out rate and that after the survey the attendance has steadily increased. Such evaluation of teaching would seem to provide vital information to all psychiatrists involved in teaching but appears to be performed relatively infrequently.

This study demonstrates the usefulness of objective measurement in planning and assessing teaching programmes and the ease of administering most measures. Such techniques may have a wider applicability for all consultant psychiatrists involved in postgraduate teaching. It also demonstrates that trainee psychiatrists have little knowledge of training in behavioural psychotherapy despite the College's recommendations and that even limited teaching input can significantly alter this knowledge. Behavioural psychotherapy, however, is concerned with practical treatment approaches and further studies are

being planned to examine the acquisition of behavioural therapeutic skills by trainee psychiatrists.

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Book Reviews

Alcohol—A Balanced View: Report from General Practice 24. London: The Royal College of General Practitioners. Pp 57. £5.00

This Report from the Royal College of General Practitioners was released a few weeks after our own College's Report *Alcohol our Favourite Drug*. They complement each other extremely well. The General Practitioner's Report is designed principally as an aide and encouragement to the family doctor and demonstrates the value and importance of taking a greater interest in the effect of alcohol on the patient's health. It points out that the primary health care team is ideally placed to recognise alcohol related problems at an early stage and identify hazardous patterns of drinking. Doctors are notoriously reluctant to become involved in working with problem drinkers. This negative view may in the past have arisen because the focus has been on the 'alcoholic' rather than on alcohol as hazardous to health. The present report takes the view that injudicious drinking can be viewed as something akin to blood pressure which is often normal and causes no concern, yet when raised can cause serious illness. The book provides advice about

taking a drinking history that is both brief and realistic and describes techniques of drawing patients into a therapeutic alliance with their doctor in seeking ways of reducing his or her drinking. There is much clear practical advice about the management of alcohol problems.

The book ably and succinctly spells out the extent of alcohol related problems in the United Kingdom. There is a particularly interesting discussion on the question of relative risk at different levels of consumption. This is something most patients wish to know about, they want to know the chances of damage associated with a particular course of action.

The authors do acknowledge that rescuing the casualties of drinking will never suffice and that the root causes of the problem such as price and availability needs to be confronted by the population and by politicians. This book does not dwell on these issues which are addressed much more fully in the Royal College of Psychiatrists' Report. This position is of course justified by the focus on the practical and clinical contribution which the general practitioner can make. They might, however, have given a little