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# Does protected time improve psychotherapy training in psychiatry?

## A response to College guidelines

**AIMS AND METHOD**
We surveyed all our senior house officers (SHOs) in 1998 to ascertain the nature and quality of their psychotherapy training. Following the introduction of a structured psychotherapy training programme, we wished to see what difference this had made to their training experience. The same questionnaire was used to survey all SHOs currently training in our trust, and compared their responses with those of the earlier cohort.

**RESULTS**
There was a statistically significant increase in the number of trainees seeing patients, in the number of psychotherapy patients being seen, and in the expectations of trainees of being able to fulfil College requirements.

**CLINICAL IMPLICATIONS**
Our results demonstrate the value of a formal psychotherapy training programme for the quality of psychotherapy training at SHO level. In particular, the introduction of protected time may have been crucial in allowing the SHOs to gain the necessary experience.

Basic specialist training in psychiatry requires experience in several forms of psychotherapy (Royal College of Psychiatrists, 1993), in order to promote greater understanding and skill in the different psychotherapeutic approaches and to develop interpersonal skills. However, there is concern that doctors training in psychiatry do not gain the required experience; in fact, many areas of the country have no consultant psychiatrist in psychotherapy. If trainees have not received sufficient grounding in these skills, it will be difficult for them to practise psychotherapeutic psychiatry effectively at consultant level. This may be contributing to the national shortfall in consultant psychiatrists who, without these skills, may view their role somewhat pessimistically as that of drug dispenser and custodian, with the therapy being delivered by other members of the multi-disciplinary team, or by specialist psychotherapists.

In 1998, we undertook a survey of our senior house officers (SHOs), enquiring about their experiences of psychotherapy training on the South London and Maudsley National Health Service (NHS) Trust rotation. At that time, psychodynamic and family therapies were offered by the psychotherapy unit, with a few trainees gaining experience in cognitive–behavioural therapy (CBT) elsewhere. The results highlighted inadequacies in the training, particularly with respect to the ability of SHOs to meet Royal College of Psychiatrists guidelines. These findings were strongly reinforced by a College accreditation visit at about the same time. The College's concerns were such that for each trainee the trust subsequently introduced a 2-hour period of protected time per week and a structured programme for psychotherapy training, formally started in October 1999. Senior house officers are now taught basic principles of psychotherapy for the first 6 months of their rotation; thereafter time is allocated for seeing patients and for supervision. The appointment of a consultant psychiatrist in CBT in the autumn of 1999 has also meant that training in this form of therapy is now available to all SHOs.

We repeated the survey in 2002 to monitor the effect of the introduction of protected time. In particular, we wanted to know whether this had increased trainees' expectations of meeting College guidelines, and the number of trainees seeing patients.

## Method

We devised a questionnaire (available from the authors on request), which elicited:

(a) the number of psychotherapy patients treated;
(b) if no cases had been seen, the reason why;
(c) trainees' expectations of meeting College guidelines.

The questionnaire asked about the SHOs' views concerning the possibility of protected time for psychotherapy, and the 2002 version enquired whether those affected had found it helpful. We asked if the



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trainee would be interested in a one-year psychotherapy post, possibly leading to a diploma. The form also had some room for comment. The questionnaire was posted to the SHOs with an enclosed stamped, addressed envelope and an assurance of anonymity. We enclosed a copy of the appropriate Royal College Requirements for Psychotherapy Training as part of Basic Specialist Psychiatric Training (http://repweb/trainder/postgrad/pt Basic.pdf). Thus the SHOs appointed in April 2002 received the newest guidelines (Bateman & Holmes, 2001), while all others received the older versions.

## Participants

In 1998, our department was part of an expanding but still medium-sized NHS trust; in 1999, we amalgamated with two other trusts to become the largest mental health trust in the country. All SHOs employed by the trust were included in the survey: these were trainees on the rotation in the vast majority of cases, but also included a few long-term locums.

## Statistics

Chi-squared or Fisher's exact tests were used to compare categorical data between the two cohorts, and Mann–Whitney *U* tests were employed for continuous data. Chi-squared values are given with the continuity correction where appropriate. Some SHOs endorsed more than one therapeutic modality practised or more than one option for not having seen patients; chi-squared tests comparing the two cohorts are therefore computed separately for each of the modalities and for each of the obstacles cited.

# Results

## Response rates

Fifty-one of 70 SHOs responded in 1998, compared with 61 out of 84 in 2002, giving a response rate of 73% on each occasion. No more than four of the 61 respondents in 2002 could possibly have participated in the 1998 survey: removing them from the analysis did not significantly alter the overall results and so these are given for the whole samples, which are treated as independent.

## Experience

Figure 1 displays the distribution of the numbers of patients seen by individual SHOs in the two cohorts, which is significantly different at the two time points ($\chi^2$=14.4, $P$=0.002). Table 1 lists the forms of psychotherapy practised, and for SHOs who had not seen any psychotherapy patients, Table 2 sets out the obstacles to doing so. Of the 19 SHOs who had seen at least one patient in 1998, the numbers treated varied between 1 (6 respondents) and 11 (1 respondent). The corresponding range in 2002 was 1 (19 respondents) to 14 (1 respondent). Overall, the number of patients seen by the 2002 cohort was significantly greater than that in the 1998 survey (Mann–Whitney $U$=1129.5, $P$=0.017).

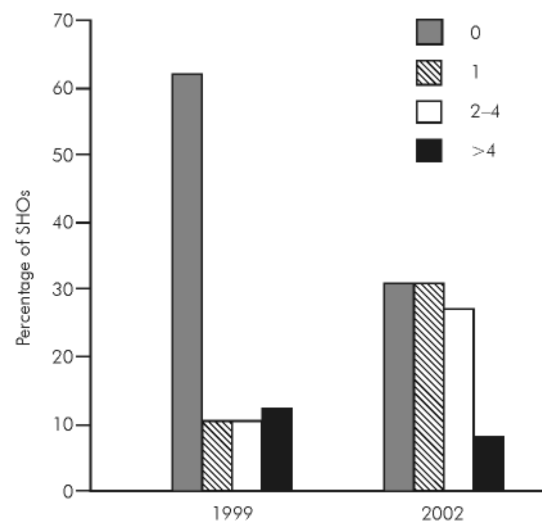


*Fig. 1. Trainees' experience: numbers of patients seen, given as proportion of senior house officers (SHOs) within each category. $\chi^2$=14.4; P=0.002 for difference between the cohorts.*

## Expectation of meeting Royal College of Psychiatrists' guidelines

There was a statistically significant difference between the cohorts in their expectations of being able to meet College guidelines ($\chi^2$=17.6, $P<0.001$): 87% expected to meet them in 2002, compared with 51% in 1998. In 1998, there was a differential intake effect, with those in the first year having significantly lower expectations than those further along the rotation (Pearson $\chi^2$=6.34, $P$=0.04), but there was no statistically significant differential effect in 2002. There was no statistically significant difference in expectation between those receiving the new and the old sets of guidelines within the 2002 cohort. In 1998, more than nine-tenths (92%) of SHOs endorsed the suggestion of protected time for psychotherapy training.

**Table 1. Trainees' experience of psychotherapeutic approaches**

| | Number of trainees | |
|---|---|---|
| Therapy | 1998 *n* (%) | 2002 *n* (%) |
| Psychodynamic | 15 (29.4) | 37 (60.7)[1] |
| Cognitive–behavioural | 10 (19.6) | 26 (42.6)[2] |
| Other | 6 (11.8) | 10 (16.4)[3] |

1. $\chi^2$=9.7, $P$=0.002.
2. $\chi^2$=5.7, $P$=0.02.
3. $\chi^2$=0.2, $P$=0.7.



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**Table 2. Trainees' reasons for not having seen any psychotherapy patients**

| Reason | Number of trainees 1998 *n* (%) | 2002 *n* (%) |
|---|---|---|
| Job too busy | 20 (39.2) | 4 (6.6)[1] |
| Placement too far away | 17 (33.3) | 8 (13.1)[2] |
| Other reasons | 15 (29.4) | 9 (14.8)[3] |

1. $\chi^2$=15.7, $P$=0.000.
2. $\chi^2$=5.4, $P$=0.02.
3. $\chi^2$=2.7, $P$=0.1.

## Interest in a one-year psychotherapy post, possibly leading to a diploma

There was no statistically significant difference in the level of interest in this proposal between the two intakes, with 37 out of 51 (73%) personally interested in 1998, and 39 out of 61 (64%) interested in 2002. Inclusion of those who were not personally interested, but thought it would be a useful addition to the rotation, brought the level of interest to 92% in 1998 and 93% in 2002.

## Discussion

The main finding of our audit was that there was a significant increase in the number of trainees seeing psychotherapy patients following the implementation of protected time for psychotherapy. More SHOs believed that they would fulfil the Royal College of Psychiatrists' psychotherapy training guidelines, and fewer found difficulties dovetailing this work with their SHO placement. A corollary from the training point of view is the significantly increased number of psychotherapy patients now being treated by SHOs; this has also had an important positive impact on the service, with a reduction in waiting times for treatment. Although our results might be distorted by the changes in the College guidelines, we think that this is unlikely because the basic requirements are broadly similar, with the main focus on acquiring experience in psychodynamic and cognitive–behavioural therapies. In addition, only a small number of SHOs ($n$=12) in the 2002 cohort were subject to the changed guidelines, so this alone is unlikely to explain the differences. Neither can the differences be explained as being due to the appointment of a CBT consultant, as there was an increase in the number of patients seen for both CBT and psychodynamic therapy.

Trainees consider psychotherapy important and think that they do not receive sufficient training. Hwang & Drummond (1996) found that almost a quarter of post-membership trainees had no experience of individual dynamic therapy. The survey found that entire regions were uable to provide group and/or family therapy, and half the trainees lacked experience in these modalities. Trainees in both of our surveys strongly endorsed the value of psychotherapy; however, improving training in this subject is difficult without a consultant psychiatrist in psychotherapy to coordinate and deliver the teaching, and such consultants are not available in some areas of the country. Other psychotherapy training schemes report difficulties in offering a variety of psychotherapeutic modalities, and in meeting College guidelines. A survey in South West England (McCrindle & Wildgoose, 2001) found only one scheme achieving the standards set in the College guidelines. In the absence of a consultant psychiatrist in psychotherapy, Davies (1998) devised a trial post in which the SHO did psychotherapy half-time, supervised by identified multidisciplinary staff. Hamilton & Tracy (1996) suggested increasing the motivation of SHOs through the use of log books and by making sure they are aware of the requirements. McCrindle *et al* (2002) proposed a half-day release model incorporating formal organisation, protected time, adequate theoretical teaching and supervised clinical practice, which might be the basic ingredients for a successful scheme. Our experience suggests that this requires both considerable time, and a good level of coordination between the consultant psychotherapist and the overall training scheme organiser; one of our consultants undertook responsibility for overall coordination of the psychotherapy input.

We have calculated that for our service our theoretical introductory course requires 20 half-hour sessions. On average four to six assessments (taking 3 hours each), yield one patient suitable for individual psychodynamic psychotherapy with an SHO, i.e. 120–180 assessments per year for 30 trainees joining the rotation annually. Each trainee requires 10 hours of supervision for a 1-year therapy (30 hours per year per group of three supervisees). Thus the total amount of consultant time required per week is 9–12 hours assessment time, 10 hours supervision and 1½ hours of seminars, i.e. seven sessions.

Our study had a number of limitations. There was no statistically significant difference in expectation between those receiving the new and the old sets of guidelines, but only 12 respondents received the new ones, reducing the reliability of this finding. Our SHOs and our system of rotation may not be a representative sample of other schemes throughout the country. Although many of our trainees are working in well-staffed services, the scheme includes peripheral hospitals comparable to those in other parts of the country, and our trainees have to often travel large distances between sites. We asked trainees about their expectations of fulfilling College guidelines, rather than whether they were actually achieving this, on the assumption that the discrepancy would not be too great – or at any rate, not substantially different between the two cohorts. This assumption may not be warranted. We were interested to note that some trainees in the 2002 cohort declared that they did not have protected time (whereas in fact they do); however, our study design did not allow us to enquire further into this. Similarly, we did not ask trainees how many patients they saw in each therapeutic modality, which would have been interesting to know. Both a strength of the training and a potential limitation from the point of view of other,



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smaller, schemes is the concentrated input from senior psychotherapists.

This is the first audit of an SHO training scheme before and after the introduction of protected time, for psychotherapy training. Our results suggest that such a scheme facilitates trainees' experience and enables them to feel significantly more confident about achieving College guidelines for SHO training in psychotherapy. A welcome by-product is that more patients are now being treated with our two main forms of psychotherapy: psychodynamic therapy and CBT. We are aware of the personnel limitations faced by other schemes, and hope that the publication of studies such as this might contribute to the pressure for the creation of further consultant posts. In terms of future audits, the Royal College of Psychiatrists has just brought out a new set of guidelines, and so there is scope for this study to be repeated. Alternatively, a more qualitatively-oriented study could look in greater depth at the experience of SHOs. In particular, we might want to assess the effect of including SHOs who might formerly have 'voted with their feet' and evaded any kind of formal therapeutic training.

## Declaration of interest

None.

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