

## Training matters

### Training and appointment of consultants in behavioural psychotherapy

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This article argues for a new initiative in the training and appointment of consultants in behavioural psychotherapy or with a special interest in behavioural psychotherapy.

Behavioural psychotherapies are time-limited, directive and problem-orientated. The theoretical models focus on understanding the factors maintaining current problems rather than on their origin. The major emphasis in the therapeutic alliance is not on the bond, but on determining specific and more adaptive goals that the patient wishes to achieve and persuading the patient to carry out specific homework tasks as a means towards achieving these goals. The effects of the tasks are carefully monitored in each individual and the overall efficacy of the strategies used have been evaluated in controlled clinical trials. I include under the rubric of behavioural psychotherapies the cognitive psychotherapies such as rational emotive therapy, cognitive therapy, stress inoculation training, and problem-solving strategies, because they too emphasise goals and tasks and include a significant behavioural component. My own view is that titles such as cognitive-behavioural psychotherapist are too cumbersome and the general trend within the speciality is towards integration of the various approaches and determining which therapeutic strategy is best for which type of patient.

#### *The scope of behavioural psychotherapies*

Behavioural psychotherapies are of established value in the treatment of agoraphobia, social phobia and specific phobias, obsessive compulsive disorder, generalised anxiety disorder, unipolar depression, morbid grief, bulimia nervosa, rehabilitation and family interventions in chronic schizophrenia, habit disorders and tics, social skills deficits, and sexual variations. They form the cornerstone of sexual and marital therapy and are being further evaluated in areas as diverse as panic disorder, sexual abuse, anorexia nervosa, morbid jealousy, dysmorphophobia, hypochondriasis, chronic pain, epilepsy and

irritable bowel syndrome. Behavioural psychotherapies are therefore applicable to a wide range of psychiatric disorders. (A full list of references is obtainable from the author). The treatments are acceptable to patients, cost-effective and produce long-term improvement. In addition behavioural therapists have pioneered the use of clinical audit in psychiatry.

#### *Behavioural psychotherapy in the NHS*

Despite this impressive background, the provision of services in behavioural psychotherapy in the UK is patchy. In addition, few psychiatric trainees receive basic experience in behavioural psychotherapy (Drummond & Bhat, 1987). This is partly because of the lack of expertise in behavioural psychotherapy among consultants and partly because clinical psychologists are unable to provide the requisite training and supervision for junior doctors. As long as trainees continue to be denied basic training in behavioural psychotherapy, they will not be confident enough to use it, and will not, in turn teach it to their trainees.

Psychiatrists often tend to assume that psychologists provide a service in behavioural psychotherapy but this is not always the case and where it is, there is often a long waiting list. Otherwise what often seems to be offered is a mixture of dynamic therapy, hypnosis, Gestalt and relaxation—reflecting the diversity of training in clinical psychology. It is also interesting to note that members of the psychotherapy section of the British Psychological Society are predominantly analytical.

Some districts have appointed behavioural nurse therapists who are trained as independent practitioners, mainly for the treatment of anxiety disorders, habit disorders and sexual disorders (Bird *et al*, 1979). There is no reason why the provision of services and training in behavioural psychotherapy should be the sole preserve of psychologists or nurse therapists and there are excellent reasons for psychiatrists to be involved. A consultant may provide a

wider breadth of expertise and lead a team providing a comprehensive service and training for all grades of staff. They may have special expertise in complex or severe cases or in patients requiring admission or additional medication. As yet there are only a handful of consultants in behavioural psychotherapy in the United Kingdom but there are no clear guidelines from the College for their appointment or higher training.

### *Existing training schemes in psychotherapy*

Why then are there not more consultants in behavioural psychotherapy? For historical reasons psychotherapists are analytically trained and this is reflected in the College's requirements for higher specialist training in psychotherapy. At first sight they appear to satisfy every possible vested interest of the various psychotherapies. They state that the clinical experience should be broadly based – that trainees should obtain knowledge and experience of most of the various psychotherapies available. They stress that uniform inflexible training schemes are undesirable; that centres may emphasise different approaches but educational aims should be balanced.

However, further reading reveals that the emphasis is predominantly analytical. The essential requirement consists of 'extensive' experience in conducting individual psychotherapy based on psychodynamic principles. Trainees are encouraged to seek personal analytic experience. 'Extensive' theoretical knowledge and experience is also required in group psychotherapy and therapeutic community approaches.

Behaviour therapy and marital therapy are reduced to a 'thorough' knowledge and 'adequately' supervised experience in treating a range of patients. Problem-orientated therapy, sexual dysfunction work and cognitive therapy are placed at the bottom of the pecking order – they have to be content with a 'working' knowledge!

This psychotherapeutic hierarchy is reflected by what happens in practice. Current training schemes in psychotherapy provide extensive training in analytic individual and group psychotherapy and, *with a few exceptions*, minimal or no experience in behavioural psychotherapies.

The current training schemes in psychotherapy discriminate against behavioural psychotherapies and are out of date. They ignore the aspirations of many trainees who would like to receive higher specialist training in time-limited, directive and problem-orientated therapies which have been evaluated as effective. In the present economic climate and the restrictions on manpower, the necessary funding will only come from existing training schemes in

psychotherapy. This should not be construed as an attack on dynamic therapies – it is a realistic appraisal of how to achieve the goals I have set out.

I suggest that the requirements for higher training in psychotherapy be redrafted to produce two types of training scheme with different emphases – one, as at present, for trainees who wish to concentrate on individual analytic and group psychotherapy and the other for trainees who wish to obtain training in the brief psychotherapies. The latter would involve 'extensive' theoretical knowledge and clinical experience of conducting behaviour therapy, cognitive therapy, problem orientated therapy, crisis counselling, and marital and sexual therapy for the whole range of psychiatric disorders listed at the beginning of this article. On such schemes the psychotherapeutic hierarchy would be turned upside down: such trainees would be expected to gain only a 'working' knowledge of analytic and group psychotherapies. The consultants required to supervise such training already exist at a number of teaching centres – it is the approval and funding of such schemes that is missing.

### *Consultants in behavioural psychotherapy*

The existing bias in the training is reflected in the appointment to consultant psychotherapy posts which are usually exclusive to dynamic therapists. I would question the assumption that consultants in psychotherapy *have* to be dynamic – a behavioural psychotherapist can provide as least as good clinical service and training for junior staff. After a senior lecturer in behavioural psychotherapy was appointed in one region, the trainees found the training useful, interesting and relevant to clinical practice. In addition 25% more of the trainees were treating patients using behavioural psychotherapy than had previously been the case (Drummond & Bhat, 1989).

There is an imbalance between the evaluation and the provision of the different psychotherapeutic services within the NHS. Until now academic psychiatrists have played an important part in the development and evaluation of behavioural psychotherapies but this has not yet been translated into the provision of services in the NHS. In contrast there are a relatively large number of consultants providing a service in dynamic psychotherapies and relatively little academic evaluation of them in terms of outcome. I would like to suggest the establishment of new consultant appointments in behavioural psychotherapy or consultants with a special interest. The service may be provided either at a regional or a district level for out-patients. Regional consultants could also be responsible to six to ten bedded

specialist in-patient units for the treatment of severe obsessive compulsive and phobic patients. At present there are only three such specialist in-patient units including the Bethlem and St George's Hospitals, which are stretched to receive patients from all over the country.

The second option is for more consultants to be appointed at a district level. These appointments should be prioritised to those areas where the provision of behavioural psychotherapy is at present poor. Funding for such regional or district posts will have to compete with all the other demands for new consultant posts in other specialities. The posts envisaged could be modified from general adult psychiatry posts to include a special interest in behavioural psychotherapy. Alternatively some consultant posts in dynamic psychotherapy could be converted to posts in behavioural psychotherapy following the retirement or resignation of some of their incumbents.

No doubt these proposals will be fiercely resisted by some vested interests. I believe that the College should lead the way by redrafting its requirements

for specialist training in psychotherapy and that more psychiatric services should consider whether they should appoint more consultants in behavioural psychotherapy in future. How many more successful clinical trials have to be done before there is a greater provision of services and teaching of behavioural psychotherapy by consultant teams?

### References

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*A full list of references and information on training in behavioural psychotherapy for psychiatrists is obtainable from the author.*

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## The Institute of Psychiatry cognitive behaviour therapy course

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Cognitive behaviour therapy is now widely accepted clinically as a treatment for depression and anxiety, and there is increasing research evidence to confirm its efficacy (Rush *et al*, 1977; Blackburn *et al*, 1981; Murphy *et al*, 1984; Butler *et al*, 1987; Beck, 1988). Of the various short term psychotherapies currently available, it is probably the most widely known and best researched. Despite this, and the recommendation of the Royal College of Psychiatrists (1986) that trainees receive training in cognitive therapy, there is little opportunity to gain a formal training in

this psychotherapy. Short workshops are often available through the British Association for Behavioural Psychotherapy and from other sources, and *ad hoc* supervision from interested psychologists and psychiatrists may be available in some centres. Scott *et al* (1985) described a workshop and peer supervision training scheme in Newcastle. Macaskill (1986) reported a course for psychiatrists in training in Sheffield which extended over 20 weeks and combined Beck's cognitive therapy and Ellis' Rational Emotive Therapy.