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KATHARINE E. LOGAN AND NABILA MUZAFFAR

Psychotherapy training and the Calman reforms

AIMS AND METHOD
There have been major changes in the duration and the requirements of higher specialist training in psychotherapy in the UK. A postal survey was sent to all higher specialist trainees in psychotherapy to study their attitudes to, and experience of, these changes.

RESULTS
Eighty-nine per cent of trainees responded. The majority of trainees expressed concern about the reduction in length of training. There were gaps in provision of some essential training modalities. A substantial group of trainees did not have protected research time.

CLINICAL IMPLICATIONS
Psychotherapy trainees believe the changes in training sacrifice depth for breadth. This highlights the ongoing debate about the future of psychotherapy within the NHS.

Following the Calman report (Department of Health, 1993) the introduction of the specialist registrar (SpR) higher training grade in 1996 was associated with considerable changes in psychotherapy training requirements. SpRs can now train in general adult psychiatry with a special interest in cognitive–behavioural therapy (CBT), but can also train as psychotherapists specialising in CBT. Those training in psychodynamic psychotherapy previously had contracts of up to 6-years' duration (Monaghan & Moorey, 1999). The new regulations cover training in both CBT and psychodynamic psychotherapy. Each trainee must gain 700 hours supervised experience in their main discipline (CBT, psychodynamic or systems-based) and 100 hours in each of the other two areas during a 3-year training period (Royal College of Psychiatrists, 1995). There has been much discussion about whether CBT training should have become a stand alone training of similar status to dynamic psychotherapy or whether it should have remained as a sub-speciality within general psychiatry, for example similar to liaison psychiatry.

The previous specialist training was viewed as too long and unproductive (Hunter & McLaren, 1993). The changes aim to shorten the training and to produce more broadly trained psychotherapists who will be able to coordinate psychotherapy services. This move may seem appropriate in the current NHS climate as resources are limited and managers are increasingly seeking cost-effective, short-term, evidence-based treatments. There is also no clear plan to create consultant posts in cognitive therapy. Therefore, CBT trainees may find themselves highly qualified but unemployable. Despite a good evidence-base for the efficacy of psychotherapy (Parry & Richardson, 1996; Roth & Fonagy, 1996) there has been no recent expansion in consultant psychotherapy posts, unlike other psychiatric specialities.

Following a Royal College of Psychiatrists approval visit in 1998 we were interested to find out how other psychotherapy trainees and schemes were adapting to the post-Calman report changes.

The study

A postal questionnaire was sent to all psychotherapy trainees in the UK. A reminder letter was sent to those who failed to reply. Replies could be returned anonymously but only four trainees chose this option.

Comments

Fifty-seven out of 64 trainees replied, giving a response rate of 89%. Forty-one (72%) trainees work full-time; 100% of men and 62% of women work full-time. Forty-five per cent are doing dual training with general psychiatry, 84% are doing their main training in psychodynamic psychotherapy, 14% in CBT and 1.8% in cognitive–analytical therapy (CAT) (one trainee).

Training in non-core modalities

All trainees had access to psychodynamic psychotherapy. There were gaps in provision of the other two core modalities, with 89.5% availability of CBT placements and 87.7% availability of systems placements. Placements in other psychotherapy models are available but the level of availability is variable (CAT, 49.1%, interpersonal therapy 28.1%, marital therapy 40.4% and sexual problems

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therapy 17.5%). Some trainees have had difficulty setting up placements in their non-core specialities. One-third of trainees (27% psychodynamic and 33% CBT) felt they would be capable of giving treatment in the model after 100 hours of training, while the majority believed they would only be able to do assessments and recommend treatment in the model. Concerns were also expressed about the difficulty of integrating different psychotherapy models and this has been discussed elsewhere (Monaghan & Moorey, 1999). Eighteen trainees (31.6%) felt models should be studied concurrently and 15 trainees (26.3%) felt the subsidiary models should be studied at the end of training. Fourteen trainees (24.6%) felt the decision should be made on an individual basis dependent on the specific trainees' needs and the remaining 10 trainees (17.5%) felt the training was unimportant. Two-thirds of trainees are studying two or more models concurrently at present.

Length of training

Eighty-four per cent of trainees believe that 3 years is not long enough to fulfil all the current training requirements. Many pointed out that the training requirements had increased while the length of training had reduced, and expressed fears that this will lead to trainees receiving a broader but more superficial training.

Funding arrangements

There is a wide variation in arrangements for funding personal analysis for psychodynamic trainees. Six trainees (12.5%) were completely self-funding, eleven (23%) received full reimbursement and the remainder fell somewhere between. We were surprised that thirteen trainees (23%) had to pay for supervision.

Research in psychotherapy

Of the forty-one trainees (72%) working full-time, only 22 (54%) regularly had two sessions of research per week. Clinical work and supervision regularly impinges on research time. However, forty-two trainees (74%) were doing research related to psychotherapy. Most trainees (86%) had regular meetings with their peers, which 54% regarded as fulfilling both educational and supportive functions.

Discussion

Although psychotherapy senior registrars did have cases in other treatment modalities, recent changes in training have introduced specific requirements for trainees to 'clock up' certain numbers of hours in specific modalities. The majority of trainees are concerned about the reduction in length of training, believing this is likely to sacrifice depth for breadth.

The survey indicates a need for supervisors to provide more help and support to trainees setting up non-core placements. Trainee placements provide an opportunity to improve communication and inter-departmental relationships. The majority of trainees are doing research related to psychotherapy, which is a positive sign for the future. Psychotherapy has been accused of not being open to scrutiny and research. However, it is concerning that only half of the full-time trainees have protected research time.

The vast majority of trainees expressed concern about their current training. The predominant issue was that 3 years' training is too short to equip trainees with the skills needed to allow them to develop their thinking and change their conceptualisation in order to become a specialist, rather than have a special interest. It has also been suggested that training (e.g. personal analysis) may need to be completed as a consultant. In common with some other specialities, there may be a move to increase the length of training again.

Recent changes in training requirements appear to be aimed at producing more eclectically trained psychotherapists who will be able to head multi-disciplinary psychological therapy services. There is a danger that psychotherapists of the different models will become competitors for the limited number of jobs available, rather than joining forces to work together and complement each other's work. The broader-based training could lead to increasing emphasis on short-term symptom focused work, while longer-term psychotherapy will become exclusively available in private practice. Psychotherapists must ask whether this is how they wish NHS psychotherapy to progress. We believe this would leave a large gap in service provision and clinical care. This is against the background of increasing public demand for psychological therapies and political expectation that psychiatry will treat patients with personality disorders.

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Katharine E. Logan Specialist Registrar in Cognitive Behavioural Psychotherapy, **Nabila Muzaffar** Specialist Registrar in Dynamic Psychotherapy, Royal Edinburgh Hospital, Morningside Terrace, Edinburgh EH10 5HF

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