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The College

Guidelines for psychotherapy training as part of general professional psychiatric training

1. Introduction

These guidelines replace previous documents on psychotherapy training at general professional level, the last being in 1986. It is a joint statement from the General Psychiatry Section and the Psychotherapy Section.

All psychiatrists, whatever the branch in which they ultimately specialise, require to develop interview and communication skills. They need to be able to handle emotionally stressful situations with sensitivity and awareness. Patients should always be treated with humanity, dignity and respect. An appropriate attitude should be maintained which is not authoritarian or judgemental but ensures that professional and ethical boundaries are kept and standards preserved.

With the development of multidisciplinary working and community approaches, the psycho-social aspects of treatment have become increasingly emphasised. The public and professional colleagues expect that all psychiatrists should have a basic grounding in psychotherapy, and should be able to treat a range of patients by psychotherapeutic methods. There is a danger, however, that there is a devaluation of the need for rigorous training. It is often claimed that "we all know how to talk to patients". The evidence is to the contrary – but interpersonal skills can be learnt and it can be shown that patient outcomes improve if they are. Supervision with a psychotherapist is a fundamental learning experience to which all trainees should be exposed, and which many will need to call upon later as part of their work as consultants.

These guidelines emphasise the need for more basic training in counselling and psychotherapeutic skills for all psychiatrists. Revised guidelines for specialist training at senior registrar level will be produced shortly.

2. Objectives of training

(a) First year

By the end of the first year the trainee should be able to:

1. Interview a patient for assessment in a manner which elicits the required information, including mental state examination, and which also demonstrates the capacity to establish rapport. The trainee should be able to know how to gain information without appearing to work through a check-list. The patient should have his say and feel listened to, but not be allowed to control the interview. Skills in interviewing silent, verbose, hostile or psychotic patients should be evident. The capacity to handle distress in a supportive way is essential. The beginning and ending of an interview should be conducted sensitively, demonstrating the psychiatrist's awareness of the stress of such an interview for the patient. The patient should be given appropriate information and allowed to participate in discussing treatment options when relevant.
2. Be aware of and describe the importance of non-verbal communications from the point of view of the patient and the psychiatrist, and monitor his or her own communication style.
3. Recognise the relevance of historical and current psychological and social stresses in the development and maintenance of psychiatric disorder, and use this to form the treatment plan and prognosis.
4. Understand the various ways in which patients may view their illness and its treatment, and be able to discuss such issues with a patient to encourage co-operation with treatment plans and allay anxiety.
5. Understand and practise the principles of supportive counselling: use of open questioning; non-directive, non-judgemental interview style allowing affective expression; acceptance of negative feelings; emphasising positive strengths. Be able to use these principles in the management of severely ill as well as neurotically disabled patients.
6. Assess the potential for suicide or violence and discuss these sensitively with a patient.
7. Recognise the impact of psychiatric illness on a patient's family, and the importance of family relationships on the course and maintenance of symptoms. Be able to interview family members without being caught up in "taking sides".

8. Be aware of the complexities of the doctor-patient relationship and the significance of the psychiatrist's own feelings in any situation, recognising when there is need for supervision and support.
9. Be clear about the ethical responsibilities of psychiatric practice, including the need to preserve boundaries and avoid inappropriate self-revelation and physical contact.
10. Know the basic principles of behavioural/cognitive therapy and dynamic psychotherapy. Some trainees will have already started such treatments under supervision.

(b) Subsequent years

By the end of general professional training the trainee shall have further developed these core skills and also be able to:

1. Offer skilled counselling, and, where appropriate, be able to supervise co-professionals, in a wide range of psychiatric disorders.
2. Recognise the indications for behavioural/cognitive, dynamic, family and group approaches.
3. Be familiar with the relevant theories and techniques.
4. Be aware of the problems and limitations of such approaches.
5. Have the skill and confidence to engage in the various forms of psychotherapy at a level appropriate to their experience.

3. Teaching methods

Trainees vary in their interest in and aptitude for psychotherapy. There is, however, a core level of psychotherapeutic experience that should be a mandatory requirement in the training of all psychiatrists. Mandatory experience should include one long-term dynamic psychotherapy case and one long-term behavioural/cognitive (BCT) case; two brief dynamic psychotherapy cases and two brief BCT cases; some experience of groups, whether on an in-patient unit, in a day hospital or specialist psychotherapy group; and some experience of family/marital therapy. It is recognised that for many schemes it will not be possible to implement this requirement immediately. Some districts will need to 'buy in' psychotherapy supervision time. It is likely that most trainees will receive the full range of psychotherapeutic training, including the non-mandatory aspects.

First year

1. Interview methods training, with video.
2. Doctor-patient relationship seminar along 'Balint' lines.

Both of these should be in a small group format, with GP trainees as well as psychiatric SHOs. Ideally, these groups should be run jointly by a general psychiatrist and a psychotherapist, if resources allow. The interview methods course should run for six months on a weekly basis, and many will continue as a doctor-patient seminar in the second six months. Depending on the local scheme and the aptitude of the trainee, patients may be taken on for therapy within this time, providing formal instruction and supervision is available. The bulk of such clinical experience should however be done in later years of training.

Subsequent years

1. Psychotherapy supervision

It is essential that all trainees have regular, continuing experience of psychotherapy under supervision throughout training. Some training schemes offer a full-time placement in a psychotherapy department for six months or longer, with a few cases being carried on after the attachment. Other schemes offer part-time training throughout the registrar years. There are advantages to both approaches. Schemes which rely on part-time attachments may find that the pressure of other commitments interferes with the psychotherapy. One half-day a week will ideally be available for treatment and supervision although not necessarily in a block. Supervision is not only a teaching exercise, but is a way of monitoring the quality of patient care. Senior psychotherapists continue throughout their career to discuss their work with colleagues often as a form of audit. For trainees the experience of learning with peers in a small group run by an experienced therapist provides support and mutual learning.

It is recommended that the College considers the introduction of a log book for a group of long-term or paradigmatic cases, including psychotherapy cases. Adequate supervision will be essential for such cases and it is important that the log book is seen by trainees as a useful training exercise, rather than a burdensome imposition.

4. Clinical experience

Trainees should be encouraged to see psychotherapy as arising out of and as an integral part of clinical work. After the first year of basic training in psychotherapeutic aspects of general psychiatry detailed above, trainees should gain experience in detailed psychotherapeutic casework. Ideally this will be supervised from a specialist department of psychotherapy but the clinical work will arise and can physically take place in a general psychiatric setting such as a catchment area practice or day hospital or an in-patient unit.

The following areas of experience will be required.

1. *Individual dynamic psychotherapy*
   One long-term case.
   Several cases in brief time-limited therapy, e.g. 10 sessions.
   The patients will have been assessed as suitable for a dynamic approach, and will be likely to have neurotic symptoms and/or relationship difficulties.
2. *Individual behavioural/cognitive therapy*
   One intensive case.
   Several cases in brief time-limited therapy as above.
   The patient will have been assessed as suitable for a behavioural/cognitive approach and will be likely to have specific symptom complexes such as eating disorders, anxiety and phobic states or obsessive-compulsive disorder.
3. *Group therapy*
   Group experience in in-patient and/or out-patient settings, with an experienced co-therapist and/or supervision.
4. *Marital and family therapy*
   Experience may most likely be gained in a child and family setting, but should not be exclusively so. Psycho-sexual therapy is included under this heading, although it may also involve some individual work especially with those whose problems stem from childhood sexual abuse.
5. *Other experience*
   Work in a variety of settings (e.g liaison psychiatry) should give the opportunity for the psychotherapy of pathological bereavement, somatisation disorder and post-traumatic stress disorder. Knowledge can also be gained of special techniques such as psychodrama, art therapy and music therapy.

5. Theoretical teaching

Lectures and seminars provide a theoretical underpinning to the practical work. For dynamic therapy the central concepts of transference and counter-transference, and unconscious processes should be clearly understood. For cognitive-behavioural therapy the trainee requires knowledge of learning theory and cognitive psychology. In both approaches, links need to be made between the theory and what the therapist actually says and does in his or her experience with patients.

6. Occupational stress

It should be acknowledged that all psychiatric work is emotionally stressful and taxing, especially at times of personal upheaval or organisational change. Psychiatrists are increasingly called upon to provide support for other mental health workers. They need to be aware of their own personal stress and learn to cope with it, whether by support networks, staff sensitivity groups, or stress management techniques. Such opportunities should be made available to trainees.

Dynamic psychotherapists take this requirement further by acknowledging the prime importance of a personal therapeutic experience in their own training. This increases awareness of unconscious processes and personal blind spots, and provides a support for the stressful work of intensive therapy.

7. Team working

The trainee is one part of a clinical team drawn from a variety of disciplines. The communication and interpersonal skills that are required for the treatment of patients should be used in an organisational context to understand the inevitable tensions and rivalries that arise. Team building skills will become an increasing requirement for future consultants, and trainees should be encouraged to attend workshops, staff support groups and organisational consultancy to become more aware of this aspect of their work.

8. Organisational requirements and difficulties

Since the last guidelines were published there has been a slow increase in the number of consultant psychotherapists, although some parts of the country remain very poorly served. They have primary responsibility to develop training programmes at a basic, general and specialised level. They will undertake supervisory responsibility for formal psychotherapeutic work, together with consultants with a special responsibility and selected highly trained non-medical psychotherapists. Clinical psychologists and specialist nurse therapists may be needed to augment the teaching of cognitive-behavioural approaches in many centres until the numbers of psychiatric staff specialising in this field becomes more substantial. Any such arrangement should be contractually recognised.

The provision of basic training in psychotherapeutic aspects of psychiatry requires considerable resources and the task needs to be shared with general psychiatrists. The role of tutor is important as co-ordinator of such complex arrangements. In many cases the tutor will share the teaching.

It is important that psychotherapy skills are seen as a core element of psychiatric practice, not in opposition to psycho-pharmacological approaches.

The involvement of general psychiatrists in psychotherapeutic training enhances this. Many general psychiatrists will wish for further psychotherapeutic training as part of their continuing medical education – this will enable psychotherapeutic skills to cascade down to trainees. Convenors of College approval visits should demonstrate the importance placed on such experience in their recommendations and requirements. This in turn will need to be backed up by greater attention to psychotherapeutic issues in the membership examination.

SANDRA GRANT
JEREMY HOLMES
June 1993 JIM WATSON

Locum consultants

The College continues to receive reports of a national shortage of suitably qualified psychiatrists able to carry out locum consultant works.

It has been agreed that the College will forward, to relevant College Regional Advisers, the names of those consultant psychiatrists who have recently retired and who have contacted the College because they are willing to undertake locum consultant work on a short-term basis.

If any retired member is interested in this type of work, could they write to the Secretary, enclosing a brief curriculum vitae, together with some indication of the geographical area where they would be willing to work. It would also be helpful to know the length of locums which they would be prepared to fill.

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Membership examination

At the end of last year, I invited further nominations for both Boards of Examiners, through Regional Advisers and academic departments. As a result of this, I have learnt that some colleagues have been discouraged from allowing themselves to be nominated because of problems in obtaining appropriate leave from employing authorities. I would draw your attention to the reply from the Chief Medical Officer for England and Wales to our immediate past President (*Psychiatric Bulletin*, 1992, **16**, 317), referring to paragraphs 250 to 252 of the Terms and Conditions of Service and making it clear that examining falls within study leave entitlement and that all employing authorities can grant additional periods of study leave for this purpose.

I would also draw attention to the wish expressed by the Chief Medical Officer in the same document, that NHS units should not charge for "facilities made available to further post graduate medical education".

As I will shortly be inviting further nominations to the Boards of Examiners, and for suggestions for additional centres to host both MRCPsych Part I and Part II Examinations, in view of the increasing number of candidates, I would be grateful if members could note the contents of the Chief Medical Officer's letter.

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Chief Examiner