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# This year in a school of psychiatry near you: psychotherapy training within the new curriculum†

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**Abstract** This article outlines the changes to psychotherapy training for psychiatrists proposed in the Royal College of Psychiatrists' new specialist training curriculum. There is some debate about whether this curriculum should be taken up in its present form because of the limitation of resources to implement it. I describe the effect of taking the College at its word that psychotherapy training should be mandatory and the improvement this has already brought about in psychotherapy training on the Exeter and South Devon training rotations. I also discuss what will be required to implement the new requirements.

Sally Mitchison (2007, this issue) has written a compassionate and thoughtful account of the state of play with psychotherapy training for psychiatrists locally and nationally and the experience of offering psychotherapy training for trainers and trainees as it is currently provided. Although the Royal College of Psychiatrists' elevation of psychotherapy training for trainee psychiatrists from the status of 'recommendation' to 'requirement' represents a considerable step forwards (Royal College of Psychiatrists, 2004), the ultimate stumbling block to these requirements becoming mandatory is that resources are not available nationally to offer this training.

This is surely insufficiently thought through and a position that would not be countenanced in relation to training in a whole range of other areas such as sectioning patients, electroconvulsive therapy and prescribing. Yet psychotherapy is as basic to the practice of psychiatry as these.

Making competence in psychotherapy mandatory needs to be a major priority for the College if it is ever to happen. To date the College has adopted a gradualist approach to building capacity to deliver training nationally. The case for doing this has been that it overcomes the problem of disaccrediting rotations that are not able to offer the required training. It is abundantly apparent from Mitchison's account of training nationally that, despite the valiant efforts of consultant psychotherapist trainers to 'feed the five thousand' this gradualist approach has not yielded the hoped for development in training capacity.

Among the concerns about mandatory psychotherapy training that continue to be an obstacle to making progress with this issue is the idea that doing so will:

- disaccredit training rotations rather than enable psychotherapy training to be funded
- be too demanding on trainees' time
- be an organisational task beyond the capacity of the limited number of available consultant psychotherapists
- require trainees with little aptitude for psychotherapy to treat patients regardless of competence
- require suitable patients, few of whom are to be found within secondary mental health services.

I think it important to establish that it is quite possible to overcome these obstacles and to identify the benefits to be expected from doing so. This has been done in the Exeter service, thanks to the hard work of my predecessor (Wildgoose *et al*, 2002), the timely publication of the 2004 requirements and some creative reorganisation.

†For a companion article see pp. 276–283, this issue.

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## The Exeter experience

When I took up my post in Exeter the resources available from which to set up a training scheme were some surplus room space for teaching and trainees' therapy sessions and a few hours of adult psychotherapy time for SHO teaching (about half of what was needed). The busy clinical service had a tradition of trainees being available for one afternoon a week for psychotherapy training. Some elements of that training were already in place.

The College's new training requirements provided an opportunity to make clear to managers the likelihood that accreditation for the local rotational training schemes would be withdrawn if psychotherapy training was not funded and to put to them a proposal for how it could be provided and the costs of funding additional trainers. This funding was agreed.

The training caters for 22 trainees on two training rotations. The annual cost is around £600 per trainee. The programme is set up over the 3 years of their basic specialist training to offer an introductory course with theoretical teaching in psychodynamic therapy (6 months), cognitive–behavioural therapy (CBT) (3 months) and cognitive analytic therapy (CAT) (3 months). Trainees attend a Balint group for the first year.

After an introductory 6 months in a long-term psychodynamic supervision group, trainees take on a long-term case. In addition they join a short-term therapy supervision group and, in a sequence of placements, rotate through supervision of three short-term cases: CBT (usually first), CAT and brief dynamic therapy. They also receive a 6-month theoretical introduction to group analytic theory and systemic family therapy theory, and in their final year are offered a clinical placement in either group analysis or systemic family therapy.

Over the 3 years that we have been offering this programme it has received the warm appreciation of the trainees. All trainees who have completed their training rotation have also completed their psychotherapy requirements, not just those who have an interest in the subject. It has been possible to observe the changes in trainees' capacity to think psychologically as training progresses. In most instances a degree of psychological mindedness is learned even where the trainee did not demonstrate this at the outset.

Trainees are issued with a list of minimum requirements of professional practice, similar to the 'guidelines for visiting therapists' identified by Mitchison. Trainees are informed that the department reserves the right to not allocate patients to individuals who do not meet these basic standards of professionalism. In a very few instances it has been clear that a trainee's clinical work did not meet these requirements. In each such case, when the training committee notified the psychiatric tutor of its concerns it became apparent that the trainee had been in difficulty in their wider psychiatric training.

The problem of finding four cases each for 22 trainees has been eased by the setting up of an arrangement with the primary care trust that enables patients to be referred directly from primary care for assessment and placement on a trainees' waiting list. In this way a service is offered to patients who need a longer-term intervention than can be offered in primary care. It gives trainees the opportunity to work with less complex cases than are usually available through the secondary mental health system, although some referrals still come from this source.

A trainee's progress is monitored through a psychotherapy training logbook, tailored to the training. In addition, a training committee meets every 6 months. One of the tasks of this committee is to compile a collective impression of trainees' competence and progress and to identify trainees who are in difficulty.

The consultant psychiatrist in psychotherapy (consultant psychotherapist) has a central role in planning, organising, obtaining funding and offering some 'hands on' training (teaching and supervision). However, the whole burden of training does not fall on this one individual. The consultant psychotherapist meets trainees yearly to review their progress and sign their logbooks. Clearly this is different from the supportive role taken by Dr Mitchison and no doubt something important is lost in this more administrative function.

One of the most obvious positive outcomes of the training has been a considerable increase in the number of trainees expressing an interest in and pursuing further psychotherapy training either as specialist registrars or through independent psychotherapy trainings and MSc courses.

### *The effectiveness of trainees as therapists*

All psychotherapy patients in the Exeter service receive the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE–OM) battery and we have used data from a representative sample to compare the response to therapy of patients treated by trainees and those treated by qualified therapists in the psychotherapy department. A summary of results is shown in Box 1.



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**Box 1 Outcomes of psychotherapy by trainee and qualified therapists**

We analysed CORE–OM results of 88 patients for whom complete data were available at the beginning and end of therapy; 64 of these individuals had been treated by qualified therapists and 24 by trainees.

The higher the CORE–OM score, the poorer the outcome. A difference in score between the beginning and end of therapy of >0.5 is significant.

- For patients with the qualified therapists, the 'best' difference in score was –2.44 and the 'worst' +1.15
- For patients with the trainee therapists the 'best' difference in score was –1.5 and the 'worst' +1.68
- Out of the top 20 highest 'best' differences in score, 16 were with qualified therapists and 4 were with trainees.
- 46 of the patients seen by qualified therapists scored highly on risk questions, compared with 12 seen by trainees

(A. Sharma, personal communication, 2007)

## Modernising Medical Careers and maintaining standards

So, it is possible to fulfil the College's 2004 training requirements as they stand. However, the National Health Service's Modernising Medical Careers (MMC) initiative presents a number of new challenges to consultant psychotherapists charged with delivering psychotherapy training as part of the new curriculum in the new schools of psychiatry being set up in each deanery.

Well-developed psychotherapeutic skills will be increasingly essential to the consultant role as described in 'New Ways of Working' (Care Services Improvement Partnership, 2005), both in consultants' provision of consultation and leadership to teams and their clinical work with the most complex cases. Among the burgeoning list of tasks to be undertaken, a high priority must surely be the maintenance of standards of training in psychological therapies. Perhaps one of the greatest concerns about the new MMC curriculum is that it may result in a lowering of the quality of training, especially in specialties where there are problems resourcing training of a high standard. This would undermine the establishment of what should be a basic principle of modern psychiatry: that psychological treatments and a psychological attitude should be as fundamental as drug treatment and biological approaches to mental ill health.

The vexed question of how to assess competence in psychological therapies is being addressed both within the College, by the Psychotherapy Faculty Education and Curriculum Committee, and nationally, by a working group charged with implementing the 'Improving Access to Psychological Therapies' agenda (http://www.mhchoice.csip.org.uk/psychological-therapies.html), as part of the Layard proposals (Layard, 2004). Even in manualised therapies such as CBT, where technique is relatively uniform although personal style may not be, assessment is a complex task. Identifying which interventions and competencies are essential to effective practice in therapy is in itself not straightforward; finding a way of measuring them that does not intrude excessively on the therapeutic process is even more difficult.

The list of proposed psychotherapy competencies drawn up by the Psychotherapy Faculty Education and Curriculum Committee (Box 2) is currently under consideration by the College. The proposed

**Box 2 Psychotherapy competencies**

The following competencies for psychotherapy within MMC have been proposed by the College's Psychotherapy Faculty Education and Curriculum Committee

- Applying a psychological understanding to the general practice of psychiatry, including its application both in clinical work and in understanding personal and organisational dynamics
- Assessing the value of formal psychological therapy for individual patients and making appropriate referrals
- Informing patients about psychological therapies and helping them to decide whether to take up psychological therapy, which therapy to choose and how to make best use of it
- Undertaking a certain amount of psychological therapy with appropriate patients: all psychiatrists should have experience of conducting a range of psychotherapeutic treatments with patients
- Teaching doctors and other mental health staff about psychotherapy
- Acting as consultants to managers and teams on the psychological treatment services and the provision and planning of psychological therapies relevant to their own service/chosen specialty



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**Box 3 Psychotherapy competencies in ST 1–6**

| | *ST 1* | *ST 2–3* | *ST 4-6* |
|---|---|---|---|
| Competency 1 (Psychological understanding) | Discuss routine casework in psychological terms<br>Understand impact of psychosocial factors on presentation and management<br>Begin to understand contribution of own feelings to encounter with patient | Progress towards and achieve capacity in presenting a full psychodynamic case formulation<br>Be able to discuss team dynamics as they relate to patient care and divisions of opinion<br>Reflect on own feelings<br>Be able to interview, think psychologically and develop rapport with most patients | Understand interpersonal and team dynamics in psychiatric practice – a balanced view of complex and emotionally arousing patients<br>Be able to interview aroused, defensive or technically demanding patients sensitively<br>Have specific knowledge of dynamic and psychological issues in relation to practice in chosen specialist area |
| Competency 2 (Referring) | Be aware of the range of therapies available, basic theoretical tenets<br>Be aware of patient characteristics that are important for a good outcome | As per ST1<br>Be able to summarise the evidence base for these therapies in different conditions<br>Be able to assess patients' presentation and motivation for therapy and make appropriate recommendations | Be able to assess suitability for psychotherapy (including difficult patients)<br>Refer appropriately for specialist assessment<br>Have detailed knowledge of the indications and contraindications for therapies<br>Evaluate the effect of a completed treatment<br>Able to discuss difficult or failed treatment with patient<br>Have more detailed knowledge of therapy within chosen field |
| Competency 3 (Advising) | As in competency 2 above<br>Discuss possibility of psychological treatment/ referral for selected cases with educational supervisor or patient's consultant | Be able to explain to patients the basic principles of a range of treatments<br>Be able to discuss pros and cons of treatment | Discuss treatment options in psychotherapy with all patients<br>Give the patient information to allow informed choice<br>Discuss risks of therapy and interactions with other interventions |
| Competency 4 (Providing therapy) | Begin to undertake simple psychological treatments (supportive or CBT) under supervision | Acquire further capacity to treat a range of patients with a range of problems using a range of treatment modalities | See ST 2–3 |
| Competency 5 (Teaching) | Be able to assess the quality of teaching and be aware of basic educational methods<br>Be able to prepare case presentations and present to a group of peers | Be able to construct own presentation to peers and wider group on a psychotherapeutic topic<br>Be able to critically appraise literature on psychological treatments and discuss contents with peers | Be able to teach more junior trainees about psychological treatments<br>Be aware of standards expected for teaching psychiatrists in psychological treatments<br>Be able to advise more junior trainees about ways to gain psychotherapy experience |
| Competency 6 (Service design) | Be aware of difference between therapeutic modalities and range of professionals providing them<br>Be aware of the indications of different psychological therapies for particular conditions | As per ST1<br>Be able to gather knowledge of local structures for psychological treatment provision | Understand national and local guidance about psychological treatments and application to their chosen field<br>Understand team dynamics and the place of external consultation and supervision |



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**Box 4 Methods of assessment**

Assessment is a vital element of successful implementation of MMC requirements. Specific assessment methods will be needed to track and validate the learning process.

***Structured logbook***

This records the experiences and treatments conducted by the trainee. It should show an account of each treatment and include one longer case report. Each treatment must be signed off by the supervisor. Completion of the logbook should be mandatory before a Certificate of Completion of Training is granted.

What the logbook should contain:

*ST 1*

- Record of Balint group attendance
- Balint group leaders' assessment record
- Record of three case presentations at Balint group
- Record of treated case (supervisor's report and case description sheet)

*ST 2–3*

- Record of Balint group attendance
- Balint group leaders' assessment record
- Record of three case presentations at Balint group
- Educational supervisors' report
- Reports by leaders of paper-reading seminars
- Record of three treated cases (supervisor's report and case description sheet)

*ST 4-6*

- Educational supervisor's report
- Record of six treated cases (supervisor's report and case description sheet)
- Record of teaching experiences and feedback from students
- Extended essay and mark sheet

***Educational supervisors***

Much will depend on the reports given by the educational supervisor. These should be structured and detailed. Specific training of educational supervisors in the requirements and assessments will be needed.

***Extended essay/case report***

Each trainee should be required to produce an extended case report (5000 words) on a psychotherapeutic case (either, and most often, a formal treatment or a series of treatments or a description of an intervention in a different setting, e.g. as a group facilitator on a ward). The aim of the report is to demonstrate that the trainee:

- has a working knowledge of psychological treatment
- can reflect in an emotionally appropriate way on psychological issues
- is able to formulate psychological reflections into a coherent account

The essay could be marked locally or be part of the central examination process.

progression in the development of these competencies from specialist training (ST) posts 1–6 is summarised in Box 3. A heavy emphasis will be placed on assessment of competence and Box 4 shows the currently proposed methods of assessment. The purpose of assessment will be to establish the presence of basic standards of knowledge and skill in psychological treatments without which no trainee should be allowed to take up a consultant post in any branch of psychiatry.

## The role of the consultant psychotherapist

So what part will the consultant psychotherapist play in implementing these training requirements? One role will be as psychotherapy leads in the schools of psychiatry with a remit to oversee the provision of mandatory psychotherapy training within each deanery, monitor the quality of training provided and identify gaps in provision. A job description for this



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**Box 5 Pragmatic issues: what is needed to meet the College's new psychotherapy training requirements**

*Personnel*
- Psychotherapy tutor(s) These should be consultant psychiatrists in psychotherapy or consultants with a special interest in the field
- Psychotherapy supervisor(s) These specialist supervisors should hold a recognised qualification in the therapy modality that they are supervising

*Inputs*
- Balint groups
- Didactic input on psychotherapy, including reading (journal) groups focusing solely on psychotherapy papers or significant coverage of psychotherapy in general academic reading groups
- Sufficient number of assessed and appropriate treatment cases to provide two long and eight brief cases per trainee over the training period
- Opportunities to gain experience of assessing and delivering psychological treatments in a range of clinical settings, including extended discussion time with senior psychological therapy practitioners

*Training*
- There will be a need to inform and train tutors, scheme organisers and educational supervisors

important role will be considered by the College's Education, Standards and Training Committee at its next meeting.

In many deaneries there may be only one consultant psychotherapist available to fulfil this role. In this instance this person will be charged with a set of responsibilities over and above those required of other specialties within psychiatry. Because psychotherapy is both part of generic training in psychiatry and a specialty in itself the psychotherapy advisor's role will include:

- implementation of psychotherapy training for all ST1–6 trainees across all specialties, as described above
- implementation of training for ST4–6 doctors who want to develop a special interest in psychotherapy
- possibly a further role in providing introductory courses for 'fixed term specialty training appointment' (FTSTA) doctors
- probably a role in making training opportunities available as part of CPD following attainment of the Certificate of Completion of Training (CCT).

In addition to these organisational tasks, it will be important that consultant psychotherapists maintain direct input in the training of psychiatrists. Having both a psychotherapeutic and psychiatric training places consultant psychotherapists in a unique position to convey to trainees the knowledge and skills required not only for formal psychological therapies but also for their application in psychiatric practice. The implications of this are profound for the development of a psychotherapeutically informed mental health service as well as for patient management and the proper therapeutic use of the patient's relationship with the whole professional team.

Over and above these training responsibilities it will be important that consultant psychotherapists are not so taken up with the training aspects of their post that they are unable to provide the clinical services that are, after all, the desired end point of these training experiences.

There can be little doubt that this is a large remit but not one that need be fulfilled in isolation.

The Exeter training programme is already turning its mind to how it can address itself to these tasks. The detail of this is beyond the scope of this article, but some of the pragmatic issues to be addressed are listed in Box 5.

## Conclusions

It would appear that setting down requirements for training can be an effective way of improving the provision of psychotherapy training nationally, and it is to be hoped that the Royal College of Psychiatrists and the Postgraduate Medical Education and Training Board (PMETB) will grasp the opportunity provided by the current changes in medical education to raise the standards of training. We can surely no longer justify allowing our reservations to stand in the way of offering this essential training to future consultant psychiatrists. If we fail to do so we run the risk of falling well behind the standards of training being established in other countries (Holmes *et al*, 2007). This is a large organisational task for consultant psychotherapists, especially where these posts



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are thinly spread. It is important that the magnitude of the task is recognised and that the burden of implementing the requirements is shared across the College and locally by consultant colleagues. In this way consultant psychotherapists can fulfil their training and clinical functions, continuing their clinical contribution to the management and treatment of complex cases.

## Declaration of interest

S. M. is a member of the Psychotherapy Faculty at the Royal College of Psychiatrists.

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## MCQs

**1 The Royal College of Psychiatrists' requirements for psychotherapy training require SHOs to:**

a see a total of four cases for psychotherapy
b attend a Balint group for 6 months
c run a psychotherapy group
d complete their logbook, documenting their completion of the College's psychotherapy training requirements, before sitting the MRCPsych exam
e be competent psychotherapists.

**2 Problems encountered in Exeter as a result of offering training according to these requirements have included:**

a pressure of time preventing trainees seeing cases
b identifying trainees who are in difficulty with their cases
c differences of opinion with psychiatric colleagues over the competence of trainees
d finding reliable ways of monitoring the quality of therapy offered by trainees to patients
e finding appropriate cases for trainees to see.

**3 The advantages of offering training that fulfils the College's requirements have been:**

a the delivery of a cohort of psychiatrists qualified to practise as therapists following basic specialist training
b an increase in the number of trainees expressing an interest in pursuing further psychotherapy training
c shorter waiting lists for complex secondary mental health cases in psychotherapy departments
d an opportunity to delegate training tasks, lightening the commitment to SHO training for the consultant psychotherapist
e widely recognised, leading to an increase in the national resources available to training SHOs in psychotherapy.

**4 Modernising Medical Careers is bringing about the following changes to psychotherapy training for psychiatrists:**

a the principle that psychological treatments and a psychological attitude are as fundamental as drug treatment and biological approaches to mental ill health is enshrined in the new MMC curriculum
b a greater focus within psychotherapy training on formal psychotherapy experience and a shift away from its application to psychiatric practice
c a change from establishing the number of hours spent seeing patients as a measure of clinical expertise towards establishing the doctor's competence to practise
d a more marginal place for the Balint group in training
e a move towards central assessment of competence through externally marked examinations.

**5 Assessing competence in psychological therapies is:**

a optimally achieved by audio or video recording of psychotherapy sessions across all modalities of therapy
b straightforward in manualised therapies such as CBT
c to be achieved in the new MMC curriculum solely by testing theoretical knowledge
d likely to be contributed to by workplace-based assessment undertaken by the educational supervisor
e only likely to be achieved by the supervisor's appraisal of the trainee's clinical ability.

**MCQ answers**

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| a T | a F | a F | a F | a F |
| b F | b F | b T | b F | b F |
| c F | c F | c F | c T | c F |
| d F | d T | d F | d F | d T |
| e F | e F | e F | e F | e F |



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