The College

Guidelines for the Training of General Psychiatrists in Psychotherapy

1. Introduction

This memorandum concerns training in psychotherapy during the initial three year period of general professional training in psychiatry. A brief statement on this training was included in the statement on approval of training schemes for general professional training (1984). This document also stated that every trainee should have a minimum of one year's training in general psychiatry and some experience from among a variety of sub-specialties. At present none of the sub-specialty experience is mandatory, but all training schemes should provide as wide a range of sub-specialty experience as possible.

The memorandum was originally prepared by a working party of the Psychotherapy Section Executive Committee—Dr Pamela Ashurst, Dr Stanford Bourne and Dr Michael Crowe. After some minor modifications it has been approved by the Education Committee, Court of Electors and Council.

J. L. T. BIRLEY, *Dean*

Previous statements on training

The British Journal of Psychiatry (1971), **119,** 555–57 published guidelines for the training of general psychiatrists in psychotherapy. Reference was then made to previous statements circulated by the RMPA (April 1970) and to a 'memorandum on education programmes for trainees in psychiatry' (*British Journal of Psychiatry* 1971, **118,** 693). The RMPA had stated that some competence in psychotherapy is an essential part of the equipment of every psychiatrist; and general psychiatric training should include training in that degree of psychotherapeutic skill which is essential for all psychiatrists.

Sixteen years have elapsed and the specific proposals formulated then are now due for re-appraisal. In spite of many auspicious developments and the improved level of psychiatric training in general, current enquiries suggest there has been little advance towards fulfilment of the recommendations made in 1971, concerning basic training in psychotherapy.

The 1971 proposals were limited. We review some of the difficulties that may have prevented implementation of even those very modest aims. We believe that the requirements should be clarified and expanded since it is clear that the earlier proposals have been extensively ignored. On the other hand, the success in implementing an acceptable training in some places demonstrates that the problem can be met without conscripting excessive staffing resources provided there is some determination and flair.

The 1971 proposals still represent a careful and realistic formulation of aims and standards. We therefore base the present proposal on these. It was then recommended that trainees have weekly specialist supervision for work with two individual patients for at least a year; weekly specialist supervision for group psychotherapy; and experience of various other forms of psychotherapy, all under supervision. Theoretical teaching was also outlined. However, the disparity between a desirable standard and a level that could be immediately achieved everywhere left some vagueness. Aims were specified but no element of psychotherapy training actually became obligatory. In revising those proposals, we now differentiate:

(a) essential areas of training in individual psychotherapy (dynamic, behavioural and supportive);
(b) optional areas of training, of which at least one should be studied during general psychiatric training (group, family and marital, counselling and crisis intervention).

Specific proposals regarding behavioural therapy and separate discussion of the place of personal psychotherapeutic experience are substantial additions. We also reappraise the previous emphasis on the role of the consultant psychotherapist.

2. Organisational requirements and difficulties

Previous guidelines emphasised the lack of specialist psychotherapists to provide supervision, but attention should be called to other crucial obstacles. Some of these are the prior claims of other service commitments and other teaching programmes for the Membership Examination. Above all there seems to be a lack of a sustained and clear sense that some competence in psychotherapy is essential for all psychiatrists. In addition to strictly practical obstacles, psychotherapy is one of the more emotionally taxing fields in psychiatry. Trainees may fail to develop their skills if adequate support is lacking.

Current provision of consultants in psychotherapy averages about one per 870,000 population—less than half the College norm of one per 400,000 agreed in 1975; and less than a quarter of the long-term aim of one per 200,000, agreed in 1977 (*Bulletin*, December 1977). A total of 84 new consultants would be needed to bring England and Wales up to one per 400,000 population. The scarcity of funding and of senior registrar posts makes a substantial expansion of trained staff unforeseeable. The vicious circle is set to continue indefinitely unless training requirements are encouraged with greater vigour. The situation may be analogous to that of general psychiatric training before

the College Approval Programme raised standards. The provision of adequate psychotherapy supervision should be available to all trainees in psychiatry.

However, the lack of specialised resources easily becomes the 'excuse' rather than the prime reason for shortcomings in psychotherapy training. At this level of general professional training in psychiatry there are usually resources for supervision in psychotherapy currently under-used, especially if interested psychiatrists and other non-medical colleagues were to be included as they should be. Even in teaching districts where there is provision for psychotherapy supervision and training, many trainees do not get it. If the situation is to improve there will have to be renewed effort by all psychiatric tutors and many other consultant psychiatrists in addition to consultant psychotherapists. Where there are local difficulties consideration should be given for providing supervision at regional centres or by a peripatetic consultant psychotherapist. There is scope for more collaboration and co-ordination between consultant psychotherapists, especially where posts are isolated. Each Region should ensure that they have sufficient consultant psychotherapists to co-ordinate training resources to ensure provision of supervision throughout the country, until such time as the provision of services at district level meets the long-term College norms.

Revised training proposals

Educational objectives

In general terms the object of training should be to produce psychotherapeutically informed psychiatrists, educated in those aspects of psychotherapy that are germane to most of general psychiatry.

The specific aims of training should be:

(a) To develop the trainees' sensitivity to the possible meanings of their patients' communications and behaviour.
(b) To enable them to recognise the complexities of the doctor-patient relationship, including their own reactions in interviews; to understand the significance of the relationship in a variety of therapeutic situations.
(c) To develop awareness of the relevance of past experience to present behaviour and the tendency for repetition of past behaviour patterns; to enhance recognition of the conscious and unconscious processes governing personal and social interactions and personality development.
(d) To help them to understand the reciprocal pressures that family members exert on each other's behaviour, the ways in which symptoms may result from such pressures and the use of various techniques to alter family interaction.
(e) To enable them to recognise the indications for behavioural, dynamic, family, supportive and other psychotherapeutic approaches and to be familiar with the relevant theories and techniques.
(f) To help develop the necessary skill and confidence to engage in the various forms and levels of psychotherapy, appropriate to their experience.
(g) To develop appropriate attitudes towards psychotherapy and interpersonal relationships.

Recommended clinical experience

(i) *Preamble*. Development in psychotherapeutic competence should grow steadily during the early years of general psychiatric specialisation and the necessary training should be a fairly continuous concomitant of other psychiatric work. Experience suggests that part-time psychotherapy training over a long period is a more realistic aim and often more effective than full-time training for a shorter period, since it takes time to develop new ways of thinking and reacting. Moreover, these developments at this level are meant to be integrated into other psychiatric work and not regarded as merely an isolated specialist option which is completed and set aside. Some of the following items might be very suitably undertaken in the context of such special areas as child and family psychiatry, forensic psychiatry, mental handicap, psychogeriatrics, drug addiction and alcoholism, as well as in general adult psychiatry.

(ii) *Note*: Items (a), (b) and (f) below are considered indispensable to good psychotherapy training for general psychiatrists. We think it could be unhelpful to try and specify minimum requirements for every item in (c), (d), (e) and (g); neither do we think it desirable for many trainees to attempt to cover all these options during their first three years. However, there should be substantial initiation in at least one of these areas.

(a) *Individual dynamic psychotherapy*. This is a crucial experience of training in psychotherapy and has implications in all other psychiatric work. Supervised experience in individual psychotherapy should extend over at least two years and problems posed by rotational training schemes will need to be overcome. Work with at least two patients is essential, one of whom should be seen over a substantial period. We envisage therapy extending over a year or perhaps 50 sessions, a duration necessary to allow some initiation in exploring the clinical phenomena of transference, regression and other processes of change and development, expected in dynamic psychotherapy. However, we wish to avoid the problems that a rigid minimum specification can create, e.g. in distorting therapeutic considerations.

(b) *Behavioural psychotherapy*. Trainees should have adequately supervised experience in treating at least two patients complaining of problems suitable for behavioural treatments e.g. phobias, obsessive-compulsive states, sexual disorders or social skills deficits. They should also be familiar with cognitive therapy and its applications. Progress in treatment

should be documented with objective measures wherever available.

(c) *Group psychotherapy*. Trainees should gain some understanding of large and small group dynamics. Knowledge of small groups should be approached by experience of conducting group psychotherapy or by acting as a co-therapist with a more experienced therapist. Adequate supervision of this work is essential.

Large groups in various settings (ward groups, day hospitals, therapeutic communities etc) will usually involve staff of several disciplines and varying seniority and will provide good learning experiences.

(d) *Marital and family therapy*. In addition to the intrinsic interest and importance of experience with couples and families, there is an important practical teaching advantage from the fact that this work is generally undertaken by staff teams rather than individual therapists working alone. This situation offers ideal opportunities for learning and teaching by example and from direct supervision at work.

(e) *Counselling*. We think specifically of such areas as student counselling and vocational guidance; bereavement counselling and work in association with the maternity services, family planning clinics, infertility clinics, services for psychosexual counselling, genetic counselling, etc. As well as promoting an understanding of individual psychodynamics, such work can serve to teach trainees about working with couples, families, or groups and about interdisciplinary group processes.

(f) *Supportive psychotherapy:* This should be part of the repertoire of skills of every psychiatrist and for that matter every physician. An understanding of interpersonal relationships, counselling and anxiety relieving techniques that are not specifically concerned with dynamic or behavioural psychotherapy, sympathy, reassurance, empathy, guidance, encouragement, advice and suggestion are all components of this approach.

(g) *Other experience*. We have already emphasised the relevance of training in psychotherapy to all fields of psychiatry; and suitable cases for psychotherapy training may be undertaken whilst working in general psychiatry or in its specialties. In particular supervised experience is valuable in treating brief episodes of psychiatric disturbance, for instance work with the bereaved or in emergency services.

Supervision and clinical seminars

For competence in all these areas of psychotherapy to evolve, emotional obstacles have to be overcome and some loosening from traditional medical models of work is required. Support, as well as teaching, is therefore needed. Seminar work in peer groups is particularly useful since it provides mutual emotional support as well as vicariously enlarging clinical experience, essential at this stage.

(a) Trainees should have weekly seminars where they can discuss problems in the psychotherapeutic management of any of their patients, including problems in the doctor-patient relationship, whether these are seen diagnostically or in the course of the various forms of psychiatric treatment. The need for emotional as well as intellectual support may thereby be recognised and met. This valuable grounding could usefully start before the trainee embarks on those cases formally designated for psychotherapy.

(b) The crucial work of individual (dynamics) psychotherapy cases requires close supervision and support, either on a one-to-one basis with a supervisor or in small case discussion seminars. A weekly supervision group not larger than three or four members presenting cases is suitable, but others, not yet reporting cases, could usefully participate.

(c) For behavioural psychotherapy, four to six trainees who are currently treating patients with behavioural techniques should meet regularly with a supervisor, preferably on a weekly basis. The supervisor should ideally be a consultant psychiatrist with special experience in this area or a consultant behavioural psychotherapist, but in some centres non-medical supervisors may carry out this task.

Theoretical instruction

Seminar teaching should cover the theories underlying the various forms of psychological treatment including psychoanalysis and analytical psychotherapy; group therapy; behavioural and cognitive psychotherapy; supportive psychotherapy and family and marital therapy. Some of this teaching will probably be given by non-medical teachers.

An adequate programme of lectures or reading seminars, to cover all these areas should be available to all trainees. In general, seminars and discussions in small groups are more effective than formal lectures in transmuting knowledge into informed understanding and clinical competence.

Personal psychotherapy

Dynamic psychotherapists largely agree on the prime importance of a personal psychotherapeutic experience in their own training to increase awareness of unconscious processes and to help the therapist to become aware of his reactions to patients, reactions which can affect the treatment itself. Personal therapy also helps therapists to cope with the anxieties that psychiatric patients can stir. Limitations of cost, availability and personal inclination make it unlikely that most psychiatric trainees would engage in personal psychotherapy themselves and nor should they be lightly advised to do so. Supervision and counselling should provide adequate support for most trainees. Trainees wishing to seek personal psychotherapy or psychoanalysis for themselves, for training purposes, should in general be advised to obtain this during higher training.

Assessment—case reports

Some centres already require their trainees to produce psychotherapy case reports: others might consider following their example. Such reports have the advantage of increasing the relevance and immediacy of psychotherapy training and of impressing more permanently on the trainee the lessons learned. Case reports should describe the case history, relevant theoretical issues, the treatment given, the patient's response to treatment and the outcome. Relevant literature may be discussed. We suggest each trainee write reports, including at least one case each of dynamic, behavioural and supportive psychotherapy. These case reports should be submitted to the supervisor. Consultant psychotherapists and psychiatric tutors in each region should arrange to evaluate the case reports for the benefit of trainees and different forms of assessment might fruitfully evolve.

Election to the Fellowship

Candidates for election to the Fellowship are considered annually by the Court of Electors.

Candidates may not make a personal approach to the College for election, *but must be nominated by two sponsors, who must be Fellows of the College.*

Sponsors should *apply in writing* to the Registrar for the relevant forms. Completed nominations should be submitted to the Registrar by 30 September in any year, for consideration by the Court at its meeting the following February.

Eligibility of nominees

a. Candidates must either be Members of the College by Examination of more than five years standing, or Members who have been granted exemption from Examination.
b. The Fellowship is ordinarily awarded to a Member for unusual distinction in teaching, research, and/or administrative ability, or for exceptional service to patients, especially where the supporting services have been inadequate. Sponsors are therefore asked to indicate any factors which go beyond the carrying out of consultant or academic duties by the candidates of their choice.

All sponsors and all successful candidates will be notified by letter of the decision of the Court of Electors.

Individuals elected to the Fellowship become entitled to use the designation FRCPsych after they have paid the prescribed registration fee.

The Missing Examination Papers

Examiners and examinees have nightmares of things that can go wrong in examinations. Last February, one of them came true.

A batch of eight Preliminary Test essay papers was lost by the Post Office. They were amongst all the others posted at the same time, by recorded delivery. Extensive searches were of no avail. Two decisions had to be made. First, how to examine the eight candidates, and secondly to review the College's postal procedures.

We decided that the fairest procedure would be to set a new essay paper for the candidates, at least for those whose MCQ marks still left them in the field. This was arranged in May, and the essay scripts were rushed to the Examiners who would have marked those which were lost.

Clearly it is the College's responsibility to decide how essay papers should be handled. Hitherto, in its 15 years of experience, none have been lost. A good record, but of course it should be impeccable. We checked with other Colleges, and discovered that there had been the odd loss from ordinary post, datapost, and registered post. On the basis of our own experience, and our enquiries, and after much thought, we have decided not to change our present system. The alternative—a courier service—might have marginally less risk, but it would add, considerably to the cost of the examination.

J. L. T. BIRLEY, *Dean*

Pass List

The Examinations Sub-Committee has decided that from October 1986 a pass list of successful candidates in the Preliminary Test and the Membership Examination should be sent out to Academic Departments of Psychiatry in the United Kingdom and the Republic of Ireland one week after the results are released to candidates.

Heads of Department have been asked to pin the list on Notice Boards for approximately one week.