

## A modernised psychotherapy curriculum for a modernised profession

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**Summary** This paper outlines recent revisions to the psychotherapy elements of the core psychiatric training curriculum of the Royal College of Psychiatrists. The reasons why psychotherapy training is important as part of psychiatry training are developed and objections to the inclusion of this element are countered. The paper sets out the reasoning that led to the revisions in the training required and discusses the obstacles to the implementation of good-quality training in this area and suggests ways in which they can be overcome.

**Declaration of interest** None.

One less remarked effect of the UK government's Modernising Medical Careers initiative has been a generalised and convulsive revision of postgraduate medical curricula. The Royal College of Psychiatrists has revised its curricula and has introduced a major series of changes to its membership examination. As part of this process, the College's Faculty of Psychotherapy took a detailed look at the place of psychotherapy in the curriculum. The need for modernisation and reform was pressing since the regulations were 'more honoured in the breach than the observance'<sup>1</sup> and in any case reflected outdated notions of both educational and psychotherapeutic practice.

The purpose of this paper is to outline the rationale behind the revisions made to the curriculum and set out the case for the current place in it of psychotherapy training. The paper does not set out in detail the regulations as they now stand (they can be found on the Royal College of Psychiatrists' website at: [www.rcpsych.ac.uk/training/curriculum/psychotherapycurriculum.aspx](http://www.rcpsych.ac.uk/training/curriculum/psychotherapycurriculum.aspx)). Schools of psychiatry are charged with delivering the curriculum and many are now actively improving the psychotherapy training in their region.

### Why emphasise training in psychotherapy for all psychiatrists?

#### Applying psychotherapy in day-to-day work

Well-taught psychotherapy is an essential part of a biopsychosocial perspective. Psychiatry without a psychological perspective is arguably in danger of degenerating into neurology 'lite', and psychiatry-free (possibly even doctor-free) mental health may lose the distinctive ethic and political independence of medical practice and risks becoming social care with added coercion. Psychiatrists who are competent in psychotherapy should be able to promote the true skill of the profession – a biopsychosocial approach

to clinical work. The capacity to develop a psychological formulation is central to this task (see Kassaw & Gabbard<sup>2</sup> for an outstanding example) and training in psychological therapies for psychiatrists sets up its competent performance as a main aim.

Patients whose conditions are resistant to treatment or coloured by personality predispositions that make management difficult (exactly those patients that psychiatrists will now more exclusively manage) often evoke strong feelings, put intense pressure on working relationships and require extended contact. Knowledge of how to manage longer-term professional relationships, especially where these involve emotional entanglements, develops in time but only if the practice of the psychiatrist is both reflective and open to a certain intensity of experience. However, this is not guaranteed and nor is it a capacity that comes naturally. For example, even the sort of supportive psychotherapy that is an ordinary part of out-patient psychiatric practice is a skill that is harder to teach than one might imagine if the objective is to teach the therapist to give more than bland reassurance.<sup>3</sup> Psychotherapists are not the sole occupiers of this emotional high ground but they can claim to have expertise in the area. Helping trainees develop habits of self-reflection and emotional curiosity is part of what is embodied in the revised curriculum as the psychotherapeutic attitude.

#### Improving psychotherapeutic competence

Psychiatrists have always 'prescribed' psychotherapy but often did so carelessly, without much thought about its interactions with other aspects of treatment and not bothering to follow its outcomes through. Recent developments in the role of psychiatrists (such as New Ways of Working) are likely to require a more accurate and informed perspective on psychotherapy. Psychiatrists will come to concentrate only on cases of complex, treatment-resistant and challenging patients, where multiple pathologies

combine. Drug treatments will not be straightforward in these patients but neither will be psychological treatments. The accurate management of such patients is often a question of careful balance and the maximisation of small advantages. In such a setting, the rational, accurate and informed use of psychological therapies as part of an overall treatment programme is going to be an essential element of psychiatric care.

### Essential skill

Most patients who need psychotherapy do not need to see a therapist who is also a psychiatrist, but some do. Some will only see their psychiatrist because that is who they trust. Some have been involved in litigation or other difficulties with their healthcare providers and need to see someone not frightened by their past. Some have a complex of medical and psychiatric problems that surround and interweave with their psychological problems – an easy knowledge of all areas makes accurate management possible. For these patients a psychiatrist with psychotherapy skills can be invaluable.

### Objections to training

Almost no one objects directly to enhancing training in psychotherapy or to the value of psychotherapeutic approaches in psychiatry. Instead, a number of difficulties are raised as reasons why this cannot be done.

### Practical difficulties

By far the most powerful objections to universally implemented training for psychiatrists in psychological therapies are pragmatic ones. The scarcity of consultant psychotherapists nationally has combined with unwillingness on the part of some other health professionals to train people who are not in their discipline, and has made finding the resources for training exceptionally difficult in some areas. Thus enhanced training in psychotherapy is almost universally supported except when it turns out to conflict with any other priority or require additional resources.

Yet giving in to a resource-based objection risks a vicious spiral of decline into further practical difficulties as the lack of training perpetuates a lack of trainers. If psychotherapy training is to be brought up to an acceptable standard then at some point, however painfully, change must come and delay will only make matters worse. Furthermore, lack of resources is not an objection that would find much purchase in relation to skimping on training in other psychiatric treatment skills such as prescribing medication or electroconvulsive therapy. Treating psychotherapy as important would involve rating failure to teach junior doctors in this area as serious as failing to teach them in these other areas.

#### *Practical solutions*

In fact, with a little creativity and using modern communication tools most of the difficulties can be overcome. There is already a lot of evidence that distance and internet-based learning is a realistic training option in the

psychological therapies. The implementation of a fully developed distance learning programme in Perth, a city which is isolated and was at the time poorly supplied with local experts, is described as long ago as 1990.<sup>4</sup> Videotape and audiotape remain helpful tools in training,<sup>5</sup> but modern distance-learning programmes based on computerised communication have opened up a wide range of new e-possibilities.<sup>6</sup>

One approach to training in time-limited therapies in Qatar has been to use a combination of intermittent on-site intensive teaching sessions with weekly supervision sessions run on an internet chat room. Three modalities of therapy are taught in 6-month blocks. All trainees take on cases in the same modality but over the 4-year training they have two opportunities to take up a block in each modality. A local coordinator is responsible for the practical aspects of the programme; local general consultants select and assess appropriate cases and retain medical responsibility.

Empowering general psychiatrists to act as trainers is another important practical step. Many psychiatrists have excellent supportive psychotherapy skills and a wealth of practical knowledge in psychoeducational and motivational techniques, yet they undervalue these skills because they do not conform to a rather stereotyped view of the psychotherapy trainer as a fully trained psychoanalyst or cognitive therapist. Other psychiatrists could consider reinforcing their skills in this area as part of their continuing professional development.

### Trainees' unwillingness or inability to train in psychotherapy

Another common worry to universal training in psychotherapy centres on a hypothetical, psychopharmacologically brilliant trainee, with irremediably poor communication skills, who would never be able safely to undertake a psychological treatment. I have never met such an individual but, more importantly, although someone with that particular balance of capabilities might be an excellent researcher they should perhaps not take on the sole care of patients whose understanding of, adherence and consent to treatment they could not ensure.

Far more common are the unwilling trainees and the unwilling trainers. Most people who teach psychotherapy to junior doctors are well aware that despite surveys which show that trainees in psychiatry<sup>7</sup> and those in general practice<sup>8</sup> value psychotherapy training and want more, their good attenders represent only a subset of trainees. Some never attend. One worry is that the trainees who do not attend are exactly those who might benefit from training. It is therefore encouraging that trainees did change their practice as a result of the input they received.<sup>8</sup> Structuring training so that every trainee will have no choice but to engage in psychotherapy training represents a major change in the modernised curriculum.

### The new curriculum: structure and rationale

#### Syllabus

The revisions made to the syllabus for the examination (which can be found at the end of the core curriculum at

www.rcpsych.ac.uk/training/curriculum2009.aspx) have partly been ones which reflect advances and changes in psychotherapeutic practice over the past decade. The emphasis is on evidence-based therapies. However, the role of the psychiatrist as intelligent referrer for psychotherapy is a prominent feature of the curriculum, as is the value and content of a more general 'psychotherapeutic attitude' to psychiatric practice.

### Competencies

The core competencies that a psychiatrist needs to acquire are set out as either general (relating to all psychiatric practice) or specific (in relation to particular psychotherapies). General competencies include the capacity to account for phenomena in psychological terms, to deploy advanced communication skills and to display advanced emotional intelligence in professional work. The specific competencies include being able to refer appropriately for formal psychotherapies, to jointly manage patients receiving psychotherapy, and to deliver basic psychotherapeutic treatments and strategies where appropriate.

### Training experiences

It is hard to set out reliably in the form of competencies every desirable piece of learning and skill in psychotherapy. For this reason the current curriculum still contains a minimum set of activities which all trainees are expected to undertake. The hope, of course, is that by undertaking these activities trainees will move significantly towards mastery of the necessary skills and competencies. The required training experiences include case-based discussion groups and psychological treatments.

### Case-based discussion groups

Trainees are asked to attend weekly case-based discussion groups for 1 year and are assessed on their performance in these groups.

Since a major aim of the psychotherapy curriculum is to help psychiatrists learn how to think in a comprehensive biopsychosocial way about their clinical work, it is important that this regular work is discussed and reflected on from a psychological perspective. The case-based discussion groups can help to develop this reflective capacity. Ideally, the groups should be led by a psychotherapeutically skilled psychiatrist who is able to model the complexities and advantages of this distinctively psychiatric fusion. Losing either the biological or the psychosocial perspective turns doctors away from the essence of their art and produces poor science. Arguably, these groups are among the most important training experiences a trainee will have.

### The case presented as an assessed clinical experience

Trainees are asked to treat a patient under supervision in a recognised modality of psychotherapy and are assessed at the end of the case both by their supervisor and an examiner.

Setting the presentation of completed psychotherapy as one of a number of required achievements means that each successful trainee will have competently treated at least one patient. They will acquire some direct appreciation of what is involved when patients receive psychological treatments and of the strengths and limitations of this approach. In doing so, they will become more rational and realistic in prescribing psychological treatments. Furthermore, the supervised acquisition of those basic psychological techniques that all psychotherapies require will enhance trainees' routine interview practice.

### 'Two therapies, two durations, two modalities'

Trainees are asked to provide evidence of treating other patients psychotherapeutically, at a minimum delivering two therapies which are in different modalities and of different durations.

Like medical treatments, psychological treatments are various and no single mode of treatment is suitable for all patients. This curriculum requirement aims to press trainees to broaden experiences of therapy beyond a single modality. Furthermore, it is hoped that in undertaking a longer treatment, trainees will also gain an experience of following a patient over a longer period. Over longer engagements emotional pressures build up and need accurate management. The failure to manage these pressures lies at the heart of quite a few instances of unethical practice on the part of psychiatrists as well as some avoidable ruptures in the relationship between psychiatrists and their patients. Psychiatrists do not in general see patients at psychotherapeutic frequencies or durations of sessions. However, over time they develop long-term relationships with patients of similar intensity. Longer-term psychotherapy offers a preview of this situation in a supervised and educational environment.

### The future of medical psychotherapy training

#### Moving away from the 'doing the minimum' approach

The introduction of any set of regulations produces an initial panic as trainees, trainers and training organisations focus on the practical aspects of training. Naturally, this leads to a focus on essentials and, in the case of psychological treatments, on frequent questions about the minimum required experience. However, one hopes that once this minimum has been implemented trainers and trainees who have had a good experience of the advantages of acquiring psychotherapeutic skills will move on from a scrape-through mindset to one that could envisage and implement excellent training in this area. Where this has been done, for example in an American programme that introduced universal training in interpersonal therapy,<sup>9</sup> there have been considerable advantages and widespread acceptance.

If we are able to move away from a minimalist approach to training then two important developments in the field of psychotherapy may come to offer trainees potentially valuable and creative training opportunities.

### Developments in training elsewhere: IAPT and Skills for Health

The improving access to psychological treatments (IAPT) initiative is one of the largest new developments in the delivery of psychological therapies. Significant sums of money are being spent over the next few years in ensuring substantially improved mental healthcare in primary practice. The IAPT scheme is highly structured and rooted in evidence-based therapies, in particular cognitive-behavioural therapy; it will deliver not only therapies but also training. In future, if there is capacity, enrolling trainee psychiatrists on IAPT-based trainings may be very fruitful. Historical accident and professional boundaries have combined to make accessing good training in cognitive and behavioural therapies difficult for some training schemes and trainees. This must be rectified. Cognitive and behavioural therapies are effective and also offer psychiatrists many therapeutic techniques with widespread application outside the domain of formal therapy but highly relevant to all aspects of psychiatric practice.

The Skills for Health council is a part of a massive UK government and business sponsored educational initiative called Sector Skills Councils ([www.skillsforhealth.org.uk/about-us.aspx](http://www.skillsforhealth.org.uk/about-us.aspx)). They delineate competencies and develop skills in all vocational areas and set out national occupational standards. The Skills for Health is currently developing competencies in psychological therapies divided into three areas: cognitive and behavioural therapies, psychodynamic and psychoanalytic therapies, and family and systemic therapies. The 'skills for health' competencies are derived from training manuals for evidence-based therapies and then developed using an expert consensus group. Considerable time, skill, thought and expertise has been expended deriving the competencies embodied in the skills for health specification and, in particular, developing sets of competencies which lend themselves to external evaluation and validation of performance. The skills for health competencies represent an important training tool.

### Conclusions

It would be fair to say that introducing the revisions to the psychotherapy elements of the curriculum into a final

approved format has not been easy. Probably their implementation will not be easy either. For those who are not minded to make the necessary changes there will doubtless be all kinds of escapes, evasions and examples of special pleading. However, as a profession we should have a care. Our niche in the ecology of healthcare is the biopsychosocial perspective and the medical ethic. Either as mere biologists or as 'state sponsored agents of social control' we are ripe for culling, to be replaced by fitter, cheaper health professionals. Psychotherapy, the Cinderella specialty in psychiatry, has been changing because it faced the same kind of obliteration that potentially now faces psychiatry. It might have some experiences to share.

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