editorials

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Psychotherapy training for psychiatrists: hope, resistance and reality†

Among the reasons, conscious and unconscious, that attract young doctors to psychiatry, an interest in psychotherapy features prominently. They are curious about the mind and its relationships – including their own. They want to learn how to use themselves more effectively to help their patients and to be able to understand the strong feelings that contact with psychological illness engenders in them. They want to meet the public's wish for 'talking treatments', and to acquire psychotherapeutic skills that put them on an equal footing with psychologists and other mental health colleagues. They want to be able to practise psychotherapy safely and ethically, and know that 'wild' therapy can make patients worse. They wish to master the psychotherapy research literature that provides an evidence-base for psychotherapy that is as rich and convincing as that which justifies drug therapies, despite the marked imbalance of research funding. They know that drug and psychotherapeutic treatment together are often more effective than either alone (Thase *et al*, 1997). As psychiatrists, they see themselves as uniquely qualified to deliver that combination and are therefore well-placed to take a lead in effective delivery of Government strategies such as the National Service Framework for Mental Health with its emphasis on the integration of psychological and biological therapies in depression and eating disorders, in suicide prevention and in the management of psychosis and personality disorder.

As part of the College's strategy of promoting psychotherapeutic psychiatry, the psychotherapy training guidelines (Grant *et al*, 1993) were developed, with the aim to ensure that every psychiatrist, whatever his or her eventual speciality, would have a good grounding in the theory and practice of the psychotherapies.

Reappraisal

For three main reasons, reappraisal and revision of the 1993 guidelines is now needed. First, there has been a radical change in the educational environment. Educational experience in itself is not sufficient. We need to consider what core psychotherapeutic competencies are to be delivered to trainees, and how they can sustain and develop them as part of a lifelong learning process. Currently psychotherapy training often stops at Membership level, and may become little more than a fond memory as trainees progress to busy consultant posts, which leave little time for formal psychotherapeutic work. Second, there is the problem of implementation of psychotherapy training and of how to embed it unequivocally in the psychiatry curriculum. Many have complained that the current guidelines are too demanding. Full implementation is a rarity (see McCrindle *et al*, 2001, this issue). Third, as the evidence-base for psychotherapy has expanded (Roth & Fonagy, 1996) there is a need to revise the curriculum in the light of this, concentrating not so much on the different modalities of psychotherapy, but on the role of psychological therapies in the major psychiatric disorders.

†See pp. 140–143 this issue.

Core requirements

Common sense, compassion and a bedside manner acquired in the course of basic medical training are necessary, but not sufficient, for competent psychiatric history taking and examination. During their first 6 months in psychiatry, trainees need to develop a knowledge of and expertise in psychological skills involved in interviewing, eliciting information sensitively and using open and closed questioning. These may be learned through observation and practice in ward rounds combined with supervised case discussion, video teaching and experimental workshops. These skills are a first step towards learning to treat patients safely with psychological treatments; to use psychological understanding as part of an overall treatment plan; and to recognise when specialist psychological treatments are necessary. In addition, the trainee needs to develop a theoretical understanding of psychological processes. Knowledge requirements should be clearly specified within a new curriculum for the MRCPsych examinations.

Next, trainees need to develop competence in basic psychotherapeutic competencies. The revised guidelines propose skill acquisition at three levels:

(a) general skills common to all psychotherapies
(b) specific skills related to different models of psychotherapy
(c) skills associated with short-term and long-term treatment.

Skills common to all psychotherapies include setting up treatment; deciding on and adhering to a focus; developing and maintaining a therapeutic process; establishing a good therapeutic alliance from the start; being aware of the relationship between doctor and patient; and being able to end treatment sensitively and appropriately.

Next there are skills in the specific forms of psychotherapy. But how do trainees find their way through the maze of differing therapeutic modalities? The new guidelines have defined three main models: 'transference-based therapies' (psychoanalytic therapy and psychodynamic-interpersonal therapy); 'cognitively or behaviourally-based therapies' (cognitive–behavioural

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therapy and behavioural therapy); and 'integrative therapies' (interpersonal therapy, cognitive analytic therapy and supportive therapy). In addition the trainee needs to be able to understand and apply a 'systemic approach' that takes account of patients in relationship to their families, to the professional team and the wider society with its ethnic and social inequalities. Further key questions concern whether a model is applied within the context of a group, couple or family and over the short-term or the long-term.

A judicious mix of skills learned in all these therapies within different contexts is needed for effective psychiatric practice. Safe patient contact of any sort, let alone the practice of psychotherapy, requires an awareness of transference and countertransference. Adequate understanding and formulation of personality function and its interaction with social and biological interventions is necessary to ensure optimal outcome of integrated treatments. Effective treatment of depression requires an assessment of cognitive style, interpersonal processes and vulnerabilities from the patient's past. Systemic thinking is indispensable as psychiatrists increasingly take leadership and management roles.

The new guidelines will specify a minimum of three short-term cases, one of which must be transference-based, one cognitively-based and one integratively focused. In addition, trainees need some experience of therapy within group, systemic, couple and family therapy. One long-term case of 12–18 months will be required in any modality in order that the trainee may experience, under supervision, the therapeutic relationship in the context of the long-term trajectory of mental health problems; recognise the intensity of the relationship that may occur between psychiatrist and patient; work with dependency and its advantageous and disadvantageous effects; and understand the importance of timely interventions within a longer-term process.

Implementation

How is all this to come about? The publication of the previous guidelines has led to a significant improvement in the comprehensiveness of psychotherapy training, but much still needs to be achieved. Training standards will continue to be scrutinised through College inspection visits; achieving psychotherapy skills must become a precondition of sitting the MRCPsych examination and psychotherapy will play an increasingly prominent part in the examination itself.

At the moment many rotational schemes lack a consultant psychotherapist who can coordinate and deliver much of the training required. Where there is no such consultant, the job is usually done as best as can be by sympathetic general psychiatrists, clinical assistants and psychologists, with family therapy often learned during the compulsory child and adolescent training post. As a long-term solution this is unsatisfactory, and unpublished evidence (N. Temple & A. Gill, 2000, personal communication) suggests that implementing existing guidelines is much less likely to happen in the absence of a consultant psychotherapist. Thus implementing the new guidelines will need to go hand in hand with expanding consultant numbers in psychotherapy – where, worryingly, there has been no growth in the past 5 years. If psychotherapy skills are to become a central part of psychiatric training, without the huge 'postcode' variations that exist today, creative thinking will be required in a number of different fronts.

A good first step is to acknowledge the work done by general psychiatrists in the training by formally designating their work as special interest sessions in psychotherapy. But specialities wither without whole-time or, as a bare minimum, special responsibility posts. College inspection teams will need to insist that special interest posts are the first step on a ratchet leading to the development of mature psychotherapy training schemes, with whole-time, or occasionally special interest, consultant psychotherapists in post, within a defined time period. Other ideas include creating 'two for the price of one' consultant posts that combine, say, psychotherapy with liaison psychiatry or eating disorders, or running a psychotherapeutically-oriented day hospital. These moves would accelerate expansion and ensure that psychotherapy training is relevant to the everyday work of the general psychiatrist. Establishing a College register of members and fellows with special skills and training in the various forms of psychotherapy would help to raise the status of psychotherapy, act as a target for continuing professional development and encourage general psychiatrists and others to make psychotherapeutic work part of their routine practice. Finally, all of this needs to be underpinned by developing an academic-base for research and teaching in psychotherapy within university departments of psychiatry.

The new guidelines are set to play a key part if we are to produce psychiatrists who are comprehensively equipped with the skills needed to work in the mental health environment of the 21st Century. It remains to be seen if the College will rise to its challenge.

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