**CT1-3 Psychotherapy Training**

**Guide for Psychotherapy Supervisors March 2016**

**Contents**

|  |  |
| --- | --- |
|  | Page |
| Why psychotherapy training for psychiatric trainees? | 1 |
| Expected Competencies | 2 |
| Core psychiatric training and assessments | 3 |
| Components of CT1-3 psychotherapy training | 4 |
| Psychotherapy cases | 4 |
| Principles of Core Psychiatry Training WPBAs | 5 |
| Psychotherapy WPBAs | 5 |
| SAPE | 5 |
| PACE | 8 |
| CBDGA | 9 |
| Using Portfolio Online for psychotherapy supervisors | 11 |
| Summary of WPBA evidence required by trainees | 11 |

**Why Psychotherapy Training for Psychiatric Trainees?**

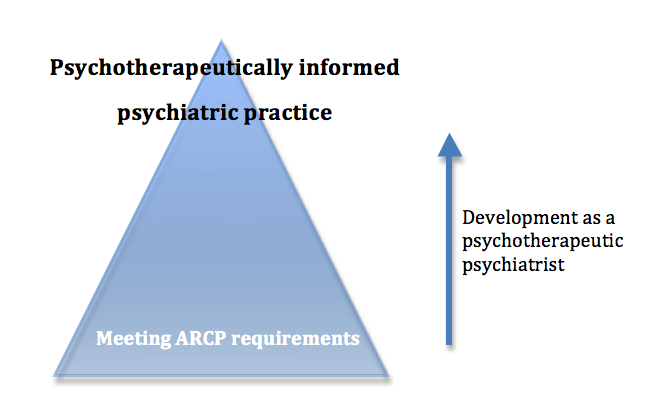
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Fig 1: ‘Maslow’s hierarchy of needs’as applied to CT1-3 psychotherapy training

The ability to think in psychotherapeutic terms about patients is a key feature of the delivery of all psychiatric care; developing psychotherapeutic competencies is thus an essential component of core psychiatry training. The main aims are: learning to think psychologically, learning to take a reflective and psychotherapeutic approach to all aspects of routine clinical practice in psychiatry and being able to respond to patients with greater understanding of emotional complexities. Trainees need to understand about different psychotherapy modalities to be able to deliver basic interventions, refer appropriately and to work with a patient undergoing therapy. Taking on patients for psychotherapy is the most reliable way of gaining skills in delivering psychological interventions and strategies. Psychotherapy training can also contribute to the development of other generalisable, and essential, skills in core psychiatry training, including self-reflection and advanced communication skills.

According to the GMC’s curricular requirements, psychotherapy training is mandatory for all CT1-3s, who will need to have achieved satisfactory psychotherapy competenciesin order to progress to higher training (Fig 1).

Mental health trusts that are LEPs (local education providers) for corepsychiatric training need to provide psychotherapy training opportunities locally to meet the training requirements of their core psychiatry trainees.This includes the employment ofa Consultant Psychiatrist in Medical Psychotherapy[[1]](#footnote-1) who can take up the role of the Psychotherapy tutor who is responsible for overseeing thepsychotherapy training of CT1-3s and quality assures the training. This includes identifying of appropriate clinical supervisors and training of supervisors in the use of WBPA tools (ie: CBDGA, SAPE see below)

Training future psychiatrists to have the ability to think in psychological terms about patients is necessary for improving and maintaining the clinical service offered to patients, and is helpful for the organisation as these trainees will become the psychiatric consultants and will thereby bring these same psychotherapeutic self-reflective attitudes to their teams.

**Expected Competencies**

The competencies expected from psychotherapy training, as summarised in the core curriculum, are:

* General
  + Account for clinical phenomena in psychological terms
  + Deploy advanced communications skills
  + Display advanced emotional intelligence in dealings with patients and colleagues and oneself
* Specific
  + Refer patients appropriately for formal psychotherapies
  + Jointly manage patients receiving psychotherapy
  + Deliver basic psychotherapeutic treatments and strategies where appropriate

Trainees should also understand which factors are important to assess for when referring a patient for psychotherapy and should have achieved enough understanding of expectations of therapies and therapists’ scope and limitations, so when jointly managing patients receiving psychotherapies, if difficulties with the therapy arise, they can understand what is reasonable and belonging to the natural struggle of therapy and what is not.

There have been recent changes to the curriculum. There is a new intended learning outcome (ILO 19) to develop reflective practice including self-reflection as an essential element of safe and effective psychiatric clinical practice, for which the psychotherapy training would be very relevant.

More information on expected psychotherapeutic competencies can be found in the core curriculum which can be accessed on the Royal College of Psychiatrists (RCPsych) website at: [http://www.rcpsych.ac.uk/pdf/Core%20Curriculum\_FINAL%20Version\_July2013\_updatedJun15.pdf](http://www.rcpsych.ac.uk/pdf/core%20curriculum_final%20version_july2013_updatedjun15.pdf)

**CORE psychiatric training and assessments**

All psychiatry trainees have an annual review of competence progression (ARCP) from their deanery and the ARCP includes review of assessments of performance including Workplace Based Assessments.

The ARCP and curriculum specify a minimum number of satisfactory workplace-based assessments (WPBAs) completed by the end of the third year of core training (CT3). More than this number can be completed if needed.

To get through the ARCP satisfactory assessments are required and psychotherapy competencies in the curriculum need to be gained.

Clinical supervisors wishing to discuss an individual trainee’s training needs or a supervisee at risk of not fulfilling the psychotherapy assessments/competencies satisfactorily should contact the local psychotherapy tutor. The trainee’s educational supervisor, the college tutor or the training programme director could also be contacted.

**Components of CT1-3 psychotherapy training**

|  |  |
| --- | --- |
| CT1 | Case Based Discussion (Balint) Group |
| CT1-3 | MRCPsych psychotherapy teaching  First therapy case  Second therapy case of a different length and modality |

**Psychotherapy cases**

Patients allocated to trainees should be appropriate in terms of level of difficulty and should have been properly assessed. Trainees should be encouraged to treat a number of psychotherapy cases during their training using at least two modalities of treatment and at least two durations of input.

This experience must be started in Core training and continued in Advanced Training, so that **by the end of Core Training the trainee must have competently completed at least two cases of different durations.**

Case length is specified as follows:

**Short therapy case: 12-20 sessions**, as a minimum with one patient.

**Long therapy case: over 20 sessions,** as minimum with one patient.

The precise number of therapy sessions is agreed with respect to the patient's needs, andthe modelforthe psychotherapy,with the clinical supervisor, (e.g. CAT is 24 session model DIT 16 sessionetc.). The therapy cases need to be supervised by a supervisor who is trained in and in current practice in the therapy model.

It should be noted that “DNAs” should not usually be included when thinking quantitatively about case length.- so if someone has a 24 session long-case and the patient DNAs 8 sessions this would notbe acceptable as a long case, but would be as a short. If however 5 sessions were DNAs then the discretion of the supervisor and psychotherapy tutor would play an important role in judging the quality of the therapeutic experience and whether competency in the ‘longcase’ had been achieved.

If there are local issues with availability of cases then this can be taken up with the psychotherapy tutor. These should be viewed as minimum requirements and psychotherapy experience beyond minimum requirements is encouraged while recognising that this is dependent on local resources.

**Principles of Core Psychiatry Training WPBAs**

The psychotherapy WPBA should adhere to the four RCPsych WPBA principles of being:

1. Focused on performance (i.e. what the trainee does in practice)

2. Evidence based

3. Triangulated when possible (i.e. if possible using different methods on different occasions and where appropriate using different assessors over a period of time)

4. WPBA records are permanent - all assessments carried out are stored on the RCPsych Portfolio Online system <https://training.rcpsych.ac.uk/> and thus become part of their e-portfolio of workplace based assessments.

**Psychotherapy WPBAs**

There are two WPBAs for psychotherapy cases (SAPE and PACE) and one for the Case Based Discussion Group (CBDGA). These are described below.

1. **SAPE (Structured assessment of psychotherapy expertise)**

The SAPE WPBA is a formative assessment which should be seen as a learning opportunity, allowing feedback on progress to modify and build on current performance and to identify any areas of difficulty. Discussion of formative issues and feedback should also occur through regular clinical supervision as well as via the assessment process.

For the short case one SAPE is required, carried out at the end of therapy. For the long case 2 SAPEs are required; one SAPE could be completed after the formulation derived early or midway in therapy, with the second one carried out at the end of the case.

The supervisor can complete the SAPE based on supervision with the trainee about their treatment including the trainee’s attitude, knowledge and rationale for methods used. If appropriate to modality, it can also be based on direct or indirect observation of performance e.g. in taped sessions.

The supervisor of the trainee completes the SAPE form (Fig 2) on the RCPsych’s Portfolio Online website (see below)

Fig 2: SAPE form: areas of competence

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Unacceptable | Much work to be done | Borderline | Satisfactory | Accomplished | Unable to comment |
| Attitude towards patient |  |  |  |  |  |  |
| Understand rationale of treatment |  |  |  |  |  |  |
| Provide working formulation of patient's difficulties |  |  |  |  |  |  |
| Develop empathic and responsive relationship with patient |  |  |  |  |  |  |
| Establishing frame for treatment |  |  |  |  |  |  |
| Use of therapeutic techniques |  |  |  |  |  |  |
| Monitor impact of therapy |  |  |  |  |  |  |
| Ending treatment |  |  |  |  |  |  |
| Use of supervision |  |  |  |  |  |  |
| Documentation |  |  |  |  |  |  |

The following table (Fig 3) gives further faculty guidance on standards that may reasonably be expected when scoring the SAPE

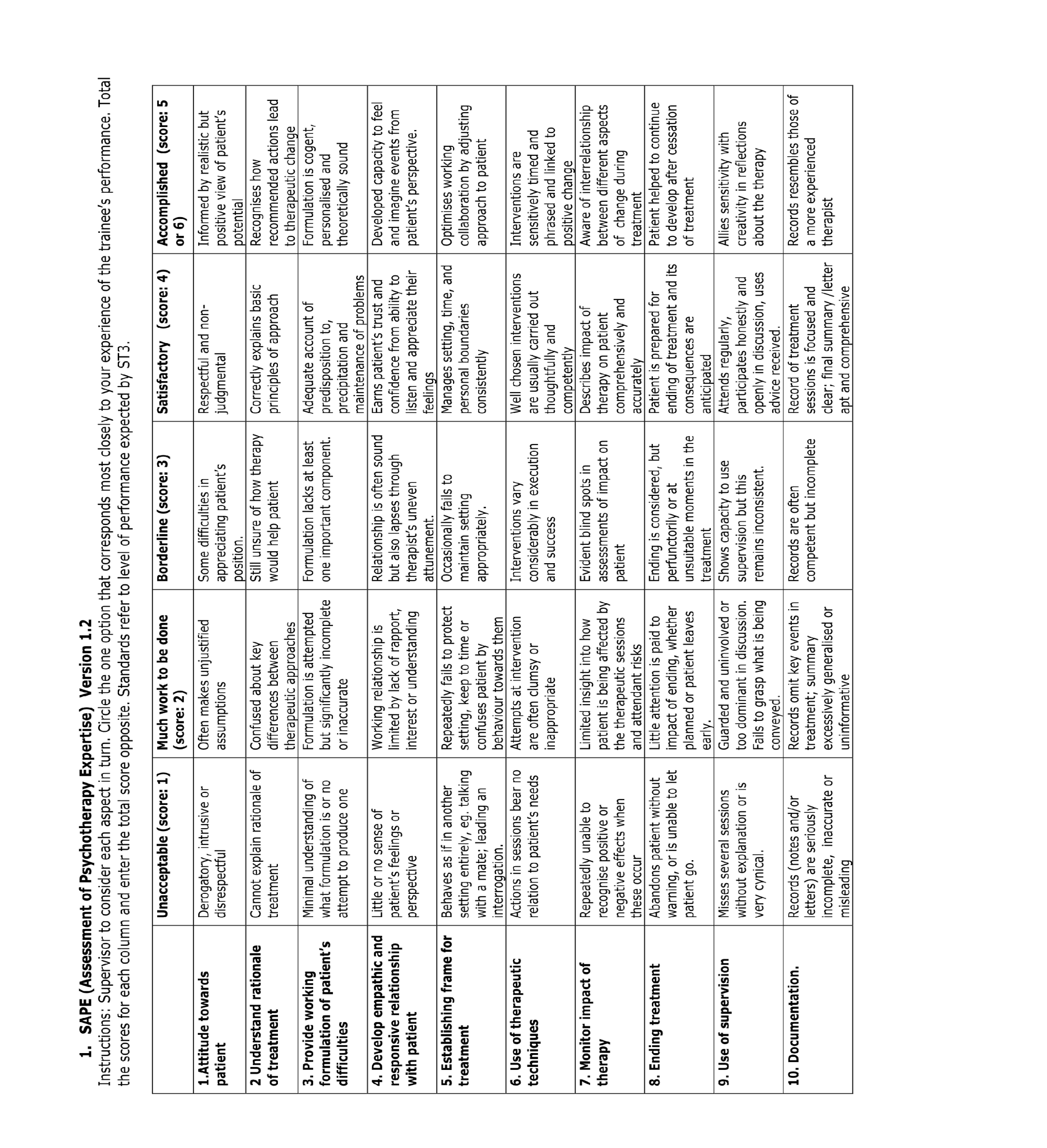
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Fig 3: Scoring the SAPE

1. **PACE (Psychotherapy assessment of clinical expertise)**

The PACE is a summative assessment for assessing levels of psychotherapy competencies. This evidence is used to inform ARCP panels on readiness to progress to next stage of training.

The psychotherapy tutor(or their delegate) completes the PACE (Fig 4)

The trainee would need to bring completed SAPE(s) and a 500 word summary of the case which has been agreed with the clinical supervisor and discuss the case with the assessor.

Fig 4: PACE form: areas of competence

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Unacceptable | Much work to be done | Borderline | Satisfactory | Accomplished | Unable to comment |
| Attitude towards patient and development of an empathic relationship |  |  |  |  |  |  |
| Understand of the rationale of treatment and ability to provide a working formulation |  |  |  |  |  |  |
| Establishing frame for treatment and noticing challenges to this |  |  |  |  |  |  |
| Use of therapeutic techniques and monitoring the impact of these |  |  |  |  |  |  |
| Management of the ending of treatment |  |  |  |  |  |  |
| Use of supervision |  |  |  |  |  |  |
| Quality of written summary in conveying key points |  |  |  |  |  |  |

1. **CBDGA (Case Based Group Discussion Assessment)**

* This is completed by the Case Based Discussion Group conductor.
* 2 CBDGAs are needed in CT1
* 8 areas of competence are listed in the CBDGA (Fig 5) and a score of 4 out of 6 is the pass mark for the end of the CT1 year.

Fig 5: CBDGA form: areas of competence

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Unacceptable | Much work to be done | Borderline | Satisfactory | Accomplished | Unable to comment |
| Able to attend regularly and manage future predicted absences |  |  |  |  |  |  |
| Demonstrates an understanding of the importance of time keeping and of having a predictable and regular setting (frame) for therapeutic work |  |  |  |  |  |  |
| Able to listen to and connect with the patient adequately containing own anxiety. |  |  |  |  |  |  |
| Able to provide a narrative account of contact with the patient without adopting a purely biological or medical model. |  |  |  |  |  |  |
| Able to respond to others in a non- judgemental way |  |  |  |  |  |  |
| Self aware enough that (s)he does not have to impose personal solutions or self management strategies |  |  |  |  |  |  |
| Able to recognise and manage the different factors (gender, culture, age, disability etc) contributing to the practitioners' emotional responses to the patient |  |  |  |  |  |  |
| Able to recognise the influence of unconscious process on the interaction with the patient. |  |  |  |  |  |  |

The following table (Fig 6) gives further faculty guidance on standards that may reasonably be expected when scoring the CBDGA.

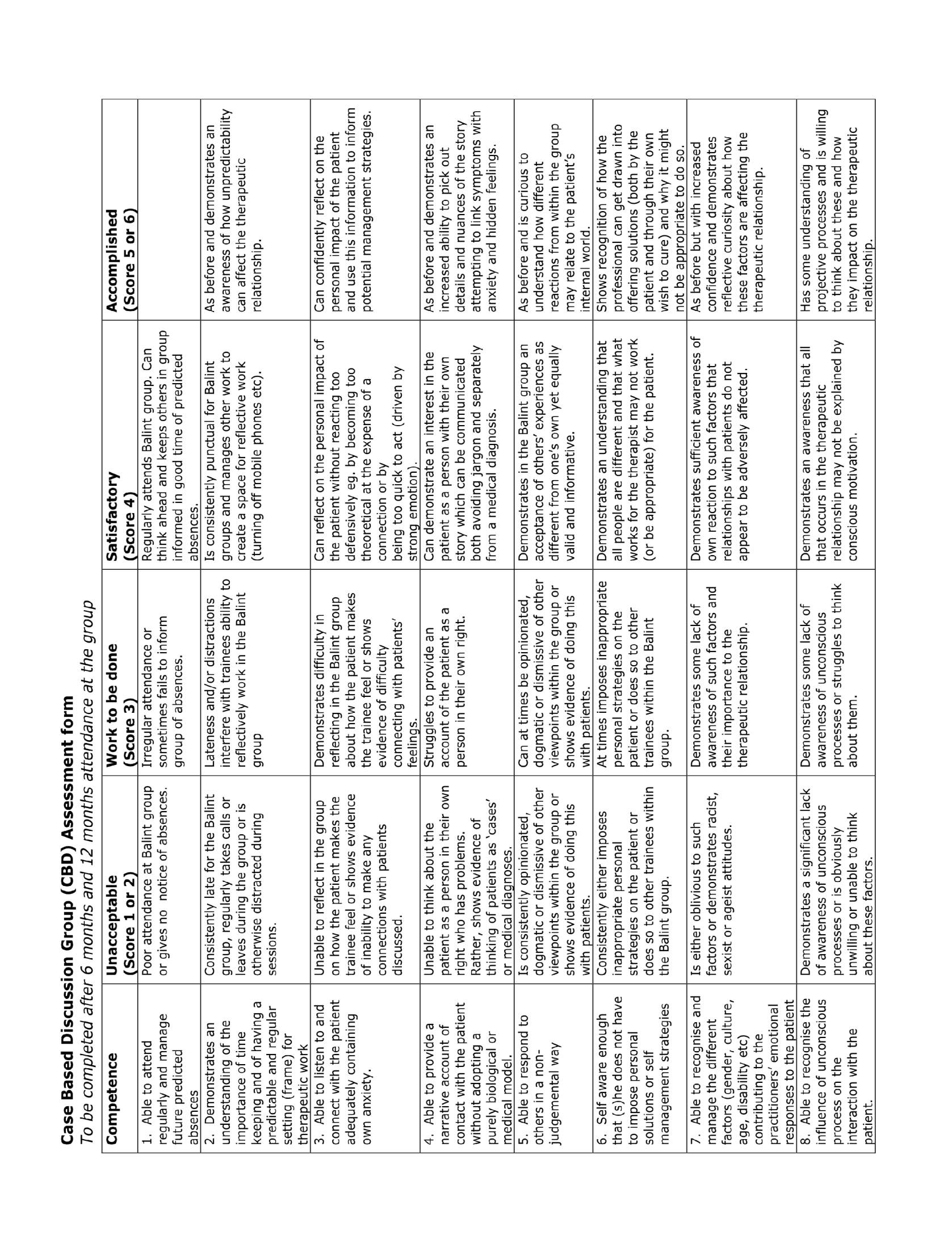
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Fig 6: Scoring the CBDGA

**Using Portfolio Online for psychotherapy supervisors:**

1. If you are accessing the portfolio online for the first time as a supervisor, you can enter the name of the trainee you are assessing on the following web page: <https://training.rcpsych.ac.uk/home>
2. If you have already registered, you can either log in first, via the following web page: <https://training.rcpsych.ac.uk/login>, or you can search for the trainee as above
3. You will then be presented with a list of potential trainee matches to pick from - select the correct trainee
4. Click on New Assessment
5. Select the trainee’s core training year from the dropdown ie CT1, CT2 or CT3
6. Select the assessment type from the dropdown ie SAPE, PACE or CBDGA
7. Complete the brief form and submit it, it will be saved automatically as part of the trainee’s portfolio

**Summary of WPBAs required by trainees**

|  |  |  |
| --- | --- | --- |
| **Evidence** | **CT1** | **CT2 / CT3**  **(unless completed in CT1)** |
| 2 CBDGAs | ✓  ✓ |  |
| SAPE for short case |  | ✓ |
| 2 SAPEs for long case |  | ✓  ✓ |
| PACE for short case |  | ✓ |
| PACE for long case |  | ✓ |

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1. The GMC have given a two year period of derogation from March 2015 that all LEPs should have a consultant psychiatrist in medical psychotherapy to oversee and quality assure psychotherapy training; in addition they need to have a suitable clinical context for their work to enable the provision of clinical training opportunities. [↑](#footnote-ref-1)