
Learning from the cradle to the grave: the psychotherapeutic development of doctors from beginning to end of a career in medicine and psychiatry





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Authors

This Occasional Paper was written by Dr James Johnston MBChB, MA, FRCPsych, on behalf of the Medical Psychotherapy Faculty Education and Curriculum Committee – the psychotherapeutic educational arm of the Royal College of Psychiatrists' Medical Psychotherapy Faculty Executive Committee. Dr Johnston was Chair of the Medical Psychotherapy Faculty Education and Curriculum Committee between 2011 and 2015 and he devised the *Cradle to Grave* education strategy as a UK framework for fundamental changes in the psychotherapeutic education of psychiatrists, medical students and continuing professional development for post-membership psychiatrists. The illustrations are also by Dr Johnston.

Introduction

The Royal College of Psychiatrists strategy document *Thinking Cradle to Grave: Developing Psychotherapeutic Medicine and Psychiatry* (Johnston, 2015) describes an education strategy for the development of psychotherapeutic medicine and psychotherapeutic psychiatry in the UK from medical school through to senior postgraduate levels for psychiatrists. It aims to enhance the therapeutic relationships of doctors with patients by placing the therapeutic attitude towards the patient of both nascent and experienced doctors at the centre of continuing professional development (CPD).

The 'cradle to grave' lifelong metaphor emphasises the importance of repeated renewal and reflection about the relationship between doctor and patient throughout doctors' careers. The *Cradle to Grave* education strategy offers a foundation in psychotherapeutic development for all medical students, regardless of future specialties. Psychotherapeutic medicine is the bedrock of psychotherapeutic psychiatry at core and higher training levels, which is built on in therapeutic continuity for consultants and specialists in their personal and professional development as experienced psychiatrists.

Background

The Medical Psychotherapy Faculty Education and Curriculum Committee undertook the first national survey of core UK psychotherapy training in psychiatry in 2012. The survey included questions about the fulfilment of the curriculum of the Royal College of Psychiatrists and the personnel leading delivery of the training (Johnston *et al*, 2013).

- 58 (80%) of the 70 core psychiatry training schemes responded to the survey.
- 49 (84%) of these schemes were fulfilling the core psychotherapy curriculum requirements.
- 38 (66%) of these schemes had appointed a consultant psychiatrist in psychotherapy with a Certificate of Completion of Training (CCT) in medical psychotherapy as the psychotherapy tutor.
- The curriculum was significantly more likely to be fulfilled when a consultant psychiatrist in psychotherapy with a CCT in medical psychotherapy was the tutor (Fisher's exact test, $P < 0.05$).
- The odds of the curriculum being fulfilled were five times higher if the tutor was a consultant psychiatrist in psychotherapy.
- 30 (75%) of psychotherapy tutors reported that their Annual Review of Competence Progression boards required all competencies to be completed before progression to higher specialty training (ST4).
- Cognitive-behavioural therapy (CBT) was used mainly for the short case (35%) and psychodynamic psychotherapy for the long case (69%).

The survey also addressed the attitude of the schools of psychiatry to dual training in medical psychotherapy, which received unanimous support.

The recommendations arising from the survey were:

- 1 Consultant psychiatrists in medical psychotherapy (medical psychotherapists) should lead the coordination and educational governance of all core psychotherapy training in psychiatry as psychotherapy tutors.
- 2 Psychotherapy training from student to core and higher trainee to consultant level needs to be developmentally adaptable, meeting the developing capacities of the individual doctor applied in their chosen specialty to ensure that psychotherapeutic psychiatry and psychotherapeutic medicine continue to evolve.
- 3 Multidisciplinary participation in core and advanced medical psychotherapy training should be formally developed, organised and led by consultant psychiatrists in medical psychotherapy.

A GMC (2013) review of medical psychotherapy incorporated the findings of the UK psychotherapy survey, including follow-up questions addressing the contributions of different professions to psychotherapy training in psychiatry. The action plan arising from the report outlined the deanery requirements and recommendations including the requirement that consultant psychiatrists in psychotherapy lead core psychotherapeutic psychiatry training.

The role of the medical psychotherapist in the leadership, governance and delivery of psychotherapy training in core psychiatry was included in the Royal College of Psychiatrists' 2015 core curriculum (Royal College of Psychiatrists, 2013/2015).

Education strategy

Thinking cradle to grave

The term 'cradle to grave' refers to the development of both the patient and the doctor. In relation to the development of the patient, the cradle and the grave represent the developmental extremes of life and the depth of mental disturbance arising from these extremes. The cradle signifies primitive or early developmental states of mind and the grave signifies loss, mourning, and the painful limitations of care, in an echo of the risk of death that can be a pervasive anxiety.

In relation to the development of the doctor, the cradle and the grave represent personal life experiences and the lifelong learning trajectory of education, CPD and revalidation. In psychiatry, the cradle signifies confronting the sometimes devastating impact of primitive developmental disturbance manifest in problems of dependency and the anxieties and destructiveness that surround the grave (the risk of death).

Developing psychotherapeutic psychiatry

The majority of people with a mental illness, personality disorder, mental pain or mental deadness will not see psychiatrists who specialise as medical psychotherapists, but many will see psychiatrists who are psychotherapeutically minded. Robust psychotherapeutic training that parallels and equals the strength of biological training is necessary for all psychiatrists, because it is necessary for their patients. For psychiatrists (and all mental health professionals) to develop and maintain the ability to bear and think with people who experience extreme mental disturbance, they need reflective space in which to examine their own emotions in response to the people who come to them.

Psychotherapeutic psychiatry may be particularly useful for those who are undecided about a career

in psychiatry, early in psychiatric training or still therapeutically receptive in their mature development. The development of psychotherapeutic psychiatry could improve recruitment to psychiatry, secure greater retention of psychiatry trainees in psychiatry and enrich the revalidation of psychiatrists who embrace therapeutic development as part of their clinical practice.

The *Cradle to Grave* education strategy aims to inculcate, develop and sustain a therapeutic attitude of mind in the heartland of mainstream psychiatry, so that psychotherapy begins to lose its peripheral position. In becoming central to the work of psychotherapeutic psychiatrists, psychotherapy becomes less an activity of others, called medical psychotherapists, adult or child psychotherapists or clinical psychologists, and more a therapeutic way of thinking about their patients that most psychiatrists perceive to be a vital part of their professional identity.

Why train psychiatrists in psychotherapy?

The aim of psychotherapy training for psychiatrists is not necessarily to turn them into psychotherapists, but to train them to be psychotherapeutic psychiatrists. The UK psychotherapy survey revealed that, when the courses were led by tutors trained as medical psychotherapists, it was five times more likely that the core psychotherapy curriculum would be fulfilled (compared with courses led by psychotherapy tutors). Consultant psychiatrists in psychotherapy are needed to lead the training of psychiatrists, but this training is only meaningful in the context of a clinical service in which psychotherapeutic psychiatry can be seen to be relevant throughout psychiatry.

The notion that psychotherapy is a peripheral activity undertaken only by psychotherapists reinforces the separation of psychotherapy from psychiatry. All the following educational interventions focus on integrating a therapeutic attitude into the development of reflective medical practitioners.

Psychotherapeutic psychiatry

The major theme underlying the *Cradle to Grave* education strategy is that a doctor who specialises in psychiatry needs a therapeutic attitude, informed by a model of mind that can help to contain and understand the disturbing feelings that working with some patients can evoke.

A psychiatrist's knowledge and skill in the phenomenological models is not in itself sufficient to contain the disturbance evoked in the psychiatrist. When difficult patients evoke difficult feelings, the person behind the observed problem and diagnosis may not be seen. Psychotherapeutic psychiatry aims to understand the subjective experience of the patient as a person, and this requires the psychiatrist to use their emotional experience to integrate personal evidence from an individual relationship with phenomenological and epidemiological evidence drawn from many people.

Reflective and reflexive examination of the mind

Socrates observed that the unexamined life is not worth living. It may be that the unexamined mind is borne from a despair that life is not worth living. The vicissitudes of living contribute to and maintain mental pain. The psychiatrist who approaches the person in pain may recall the medical phrase 'on examination'. The reflective doctor will consider their emotional responses to the patient, which implies that the examined mind is mutual and reflexive. Learning about emotions in illness (Shoenberg & Yakely, 2014) involves engaging with the affective subjectivity (Yakeley *et al*, 2014) of the professional in response to a patient. This will not, however, only include the patient's emotional impact on them; the experience of being disturbed is partly a reflection of the professional's own life experience and personality and is not to be located solely in the other (Johnston, 2010).

This introduces the reflexive dimension of self-examination to the examination of the other. This reflexivity refers to a bi-directional relationship whereby examination of the mind of the other affects the person examining that mind. Reflection on the emotional effects on the doctor of examining

the patient is a key part of self-reflective practice and of the therapeutic attitude.

Therapeutic attitude

How is a therapeutic attitude manifest in a doctor-patient encounter in clinical practice? How is it achieved? How is it developed? How is it sustained? How is it lost?

At its most fundamental level, a therapeutic attitude is the ability and curiosity to engage with the patient beyond the problem (or, more often, problems). The word 'beyond' is used rather than 'behind' to highlight the active link between the past and present in the presenting problem, which both reveals and obscures the person's past, a hidden history that may be understood in the way the presenting problems echo the past. The past is always in the present in the way a person repeats difficulties in the relationship between the patient and doctor. This insight is over 100 years old – Freud (1914) posited that the conflicts of the unconscious past repeat in the present and are remembered through interpretation of resistance in the transference with the psychoanalyst in Remembering, Repeating and Working Through.

A therapeutic attitude is manifest in the way a doctor comes to see and use the echo of past problems that resonate in their emotional experience to make contact with the person who comes to them as a patient.

A therapeutic attitude should not be understood or idealised as a state of quietude, of meditative and mindful stillness, contemplation and self-reflection, out of which it is hoped understanding of the other in need of help may emerge. Because relationships involve conflict, pain and struggle, a therapeutic attitude requires active and difficult emotional work to sustain it. The peaceful tranquillity and calmness of an observing mind implies obliviousness to the ordinary or extraordinary human struggle with the disturbing challenges of being alive or to facing the fragmented and disintegrated states of mind that are frequently experienced as oblivion.

Developing a therapeutic attitude is crucial to the clinical practice of those who consider their own emotional experience to be a source of learning about the emotional experience of their patient.

Emotional contact with the person beyond the presenting problem requires emotional contact for the doctor with their own mind.

Because a therapeutic attitude is integral to the development of a doctor, this self-reflective capacity needs to be nurtured at medical school (the cradle) and to continue to be revitalised and renewed throughout the personal and professional development of the doctor's career, all the way to retirement (the grave).

Therapeutic development, in the *Cradle to Grave* education strategy, is not considered specific to training in particular models of therapy. It is about continuously developing a therapeutic attitude in all the work of psychiatry, not just the psychotherapy part of psychiatry. When a person presents to a psychiatrist, the psychiatrist with a therapeutic attitude tries to see the person beyond the presenting problem, and the struggle to do so is seen as part of the problem.

Because developing a therapeutic attitude involves challenging emotional work, in the earliest phases it may seem to some a dissonant path to pursue (peculiar and irritating, and/or irrelevant to the work of psychiatry), whereas others will find it consonant (familiar, if painful, and a self-evidently essential ingredient of the doctor–patient relationship). The medical and psychiatric culture perpetuates a belief that the doctor should not reveal their emotions to themselves. Receptivity to the importance of emotion in the doctor–patient relationship will often be dependent on the personality and predilection of the doctor.

Spiral curriculum

In a spiral curriculum, there is a deepening sophistication of learning as the same field of learning is explored at different developmental levels according to context and capacity (Bruner, 1960). In the *Cradle to Grave* education strategy, the repeated field of learning is therapeutic literacy: translating visceral emotions into words. In each stage of development, from medical student through to retiring consultant, the learning leitmotif is therapeutic literacy, which shows organic development but may ossify within the maturing doctor.

Each developmental stage requires different expressions of therapeutic literacy, but the nature of the emotional process remains the same. The therapeutic literacy thread that runs through these stages is the capacity to value emotional examination in the interests of developing and adapting to the demands of the work.

Recruitment to psychiatry

Whether a medical student or foundation doctor decides on a career in psychiatry or not, it is important that the profession of psychiatry does not deter therapeutically minded medical students and practitioners.

A central contention of the *Cradle to Grave* education strategy is that psychotherapeutic experience at undergraduate and early postgraduate stages influences doctors with an interest in the mind and helps to develop psychotherapeutic medicine in the next generation of doctors.

Developing a therapeutic attitude

Developing a therapeutic attitude in a spiral curriculum can be approached differently at each level, from undergraduate to senior postgraduate.

Therapeutic attitude: medical student years

The emotional demands on a medical student might consist of holding on to the recollection of why they decided their vocation was to train as a doctor and retaining a sense of the whole person's humanity, rather than seeing just 'the abdomen in bed eight'. The 'past in the present' for the emerging doctor is in recalling ordinary uncertainties in the midst of extraordinary technical knowledge. Holding on to a vocation to heal, informed as it is by a reparative drive of damage, may come to be remembered as a sentimental desire to help people, as increasing competence in cure corrodes care. Not succumbing to cynicism and retaining an attitude of compassion is a crucial aim of the undergraduate experience as the student moves from a lay to a medical identity. Retaining the lay aspects of their experience will serve as protection against the dissociative effect of medical experience. The sense of the frightening and bewildering novelty of disease and death should not be lost, so that the nascent doctor can recognise these feelings in their patient.

Therapeutic attitude: foundation years one and two

As their responsibility grows, foundation year one doctors confront their own limitations, and disease and death are experienced as raw and real. Reflecting on feelings when faced with a dying or dead patient requires the ability to be vulnerable with colleagues and still return to the ward the next day.

In the career-decision-making second foundation year, doctors will be more familiar with the role of the professional but less comfortable with what might feel like unprofessional responses to treating, helping and failing to help patients. For some foundation year two doctors, recognising that honesty with themselves about strong negative feelings about a patient does not undermine their qualities as good doctors will be a milestone. Having personal feelings about patients will be experienced by other doctors as ego-dystonic and unprofessional, as their view of their professional identity is based on the rather narrow and emotionally impoverished assumption that personal feelings play no part in the competent functioning of the ideal doctor.

The foundation doctor might carry a medical-school view that a good doctor-patient relationship leads to the patient doing what the doctor wants them to do, as doctors always know what is best for them. They will have learned the mechanism of the good doctor-patient relationship in communication skills. Realising the limits of the communications skills algorithm in real-life medical experience is a key part of developing a therapeutic attitude that does not privilege the medical role over the role of patient, nor idealise the notion that the manual is more important than the man.

Therapeutic attitude: core training year one

In their first core training year, a doctor will be transitioning to what might be their lifelong career. The core training years in psychiatry involve an unconscious collision between the mind of the doctor and the disturbance in their patients, during which they may feel overwhelmed.

If the doctor does not feel overwhelmed or uncertain in this period, it would be a cause for concern; in a culture of competence there needs to be space for a struggle in which the doctor can learn from

uncertainty and the fear of having made a mistake without fear of accusations of incompetence. Vulnerability and struggling with uncertainty in the face of mental pain should not be thought of as weakness but as strength, and emotional sensitivity to disturbance as a psychic truth. To develop the capacity to think under fire, the fire has first to be registered as a reality.

At the same time, in core psychiatry training there is a need to learn the language of mental illness and disorder, which may afford some sense of precarious knowing and certainty. However, such systems may sit uneasily with feelings of confusion and personal uncertainty and a division may develop between theory and emotion.

As a core trainee beginning a Balint group, being prepared to acknowledge the fear associated with being in the on-call situation, without feeling this makes one a weak or incompetent doctor, would be an achievement. As with foundation year doctors, there is often an idea that being professional means remaining completely emotionally neutral and perceiving it to be a failure that a patient has evoked personal feelings in the doctor.

Therapeutic attitude: core training years two and three

In the later core training years, remaining curious alongside the knowledge of limitations in psychiatric care might be shown by not dividing ‘ill legitimate’ and ‘illegitimate’ patients using discriminating diagnostic categories. The validation of the patient as legitimate by virtue of illness with an organic basis is linked with sympathy and an ego-syntonic congruence with what Michael Balint (1957) called the apostolic function: the doctor as an apostle converting their patient to the doctor’s unconscious assumption or faith in how a patient ought to be. The illegitimate patient is one deprived of the illness armour, left only with a diagnosis of personality disorder, although the interpersonal strife might be more appropriately described as relationship disorder, since it is between the self and the other in a troubled relationship that the disturbance is manifest. This is a personality

whose presentation disturbs the personality of the other (doctor), and this distortion in the personal domain challenges the doctor’s assumption of how a patient ought to be.

Recognising this phenomenon might be as complex and as simple as removing the word ‘disorder’ from the diagnosis ‘personality disorder’ and realising that the problems in development of a personality remind the doctor of their own personality and their own development, which collapses space between patient and doctor in a discomfiting way.

Therapeutic attitude: higher training years

In the post-membership years, the doctor learns to become the specialist they aspire to be, and the struggle in this phase of development is in sifting their positive and negative identifications between their different mentors as they find a professional mind of their own. Each psychiatrist must discover their therapeutic interests and aptitude. As Dr Tom Main (1968), an influential psychiatrist and psychoanalyst, stated in a paper written in anticipation of the establishment of the Royal College of Psychiatrists:

‘If we are to help plan a good future for psychotherapy, we, and perhaps all in the new College, may have to recognise and respect, without blame or evangelism, the fact that psychotherapy is not and cannot and even should not be every psychiatrist’s cup of tea.’ (p. 185)

The development of a therapeutic attitude in the transition to becoming a consultant is as much a matter of how the psychiatrist relates to their colleagues, the clinical environment and the political setting in which they work as of their talent or receptivity to their patient’s feelings.

Although it is important that a higher trainee does not seek refuge from feelings in a scientific attitude or pursue the medical carapace of defensive practice, as Main (1978) also stated in describing some medical defences against involvement with patients:

‘The trained, disciplined use of subjectivity as a source of scientific information is rare; in the service of medicine, moreover, it will inevitably involve us in pain. We need not be surprised therefore, and

none of us can afford to be critical, if doctors seek ways of limiting their subjectivity and of alleviating the strains of an uncomfortably close encounter; if they distance themselves from patients' distress in various ways – emotional, temporal, social and geographic; if they adopt and institutionalize as a profession various defences against the dangers of becoming helpless and stupid by having common sense swamped in big feelings about the distress around them; and if they do their best to be fairly blind or hard of hearing or angry about distress.' (pp. 213–4)

In a Balint Society paper offering a developmental view on foundation years one and two, core trainee, higher trainee and consultant Balint groups, Fitzgerald (2012) describes in both higher trainees and consultants a toxic and moving mix of disempowerment and paralysis, almost as if they were under siege from patients and trust policies, and none of them feeling able to take a stand. He states:

'They seemed both battered by the organisational changes and the real dismissal of their skills but at the same time they felt that they had to go along with it. Yet, they keep attending the Balint group and there were some very lively discussions about disturbing patients. I wonder if maybe part of leading a Balint group is to work through the context back to what is happening (in the doctor-patient relationship) because I think maybe one can get caught up in the external politics. But what comes out more is a sense of shame I think in the service they are obliged to offer as they know it is not enough or it is not what they would do if they had their say. This leads them I think to blind themselves to the real doctor-patient relationship in front of them as it will carry obligations and demands and pleas and these go back to a more policy driven protocol way of relating. I think keeping one's eye on the internal is important, particularly when all of the external changes are so rampant and unpredictable at the present time.' (p. 29)

Therapeutic attitude: consultant years

In the early years of being a consultant psychiatrist, the doctor grapples with their place as a

leader, as well as learning to bear responsibility and uncertainty with long-term case work, relinquishing their reliance on systems of certainty from training. In the later years, maintaining and developing creative interest in the work, without despair and cynicism (which are not associated with the patient but more commonly the employing institution), are features of resilience in the mature consultant psychiatrist. Therapeutic literacy in a consultant psychiatrist will often be revealed in openness to learning from their work and remaining in some way still passionate, while cognisant of the limitations of what they personally can bear (Hinshelwood, 2004; Mercer, 2008).

Maintaining an internal view of the importance of the doctor–patient relationship in the face of external organisational political pressures is a challenge for the consultant. The leadership role can lead to conflict when they or members of their team experience devaluation that painfully echoes many of their patient's lives. In this context, remaining emotionally open is a risk compromised by being responsible for managing risks. Holding on to the doctor–patient relationship, as well as assessing and managing risk, may be challenging if faced with blame from an organisation that seeks to protect itself from exposure – a shame culture in which someone has to be exposed (Johnston, 2010). The consultant identifies with both the governance of the organisation and members of their team, and they may feel a split in loyalties between truthful appraisal of standards and seeking to maintain camaraderie in a spirit of support.

A therapeutic attitude may seem elusive and hard to define, changing according to individual growth and context, but a reliable sign is the pursuit of truth linked with compassion. An anti-therapeutic attitude is reliably seen in that cynical, yet frequently competent, state of mind in which development seems to have been paralysed, perhaps as a result of disillusionment, disempowerment and loss of desire to engage with the emotional task. Perhaps anxiety, anger or both have curtailed or killed curiosity. This state of mind is otherwise known as burn-out.

Cradle to Grave strategic changes

The following educational changes and initiatives arose from the *Cradle to Grave* education strategy from 2011 onwards.

Core psychiatry curriculum

The first UK psychotherapy survey was undertaken in 2011–2012; a second survey was undertaken in 2016 (results are due to be published in 2017) to evaluate the impact of the previous core and higher curriculum changes and the GMC action plan on training. Higher psychiatry psychotherapy training experience is included in the second survey.

The need for a consultant psychiatrist in medical psychotherapy to lead core psychiatry psychotherapy training (in schemes without medical psychotherapy CCT holders) was finalised with the Lead Dean of Psychiatry, the College Specialty Curriculum Advisor and the GMC in 2014 (Royal College of Psychiatrists, 2013/2015). The principle of a GMC regulatory requirement for medical psychotherapy leadership and oversight was underlined (GMC, 2013). Workplace-based assessment by supervisors from backgrounds other than psychiatry was strengthened with training.

Self-reflective practice was introduced to the Royal College of Psychiatrists' (2013/2015) core curriculum as a new intended learning outcome (ILO 19) in 2013. The duration of short and long therapy cases was defined (short: 12–20 sessions; long: >20 sessions), with latitude given to the clinical supervisor according to patient need.

Higher psychiatry curriculum

The curriculum requirement for ongoing psychotherapy experience in higher training across all psychiatric sub-specialties is recognised as variable in delivery across the UK among the heads of schools of psychiatry. The GMC's Annual Specialty Report 2014 specifically refers to the second UK

survey (undertaken in 2016), the results of which were intended to be used to strengthen higher psychiatry psychotherapy training (GMC, 2014).

Higher medical psychotherapy curriculum: personal therapy

A strengthened statement regarding the crucial place of personal therapy for higher medical psychotherapy trainees was introduced to the curriculum in 2015 (Royal College of Psychiatrists, 2010/2015a).

Single CCT medical psychotherapy training

Single CCT training in medical psychotherapy remains in the curriculum and is the foundation of medical psychotherapy. In its potential to link with other psychiatric specialties, the single CCT is analogous to a stem cell, which offers pluripotent potential specialty links in the possible applications of dual medical psychotherapy training (Royal College of Psychiatrists, 2010/2015a).

Dual CCT medical psychotherapy training

Dual training in medical psychotherapy with general adult psychiatry, which began in Yorkshire, has been ratified as a UK-wide model by the GMC (2013). The development of this dual training was influenced by the dual training in medical psychotherapy and forensic psychiatry that forensic psychotherapists complete (Royal College of Psychiatrists, 2010/2015a,b). The forensic model of training is sequential, and what was novel in the Yorkshire model was the integration of the two specialties throughout the 5 years' training. The aim was to blend the two paradigms of psychiatry and psychotherapy throughout the developmental period of training, in order that a dialogue between the two ways of thinking might challenge splitting.

Integrated training can be used as a foundation for developing the more challenging integrated model further down the line, as the higher training scheme becomes more established and trainers further develop the model.

The integrated CCT model of dual training combines medical psychotherapy and the other sub-specialty, currently forensic or general adult psychiatry. The combination of two different psychiatry specialties in the same training course underscores an educational relationship that fosters an internal dialogue for the trainee between two different paradigms. Because the trainee is in personal analysis or therapy, they can reflect on and learn from their emotional experience of working in psychiatry and psychotherapy and how the differences between them affect the trainee. Because this experience is concurrent, rather than consecutive as in sequential dual CCT training, the simultaneous processing of different models of mind aims for a meaningful integration of psychotherapeutic psychiatry as way of being and thinking.

Other dual CCT combinations, such as medical psychotherapy and child and adolescent psychiatry, have been introduced and dual training in intellectual disability with medical psychotherapy is currently being developed.

Medical student psychotherapy schemes and Balint groups

The Royal College of Psychiatrists' Medical Student Psychotherapy Schemes Working Group is an initiative that aims to enhance the emotional literacy of nascent doctors and enhance the empathic foundation of future doctor–patient relationships. The President of the College, Professor Sir Simon Wessely, has made it a key aim to develop UK-wide medical student psychotherapy schemes by 2017 (Royal College of Psychiatrists, 2012).

The UK Medical School Psychotherapy Scheme Working Group was established in June 2014 to establish medical student psychotherapy schemes in the 34 UK medical schools. Royal College of Psychiatrists representatives from medical student psychotherapy schemes (University College London, King's College London and Bristol) are

members of the Working Group.

Evaluation of the medical student schemes primarily includes their impact on students' empathy (compassion for others and compassion for self; Gilbert *et al*, 2011) and their impact on recruitment to psychiatry (Royal College of Psychiatrists, 2012). The aim of the medical student psychotherapy schemes is to establish Balint groups for medical students, ideally beginning during their first contact with patients, in medicine and surgery placements where possible, to emphasise the development of a therapeutic attitude before they begin psychiatry.

Foundation year psychotherapy

Balint groups for foundation year doctors in psychiatry placements have been established across the UK, beginning in Yorkshire in 2012. Chatziagorakis *et al* (2015), in a survey of foundation year doctors across medical specialties who had participated in Balint groups, found that the Balint group experience can be both beneficial and challenging. The benefits reported echo those reported by GPs, psychiatry trainees and other mental health professionals, suggesting that the benefits may be transferrable into other specialties.

Consultant and specialty psychiatry developments

The Royal College of Psychiatrists' Faculty of Medical Psychotherapy website has been developed to raise its profile and engage psychiatry colleagues. The website includes online CPD modules and 1-day workshops that build psychotherapeutic psychiatry skills for senior psychiatrists. A national communications strategy has been developed to communicate the aims of psychotherapeutic psychiatry and the Faculty. An example is the College's 2016 *Medical Psychotherapy Seminar Series: Understanding Psychiatric Illness – A Psychodynamic Approach*.

Balint groups for consultant psychiatrists have been established around the UK as a way of offering space to think. Interest in Balint groups can be fostered among consultants with analytically informed space for reflective practice about the doctor–patient relationship (Johnston & Paley, 2013).

Offering medical psychotherapy consultation to psychiatrists and teams (Johnston *et al*, 2016) is another way in which reflective practice about complexity in the doctor–patient relationship can help to develop psychotherapeutic psychiatry knowledge and skills and maintain a therapeutic attitude at senior levels.

Communications

The Medical Psychotherapy Faculty Communications Working Group was established on behalf of the Executive Committee in 2013 to improve the Faculty’s communication both within and beyond the College (with other professionals and members of the public) about the Faculty’s activities.

The Faculty’s website is being revitalised, with many changes: updating the curricula to reflect the various *Cradle to Grave* changes; describing medical psychotherapy and training with a question and answer section; films of doctors and experts by experience describing their views on medical psychotherapy; the Dean, Chair of the Faculty and Faculty Education and Curriculum Committee Chair in discussion on education and the future of medical psychotherapy; and an animation showing a psychotherapeutic relationship with the development of both patient and psychotherapist as background to their meeting to highlight different developmental journeys to securing a therapeutic relationship.

The new theme of the Faculty’s website will be ‘listening with medicine in mind’ and will reflect an aim to inspire active engagement from medical students and doctors interested in psychotherapy, including all people in therapy or curious about psychotherapy.

Medical student psychotherapy schemes and recruitment

The Royal College of Psychiatrists’ medical student psychotherapy schemes are primarily a way to think about the doctor–patient relationship, with any increase in recruitment to psychiatry a secondary outcome. The schemes reflect the central importance of an early developmental perspective, as reflected in the *Cradle to Grave* education

strategy, which the GMC (2013) has endorsed: emphasise the ‘cradle’ idea of exposing medical students to psychotherapeutic teaching methods, which has the primary aim of developing psychotherapeutic medicine but also offers a key contribution to improving recruitment to psychiatry. This was demonstrated in a 10-year retrospective study by Yakeley *et al* (2004).

Oxford Specialist Handbook of Medical Psychotherapy

The *Oxford Specialist Handbook of Medical Psychotherapy*, the first compendium of contemporary evidence-based therapies offered in the National Health Service (NHS), was published in September 2016. The editors are Dr Jessica Yakeley, Dr James Johnston, Dr Gwen Adshead and Dr Laura Allison, written with over 60 authors. The handbook offers a guide for the uninitiated as well as the experienced practitioner, providing detailed outlines of the major psychotherapies in theory, clinical practice and training written by medical and non-medical psychotherapists, medical psychotherapy trainees and other professionals. It is aimed at the ‘cradle to the grave’ lifelong learning spectrum of medical students, foundation doctors, psychiatry trainees and post-membership psychiatrists.

Medical psychotherapy leadership

The clinical context of psychotherapeutic education is essential to maintain and develop psychotherapeutic psychiatry clinically as, without this context, psychotherapy training risks being seen as irrelevant to the psychiatrist’s day-to-day work. Consultant posts that are established only to fulfil the GMC training requirement for psychiatrists, without a clinical service context in psychiatry, defeat the purpose of developing psychotherapeutic psychiatry, by suggesting that psychotherapy is merely a training box to be ticked. Newly established consultant psychiatrist in psychotherapy posts with a clinical service foundation from which to train future psychiatrists will foster a new ontology for psychotherapeutic psychiatry.

The *Cradle to Grave* education strategy argues that psychiatry and psychotherapy are different, and that this difference could infuse hybrid vigour

into training, which is in the interests of developing psychotherapeutically minded psychiatrists but, more importantly, is in the interests of developing further understanding of patients.

Academic events

Thinking Cradle to Grave was represented at the International Congress of Psychiatry in Birmingham in 2015 with Balint groups on each day of the Congress for medical students and foundation year doctors ('cradle' group), core and higher trainees ('mid-life' group) and consultants, academics and specialty doctors ('grave' group). Co-leaders for each of the three Balint groups met and reflected on the groups. Feedback indicated that all groups were well received; the 'grave' group was particularly well attended. The Royal College of Psychiatrists' Medical Students Psychotherapy Schemes Working Group will be embedded in the Medical Psychotherapy Faculty Education and Curriculum Committee. The first bi-annual Medical Student Psychotherapy Symposium took place in January 2017. The symposium provides a forum for scheme leaders to learn about establishing and developing student psychotherapy and for students to learn from presentations from others from medical schools across the UK about their Balint and psychotherapy experiences.

Cradle to grave: the NHS

The metaphor of development from 'cradle to grave' is borrowed from Aneurin Bevan's founding vision for the NHS in 1948 (Johnston, 2015). The 21st-century NHS workforce faces

many challenges but, whereas the challenges for professionals are mainly articulated in terms of economic resources, it is the emotional resources of professionals that are the prime focus of the *Cradle to Grave* education strategy. Psychotherapeutic medicine cannot provide a cure or antidote to the fragmentation that can arise in super-specialisation and silos of care where no single doctor will have a synoptic view over time and in depth with a single patient, understood in their family and social context. However the lifelong view embodied in the *Cradle to Grave* education strategy offers a lifeline in the emotional development of the doctor whose patients are living longer and becoming a complex challenge to the models of diagnosis and treatment in which future doctors are trained.

Health Education England and other drivers of change

Alongside many other reports and documents (Greenaway, 2013; Addicott *et al*, 2015; NHS, 2014), the 15-year strategic framework published by Health Education England (2015) outlines drivers of change that will shape the future health workforce. In particular, the increasing prevalence of long-term and complex conditions, the growing requirement to reduce the split between physical and mental healthcare, and the importance of relating to the patient as a whole. There is an increasing acknowledgement that both patients and professionals experience periods of deep anxiety, fear, and grief that affect the quality of care and underline the importance of developing a therapeutic attitude and behaviour in the medical workforce.

Conclusions

The next generation of doctors (the 'cradle') will need to develop skills in listening, learning, empathy and compassion beyond that of their predecessors (the 'grave'). They will need to demonstrate an awareness of the patient as a whole person and to be comfortable with an integrated approach to physical and mental healthcare, seeing the intricate links between the two and the adverse consequences that come from artificial separation. It is now widely accepted that many failures of care, and both patient and carer dissatisfaction with medical care, stem not from a lack of technical knowledge or skill in the doctor, but from a lack of empathy, compassion and skill in communication. As we move towards integrated care and an emphasis on comorbidity and long-term conditions, developing these skills and values becomes increasingly important for the next generation of doctors.

The *Cradle to Grave* education strategy offers a template for therapeutic development that addresses the professional development of the doctor with an ontological emphasis on the recovery, renewal and retention of the therapeutic attitude that informs and maintains the vocation to become a doctor. It is the therapeutic attitude that brings the sixth-form student to medicine, but it can be challenged by medical training; it brings the foundation doctor to psychiatry but can be challenged by psychiatric experience; it brings the senior doctor to clinical work but can be challenged by systems that have become oblivious to the central importance of the patient and professional relationship.

Attention to the central place of compassion and curiosity in an energetic therapeutic attitude can be compromised by both internal and external factors in circumstances where there is no recognition of the value of repeated and regular reflection, with not only one's own mind but also the minds of others. Recovering the ability to reflect requires a foundation in reflection developed early in the doctor's career, as when work-life pressure is

strong, the casualty of competence is often self-awareness and awareness of the other. The ability to reflect is what the psychiatrist may aspire to on behalf of some of their patients but, to maintain the professional environment in which this light of insight continues to burn, the psychiatrist has to ensure that they do not burn out (Menon *et al*, 2015). Practising medicine is demanding emotional work than can have an impact on the health and wellbeing of doctors and medical students (Cohen *et al*, 2013; Gerada, 2015; Heron *et al*, 2016).

In *Cradle to Grave* terms, the three Rs for psychiatry are recruitment, renewal and revalidation. Success in the three Rs depends on developing a therapeutic attitude, paradoxically by accommodating failure. In terms of recruitment, failure to recruit doctors to psychiatry who had been exposed to psychotherapy in medical school and foundation years would be a loss for psychiatry, but a gain for medicine, in that there would be more doctors who had developed a therapeutic attitude early in their careers. In terms of renewal of psychotherapeutic psychiatry, failure would represent a wake-up call to attract therapeutically minded doctors. Failure to develop senior doctors (the 'grave') in therapeutic terms via revalidation would spell the end for the cradle: children require their parents to set the example of good behaviour, in this case a therapeutic attitude (Shoenberg, 2012).

Recruitment, renewal and revalidation therefore function in a triangular dynamic, acting reciprocally to build psychotherapeutic excellence from the cradle to the grave, through the attraction of junior doctors, growth of senior doctors and retention of both. Developing and maintaining a therapeutic attitude can mitigate the challenges doctors face and maintain the curiosity that motivates in psychotherapeutic medicine. This is why it is important to begin therapeutic education early in lifelong learning and to continue throughout the personal and professional development of the student and senior doctor, thinking 'cradle to grave'.

Recommendations

- 1 Continue to develop a UK-wide model of Balint groups for medical students, building psychotherapy schemes in medical schools where the Balint foundation leads to this undergraduate curriculum change. The Medical Psychotherapy Faculty Education and Curriculum Committee should lead a programme of development with the Royal College of Psychiatrists' Medical Student Psychotherapy Schemes Working Group, building the evidence base in evaluation.
- 2 Continue to develop foundation-year Balint groups in psychiatry and other posts, such as medicine, child health and general practice.
- 3 Continue to develop core psychotherapy training in psychiatry by building on the minimum requirements of one year in a Balint or case-based discussion group and two therapy cases (e.g. extend Balint groups throughout core training years one to three).
- 4 Continue to develop higher psychotherapy training across psychiatry by developing Balint groups as a UK-wide foundation for psychotherapy cases.
- 5 Further develop dual training in medical psychotherapy to build on the forensic, general adult, child and adolescent, and intellectual disability combinations in integrated and sequential forms. The resultant consultant posts in psychotherapeutic psychiatry across specialties will provide a rich field for leadership and development in therapeutic medical education.
- 6 Maintain the single CCT in medical psychotherapy as the basis for psychotherapeutic psychiatry development, governance and leadership. Develop applied psychotherapeutic psychiatric skills for medical psychotherapy consultation as a fertile soil for a therapeutically informed clinical culture.
- 7 Continue to develop CPD and formal paths to credentialing for post-membership psychiatrists through applied psychotherapeutic psychiatric conferences, seminars and online CPD modules in the established and emerging psychotherapies. Credentialing pathways in psychotherapy for post-CCT psychiatrists will help develop supervision in training schemes to widen psychotherapeutic psychiatry.
- 8 Nourish the senior psychiatrists who provide leadership and influence for the education of medical students, foundation year doctors, and core and higher trainees through ongoing reflective practice and consultation on complex cases. Consultant psychiatrist Balint groups led by medical psychotherapists can encourage the maintainance of a therapeutic attitude among junior doctors.
- 9 Protect and develop medical psychotherapy clinical services that can provide consultation as well as psychotherapy as a clinical cultural context for applying psychotherapeutic reflection in quotidian psychiatry with a focus on the dynamic field of the patient and professional relationship.
- 10 Continue to develop multidisciplinary, reflective-practice groups across different acute and chronic psychiatric settings (e.g. crisis teams, early intervention, in-patient units and rehabilitation) as a way of recovering and developing a therapeutic attitude and mitigating the risk of burn-out.

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