THINKING CRADLE TO GRAVE

DEVELOPING PSYCHOTHERAPEUTIC MEDICINE AND PSYCHIATRY

Royal College of Psychiatrists’
Medical Psychotherapy Faculty Education and Curriculum Committee

Therapeutic Education Strategy
Developing Reflective Medical Practitioners
Developing Psychotherapeutic Psychiatry

Twelfth Iteration: Medical Psychotherapy Faculty Therapeutic Education Strategy November 2014
Dr James Johnston on behalf of the FECC Education Strategy Working Group
Thinking Cradle to Grave: Developing Psychotherapeutic Medicine and Psychiatry

Summary of Cradle to Grave Strategic Changes: 2011-2014

Developing Psychotherapeutic Medicine and Psychotherapeutic Psychiatry

FROM THE CRADLE

Medical student psychotherapy

- UK Medical School Psychotherapy Scheme Working Group established in June 2014 has begun to establish or plan student psychotherapy schemes in 12 medical schools across the UK
- The aim is to establish Balint groups in all 45 UK medical schools by 2017 when Prof. Wessely ends his College Presidency; evaluation of the schemes will include their impact on recruitment to psychiatry
- Balint groups for medical students and foundation doctors are included in each day of the International Congress of Psychiatry in Birmingham in 2015
- Royal College of Psychiatrists’ Student Associates website Drawing from Life psychotherapy section.

Foundation year psychotherapy

- Balint groups for Foundation doctors F1 and F2 in psychiatry placements (Yorkshire) 2011-2014
- Balint group developments in broad based training to extend across other placements in medicine, paediatrics and general practice: this message has been taken up by the Dean and the President
- Emphasis on reflective practice and therapeutic development in the Shape of Training review.

Core psychiatry psychotherapy

- First UK Psychotherapy Survey undertaken in 2011-2012: second UK Psychotherapy Survey to be undertaken in 2015 to evaluate impact of curriculum changes and GMC action plan on training
- Short therapy case and longer therapy case durations specified in the core curriculum requested by the GMC and ratified by the GMC 2013: short – 12-20 sessions, longer over 20, any model
- New intended learning outcome: ILO19 self reflective practice ratified by the GMC in the core psychiatry curriculum in 2013
- The role of the Consultant Psychiatrist in Medical Psychotherapy to lead core psychiatry psychotherapy training in the context of schemes without Medical Psychotherapy CCT holders was finalised with the Lead Dean of Psychiatry, the College Specialty Curriculum Advisor and the GMC in 2014. The principle of a GMC regulatory requirement for medical psychotherapy leadership and oversight was underlined.

TO THE

Advanced medical psychotherapy

- New intended learning outcome: ILO19 to strengthen personal therapy requirement for advanced psychiatry training being ratified by the GMC in November 2014
- ILO19 in the advanced curriculum includes the requirement of model congruent self reflective development (for example, required personal analysis for psychoanalytic trainees or CBT trainees if wished or suitable developmental experiences which foster emotional intelligence).

Advanced psychiatry psychotherapy

- Requirement for ongoing psychotherapy experience in advanced training across sub-specialties being reinforced amongst the Heads of Schools of Psychiatry through the Dean
- Balint groups for core and advanced trainees are included in each day of the International Congress of Psychiatry in Birmingham in 2015.

GRAVE

- Balint groups for consultants, specialty doctors and senior academics are included in each day of the International Congress of Psychiatry in Birmingham in 2015
- National communications strategy being developed to communicate aims of psychotherapeutic psychiatry and the changes taking place; propose use of credentialing to develop psychotherapeutic skills in psychiatry as part of a national Medical Psychotherapy CPD programme
- Reflective practice requirements of the Shape of Training review in 2014 for senior practitioners becoming a Trojan horse for continuing professional development and revalidation purposes
- Working with the Medical Psychotherapy Faculty to foster receptivity to reflective practice
- Updating the Medical Psychotherapy Faculty website to raise our profile and engage colleagues.

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Detail of therapeutic developments arising from the Thinking Cradle to Grave strategy: 2011-2014

Curriculum amendments to the GMC

Core psychiatry curriculum

From February 2014 the General Medical Council approved psychotherapy amendments of the length of the short and the long therapy cases in the core psychiatry curriculum were formally required in training. (Short therapy case: 12-20 sessions; long therapy case: over 20 sessions with the precise number agreed with the clinical supervisor with respect to the patient’s needs).

From February 2014 the new intended learning outcome (ILO19) to develop reflective practice including self reflection as an essential element of safe and effective psychiatric clinical practice was formally required.

Advanced medical psychotherapy curriculum

The amendment (ILO 19) to develop reflective practice including self reflection as an essential element of safe and effective reflective development in the advanced medical psychotherapy training level curriculum has been accepted in principle by the GMC in March 2014. The amendment has been strengthened to develop knowledge, skills and attitudes particular to the sub specialty in a spiral curriculum form.

Advanced general adult psychiatry curriculum

The amendment to develop reflective practice including self reflection as an essential element of safe and effective reflective development in the advanced general adult psychiatry training level curriculum will be deferred pending acceptance by the GMC of ILO 19 in the advanced medical psychotherapy curriculum.

Advanced or higher medical psychotherapy dual and single CCT training

A single CCT in medical psychotherapy (three years duration) remains an advanced training option.

Dual training in medical psychotherapy with general adult psychiatry was ratified by the GMC in January 2012. The dual training is five years in length and can be in a concurrent integrated CCT or sequential CCT model. Sequential dual training predates the introduction of integrated dual training in medical psychotherapy and general adult psychiatry in 2007. Some medical psychotherapy schemes have adopted the Yorkshire integrated or concurrent CCT model of dual training in medical psychotherapy and general adult psychiatry in parallel. Other schemes have adopted sequential model of training.

UK Psychotherapy Survey Summary March 2013

The UK Psychotherapy Survey summary report was published in March 2013.

- 58 of the 70 UK core psychiatry training schemes responded, a response rate over 80%.
- 49 (84%) of these schemes were fulfilling the core psychotherapy curriculum requirements.
- 38 (66%) of these schemes have a Consultant Psychiatrist in Psychotherapy with a 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 Psychotherapy Tutor (Fisher’s Exact test, p<0.05).
- The odds of the curriculum being fulfilled were 5 times higher if the Psychotherapy Tutor was a Consultant Psychiatrist in Psychotherapy.
- 30 of 40 (75%) of Psychotherapy Tutors report that their ARCP boards require all competencies to be completed before progression to higher specialty training (ST4).
- Several modalities of therapy are used as psychotherapy experience across the UK although the commonest are CBT for the short case (35%) and psychodynamic psychotherapy for the long case (69%).
The UK Psychotherapy 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 UK Psychotherapy Survey were:

1. Consultant Psychiatrists in Psychotherapy should lead the coordination and educational governance of all core psychotherapy training in psychiatry as Psychotherapy Tutors.

2. The aims of core and advanced psychotherapy training need to be linked developmentally focusing on training which is a better fit for trainee capacity and is fit for the purpose of the work of psychiatry.

3. Multidisciplinary participation in core and advanced medical psychotherapy training should be formally developed, organised and led by Consultant Psychiatrists in Medical Psychotherapy.

GMC Medical Psychotherapy Report and Action Plan April 2013

The General Medical Council QA review in 2011-2012 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 GMC Medical Psychotherapy Report was published in April 2013. The action plan arising from the report outlined the deanery requirements, recommendations and underlines good practice in psychotherapy training including the requirement of a leadership role for Consultant Psychiatrists in Medical Psychotherapy in psychotherapeutic psychiatry training.

The action plan following the GMC report’s requirements and recommendations was published as part of the report in April 2013. The action plan was subject to review in October 2013 and the fact that the leadership role of medical psychotherapists not being in the approved curriculum in July 2013 has been raised with the GMC and with the Royal College of Psychiatrists through the Dean and the core curriculum working group chair.

Reflective Practice Groups/Case Based Discussion Groups: What’s in a name?

To accommodate model differences a new name was proposed for the first year group in psychiatry training:

- Core psychiatry training years: the name of the groups proposed was reflective practice groups in place of case based discussion groups. This name change was approved by the Curriculum and Assessment Committee in September 2013 and approved by the Medical Psychotherapy FECC in October 2013. The name change to reflective practice groups was rejected by the Medical Psychotherapy Faculty Executive Committee in October 2013 following a vote of elected members.

Balint Groups

Balint groups are established or are being developed for the following levels of medical practitioners:

- Undergraduate: to be offered during and beyond psychiatry placement years.
- Foundation years one and two: established for psychiatry F1 and F2 in Yorkshire 2011.
- Foundation years one and two: to be extended to include non psychiatry placements in the new broad based foundation training (Psychiatry, Child Health, Internal Medicine and General Practice).
- Advanced psychiatry training years: ST4 to CCT.
- Consultant Psychiatrist: established in Yorkshire in 2008 offered to all psychiatry sub-specialties.

Undergraduate Balint Groups

The new President of the Royal College of Psychiatrists Professor Simon Wessely has sought a meeting to plan the development of UK wide medical school psychotherapy schemes and Balint groups. The working group is now established with a strategy for developing psychotherapy schemes across all the UK medical schools by 2017. Dr James Johnston chairs the working group with Dr Peter Shoenberg, Dr Jessica Yakeley and colleagues from the nations and regions of the UK to be present to develop this welcome initiative.

Medical Psychotherapy Faculty Website

The Medical Psychotherapy Faculty part of the site updated to clarify aspects of psychotherapy training:

- What is the purpose of the CT1 reflective practice groups? What are the requirements?
- What is the aim of a CT2-3 longer term therapy case? What are the requirements and WPBAs?
- What is the aim of the CT2-3 shorter therapy case? What are the requirements and WPBAs?
Structured Assessment of Psychotherapy Expertise (SAPE); who can complete this formative WPBA?
Psychotherapy Assessment of Clinical Expertise (PACE); who can complete this summative WPBA?
What is the role of the Medical Psychotherapy Tutor?
What is the role of the School of Psychiatry in delivery of the psychotherapy curriculum?

A new trainee section is to be developed on the website to include training experiences around the UK.

All the documents describing psychotherapy training are being updated to reflect changes in the curriculum.

Communication between Medical Psychotherapy FECC and Medical Psychotherapy Tutors

To develop improved communication between the Medical Psychotherapy Faculty Education and Curriculum Committee and the training leads across the UK it is proposed that the network of Regional Medical Psychotherapy Representatives act as leads to link with the psychotherapy training schemes and tutors leading training in their regions. Blog proposed for Medical Psychotherapy Tutors and TPDs on the website.

A regularly updated list of Regional Medical Psychotherapy Representatives including their College Division and work contact details will be on the Medical Psychotherapy Faculty website so the Medical Psychotherapy Tutors and Schools of Psychiatry have a local point of contact for advice on training matters.

The Regional Medical Psychotherapy Representatives can in turn liaise with the Chair of the Medical Psychotherapy Faculty Education and Curriculum Committee and members, now listed on the website.

Core Curriculum Working Group

The Core Curriculum Working Group includes the Dean and the Specialist Curriculum Advisor. The Chair of the Medical Psychotherapy FECC is a member of the group and has contributed to the core curriculum survey and the qualitative analysis of the intended learning outcomes in psychological therapies (ILO5) and communication skills (ILO 8). The core curriculum survey (April 2013) highlights trainee concerns about psychotherapeutic psychiatry training and reveals a leitmotif concerning the relevance of learning about specific psychotherapies and a theme of trainees wanting to contextualise psychotherapeutic education in everyday psychiatric practice.

Advanced or higher medical psychotherapy dual training options

The current dual training options with medical psychotherapy are:

- Forensic Psychiatry and Medical Psychotherapy (5 years)
- General Adult Psychiatry and Medical Psychotherapy (5 years)

The option of dual training in Child and Adolescent Psychiatry and Medical Psychotherapy is being met with support with the Chair of the Child and Adolescent Psychiatry FECC and is likely to be in place in 2015.

Oxford University Press Handbook of Medical Psychotherapy

An Oxford University Press Specialist Handbook of Medical Psychotherapy which is a compendium of contemporary evidence based therapies offered in the NHS will be published in spring 2015. The lead editor is Dr Jessica Yakeley with associate editors Dr James Johnston, Dr Gwen Adshead and Dr Laura Allison. The book is a compendium of therapies emphasising brevity, evidence and utility written by medical psychotherapists for medical psychotherapy trainees and other professionals as a practice based guide to an outline of therapies in theory and practice. The book is mainly aimed at students and psychiatry trainees.

Medical Psychotherapy in Psychiatry Summer Schools and Recruitment

A number of medical psychotherapists contribute to Psychiatry Summer Schools for sixth formers and medical students interested in psychiatry around the UK. The medical student psychotherapy schemes are primarily a vehicle to think about the doctor-patient relationship with any increase in recruitment to psychiatry a secondary outcome. These initiatives reflect the central importance of an early developmental perspective reflected in the Medical Psychotherapy FECC Thinking Cradle to Grave strategy which the GMC in their medical psychotherapy QA report of 2013 endorsed: they emphasise the ‘cradle idea’ that psychotherapeutic exposure to medical students is one of the key contributions to improve recruitment to psychiatry; Yakeley et al (The Psychiatrist 2011, 35). Professor Wessely is clear that the prime purpose for his supporting medical student psychotherapy schemes is recruitment to psychiatry: for psychotherapists this is a vehicle to develop psychotherapeutic medicine. These aims must be based on developing psychotherapeutic psychiatry so we are not attracting the therapeutically minded medical student into a therapeutically impoverished psychiatry.

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Medical Psychotherapy Faculty Therapeutic Education Strategy

Thinking Cradle to Grave

The cradle and the grave the reader is invited to think about in the title refer both to the development of the patient and the development of the doctor. In relation to 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 developmental states of mind and the grave signifies the gravity of facing death or mourning loss and the risk of death that is the pervasive anxiety arising from unbearable states of mind.

In relation to the development of the doctor the cradle and the grave represent personal life experiences and the lifelong learning trajectory of education, continuing professional development and revalidation.

In psychiatry the cradle signifies confronting the sometimes devastating impact of primitive emotional disturbance and the anxieties and aggression that surround the grave emanating from the risk of death.

To be or not to be: is that the question?

The ontological question to be or not to be is posed to the UK doctor with an interest in psychotherapy considering psychiatry training: do they train to be a psychotherapist and not to be a psychiatrist?

The dilemma in contemporary psychiatry training for psychotherapeutically minded doctors is that medical psychotherapy has increasingly become a separate discipline from mainstream psychiatry.

The Thinking Cradle to Grave therapeutic education strategy challenges this to be or not to be training question. It proposes an alternative: the development of the psychotherapeutic psychiatrist who questions not only their patients but themselves in relation to their patients.

The development of psychotherapeutic psychiatry involves recognition that the majority of people suffering from mental illness, personality disorder, mental pain or mental deadness will not see medical psychotherapists but many are likely to see psychiatrists. A robust psychotherapeutic training that parallels and equals the strength of biological training is necessary for those psychiatrists because it is necessary for their patients. For psychiatrists (and all mental health professionals) to be able to develop and maintain a capacity to bear and think with people suffering extreme mental disturbance they need to sustain a clinical routine of protecting reflective space in which to examine their own emotions in response to the people who come to them.

Developing psychotherapeutic psychiatry

Developing psychotherapeutic psychiatry may address those who are undecided about a career in psychiatry, early in psychiatric training or still therapeutically receptive in their mature development. Influence across the generations is vital to making a difference for future generations of psychiatrists and patients.

The difference made to the psychiatric profession could be in improving recruitment to psychiatry, securing greater retention of psychiatry trainees in psychiatry and enriching the revalidation of psychiatrists who embrace therapeutic development as part of their clinical practice.

The therapeutic education strategy aims to foster a therapeutic attitude of mind in the heartland of mainstream psychiatry so that psychotherapy begins to lose its peripheral position so it is less an activity of others called medical psychotherapists, adult psychotherapists or clinical psychologists and more a therapeutic way of thinking about their patients psychiatrists see to be vital in their identity as a psychiatrist.

Why train psychiatrists in psychotherapy?

If psychiatrists aspire to think therapeutically but will not ‘do psychotherapy’ why train them in psychotherapy?

This question was posed in the UK Psychotherapy Survey (2012) with data for the core psychotherapy training of psychiatrists in over 80% of schemes across the UK. A question posed by a psychologist working as Psychotherapy Tutor for a core psychiatry scheme, it is a question based on the premise that psychotherapy training for psychiatrists is aimed at the delivery of psychotherapy as an intervention.
The aim of psychotherapy training for psychiatrists is not to train the majority of them to be psychotherapists but to train them to be psychotherapeutic psychiatrists. The UK Psychotherapy Survey revealed that psychiatrists trained as medical psychotherapists are five times more likely to fulfil the core psychotherapy curriculum as Psychotherapy Tutor. The Consultant Psychiatrist in Psychotherapy is needed to lead 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 those trained as psychotherapists reinforces the split of psychotherapy from psychiatry.

All of the following educational interventions in the therapeutic education strategy focus on integrating a therapeutic attitude in the development of reflective medical practitioners.

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

A central contention of the Thinking Cradle to Grave therapeutic education strategy is that psychotherapeutic experience at undergraduate and early postgraduate levels will influence doctors with an interest in the mind.

It is a ‘no brainer’ that neuroscience will be enough to attract some doctors to psychiatry but for others who are in two minds based on a concern that psychiatry lacks the human touch, evidence that psychotherapeutic psychiatry is alive and flourishing will be an important recruitment ‘pull’ factor.

Developing a therapeutic model of mind

The theme underlying the therapeutic education strategy is that the doctor who specialises in psychiatry needs a model of mind which can help to contain and understand the disturbing feelings psychiatric work with some patients evokes in professionals.

The phenomenology of psychiatry is not in itself sufficient to contain the disturbance evoked in the psychiatrist and where difficult patients evoke difficult feelings the person behind the well observed problem is not seen, a blind eye being turned to the internal world of meaning of the person.

Freud to Fred

Accessibility of therapeutic thinking is essential for its acceptance in mainstream psychiatry which sometimes involves theoretical construct translation without the depth of the original idea being lost in translation.

My notion of translating 'Freud to Fred' is a way of describing a psychological translation of complex theoretical constructs devised in a psychoanalytic setting for use in an ordinary clinical practice setting. Rendering hard psychoanalytic ideas in an ordinary easier language may afford their therapeutic use as a relevant way of thinking in mainstream psychiatry outside a psychotherapeutic setting. This has to be a sensitive and truthful translation as there is a risk that original meaning is lost in the pursuit not of accessibility but acceptability.

The central psychoanalytic idea that has great utility in all clinical practice is of the centrality of the patient and professional relationship (transference) which runs through its application in day to day psychotherapeutic psychiatry in the professional experience of the patient (countertransference). Whether in the acute setting of a risk assessment, a community home visit, an out-patient meeting, an in-patient ward round or in a psychotherapy session, the therapeutic relationship remains the barometer through which the mutual emotional pressures of the professional and patient can be used as information or data with which to build understanding. The emotional response of the professional to the patient is given priority.

Socrates observed that the unexamined life is not worth living. It might be said that the unexamined mind is borne from the feeling 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 the examined mind is mutual and reflexive. The translation of the examined mind to include examination of the patient and their affective impact on the professional derives from a psychoanalytic recognition of unconscious identification in relationship, the professional turning their mind to that of the patient as being ‘like a receiver to a transmitter’. This is a translation from ‘Freud to Fred’.

The affective subjectivity (Yakeley et al 2014) of the professional in response to a patient will not however only include the patient's emotional impact on them; the experience of being disturbed is also the professional’s own experience and not one to be located solely in the other. This is a key aspect of a therapeutic attitude.
Therapeutic attitude

But what is meant by a therapeutic attitude in clinical practice? How is it achieved? How is it developed? How is it sustained? How is it lost?

A therapeutic attitude could be seen as seeking a state of stillness, contemplation and self reflection out of which understanding of the other in need of help may emerge. It requires work to develop and maintain it.

Therapeutic attitude is crucial to the clinical practise of those who consider their own emotional experience to be a source of learning about the emotional experience of the person who presents to them.

Therapeutic development in the therapeutic education strategy is not aimed at addressing training in particular models of therapy, though for some doctors this will be part of their development. Learning a specific model of psychotherapy in depth is what specialists in medical psychotherapy do as their major to obtain a CCT alongside learning two other models of therapy (their minors).

Rather, therapeutic development in the Thinking Cradle to Grave therapeutic education strategy is about developing and continuing to develop a therapeutic attitude to all the work of psychiatry, not just the psychotherapy part of psychiatry. When a person presents to the psychiatrist, the psychiatrist with a therapeutic attitude tries to see the person beyond the presenting problem. The psychiatrist with a therapeutic attitude will reflect on their own emotional responses to the patient to help them understand the patient.

A therapeutic attitude involves emotional work, and the earliest phase of developing this self reflective capacity will seem odd to some, irrelevant to others and still others will see this as a self evident ingredient of the doctor-patient relationship.

Spiral curriculum of a developing therapeutic attitude

In a spiral curriculum there is a deepening sophistication of learning as the same field of learning is explored at a different developmental level according to context and capacity.

In the Thinking Cradle to Grave therapeutic education strategy the repeated field of learning is therapeutic literacy. In each stage of the trajectory of development from the person considering and training as a doctor through to a retiring consultant the repeated learning leitmotif remains therapeutic literacy which shows development or anti-development with the maturing doctor.

The demands of each developmental stage of the nascent and mature doctor require different expressions of therapeutic literacy but the nature of the emotional process remains the same. The therapeutic literacy thread that runs through these layers remains the capacity to value emotional examination in the interests of developing and adapting to the demands of the work.

Medical student developing therapeutic attitude

The emotional demands on a medical student may be in holding on to the recollection of what they brought with them in their vocation to train as a doctor, retaining a sense of the whole person’s humanity rather than ‘the abdomen in bed eight.’ The past in the present for the emerging doctor would be in recalling the ordinary uncertainties in the midst of extraordinary technical knowledge.

Foundation year one developing therapeutic attitude

As a medical student there is a steep learning curve as their responsibility grows in the transition into the foundation year one as they confront their own limitations and disease and death are closer, experienced as raw and real. As a foundation year one doctor being able to reflect on feelings faced with a dying or dead patient would require the ability to be vulnerable with colleagues and return to the ward next day.

Foundation year two developing therapeutic attitude

In the career decision making second foundation year a doctor will be more familiar with the role of the professional but less comfortable with what might feel unprofessional responses which involve their own struggles with the task of treating, helping and failing to help patients.

A foundation year two doctor being able to recognise the professionalism in honesty with oneself about strong negative feelings about a patient not undermining their qualities as a good doctor will be a milestone for some.
Core training year one developing therapeutic attitude

In their first core training year a doctor will be in transition 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 is not able to feel overwhelmed or uncertain in this period this 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 their mistakes without fear of accusation of incompetence. Vulnerability and struggling with uncertainty in the face of mental pain should not be experienced as mistaken weakness but as signs of strength. 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 precarious certainty but such systems may sit uneasily with feelings of confusion and personal uncertainty.

As a core trainee beginning a Balint group being prepared to acknowledge the fear associated with being in the on call situation and burdened in isolation with risk without feeling this makes one a weak or incompetent doctor would be an achievement.

Core training years two and three developing therapeutic attitude

In the later core training years to remain curious alongside the knowledge of limitations in psychiatric care might be shown in being less divided about the ill legitimate and illegitimate patients using discriminating subtle or unsubtle diagnostic categories.

It has to be recognised that therapeutic development is challenging in the context of examination anxiety...

Advanced training years developing therapeutic attitude

In the post membership years the doctor will learn to become the specialist they aspire to be and the struggle in this phase of development will be in beginning to consciously and unconsciously sift their positive and negative identifications between their different mentors as they find a professional mind of their own. An advanced trainee who does not seek refuge in a scientific attitude or pursue the medical carapace of defensive practice but is prepared to remain open to risk in emotional terms and interested in meeting each patient as an individual would be showing signs of emotional resilience and the possibility of growth.

Consultant years developing therapeutic attitude

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 reliance on systems of certainty from training. In the later years the emotional demands of 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 a sense of their evident openness to learning from their work and remaining in some way still passionate while cognisant of the limitations of what they personally can bear.

As can be seen it is hard to define a deepening therapeutic attitude but one aspect of it would be in a continuous openness to a meeting of minds in a dialogue with human distress and disturbance shown in the mind of the practitioner with the mind of the patient.

A closed mind in which curiosity is inhibited or deadened would be a reflection in the professional of that deadened negative state of mind in which development seems to have been paralysed. An open mind in which curiosity is allowed free reign, relatively free association and emotional expression would be a reflection of that lively interested and questioning state of mind in which development inexorably continues.

Specific developmental tiers of the Medical Psychotherapy Faculty Therapeutic Education Strategy

The Thinking Cradle to Grave therapeutic education strategy outlined below offers a guide to some of the ways consultant psychiatrists in psychotherapy can select approaches to therapeutic education tailored to their context and resources which can be linked with the beginning, middle and end of a career in psychiatry.
The approach is developmental in that the lifelong learning of the doctor begins with the pupil at school and continues through their medical apprenticeship to practising and refining their consultant craft from a psychotherapeutic perspective.

The Thinking Cradle to Grave strategy follows the developmental trajectory from before medical school, undergraduate, postgraduate foundation years, postgraduate core years, postgraduate advanced years and postgraduate consultant and specialist years.

Psychiatry Summer Schools

Including a therapeutic reflective aspect to the School of Psychiatry Summer School would aim at fostering converts to psychiatry.

Summer Schools around the UK include psychotherapy and one way of introducing therapeutic ideas about relationships is to run a reflective practice groups for the students.

Medical School

The learning objective for therapeutic development is to lay a foundation at undergraduate level for reflection on the doctor-patient relationship, not with the aim of fostering converts to psychiatry but to enhance the emotional literacy of all future doctors.

The therapeutic experiences aimed at medical students are often best delivered by trainees with whom the undergraduates can more closely identify.

Medical student Balint groups

Balint groups facilitated by consultant psychiatrists in psychotherapy or advanced medical psychotherapy trainees.

The aim would be for the medical students who are seeing patients at different stages of training not confined solely to psychiatry training.

The medical student Balint group would not be mandatory but would be part of the course, for example, it can be written up in the personal development portfolio component of the undergraduate curriculum.

Medical student placements with consultant psychiatrists in psychotherapy

Undergraduate placements with consultant psychiatrists in psychotherapy may be offered which would include observing therapy assessments, observing professional meetings and consultations and participating in psychotherapy teaching sessions.

Medical students could shadow the consultant psychiatrist in psychotherapy to offer consultations to other mental health professionals, observing reflective practice groups on wards, crisis teams, community mental health teams and in primary care consultations, etc.

Foundation Years 1&2 placements with consultant psychiatrists in psychotherapy

Foundation placements with consultant psychiatrists in psychotherapy may be offered which would include observing therapy assessments, observing professional meetings and consultations and participating in psychotherapy teaching sessions.

Foundation 1&2 doctors could shadow the consultant psychiatrist in psychotherapy to offer consultations to other mental health professionals, observing reflective practice groups on wards, crisis teams, community mental health teams and in primary care consultations, etc.

Foundation Years 1&2 Balint groups

Balint groups facilitated by consultant psychiatrists in psychotherapy or advanced medical psychotherapy trainee, offered throughout the placements, irrespective of medical specialty.

What is the Balint group experience for? Having the Balint group solely for the foundation year doctors and not including either medical students or core psychiatry trainees is preferable as the focus is on developing a sense of one’s identity as a new doctor.
Core trainees in psychiatry

What is the first year group experience for? The aim of the reflective practice group in the first year of psychiatry training is to provide a supportive space for doctors in core training encountering psychiatric work for the first time to think about their emotional experience in relation to the mental and emotional disturbance they encounter. The aim is to foster recognition that a therapeutic attitude to reflection on all psychiatric work can be of value in helping the doctor to manage extreme mental states and anxieties.

What is the shorter therapy case for? The UK Psychotherapy Survey (2012) showed that the short term therapy cases tend to be divided equally between the more structured therapies such as CBT and the less structured psychodynamic psychotherapies. The more structured therapies are of value for trainees who prefer a therapeutic algorithm as a way of managing their first therapeutic approach to patients.

What is the longer therapy case for? The longer term therapy case is more often psychoanalytically derived and therefore less structured. The experience of remaining with a patient over time and developing a relationship involves the doctor in developing a capacity to examine their emotional responses in a way that builds on what they have experienced in case presentations in a more limited way in the Balint group.

The hard won emotional learning from experience that is defined as a therapeutic attitude here is not an insight that is secured through a battle fought and won in one day or in one Balint group or in one difficult patient encounter. Developing a therapeutic attitude involves a process of working through what is seen and lost again and again. This process requires time and space for stillness and contemplation to observe and consider the disturbing business.

The space for reflection can only be achieved by providing a consistent and sustained experience of working therapeutically in a structured setting which is stable enough to allow safe instability in the therapeutic relationship through which emotional learning from experience can take place.

There is no substitute or short cut for seeing a patient in therapy, particularly a longer term relationship, to begin to engage with this experiential and reflective practice developmental form of learning.

Advanced trainees in all sub-specialties of psychiatry

Advanced trainees in psychiatry with an aptitude demonstrated in core training or a limitation that they want to address should be supported rather than mandated to develop their therapeutic literacy through undertaking a longer term supervised therapy case.

What is the purpose of the therapy case in this training context? Even if the trainee has seen a longer therapy case in core training their further experience could enhance development and deepening of their personal therapeutic attitude. The therapy case experience of remaining with a patient over time and developing a relationship involves the doctor in developing a capacity to examine their emotional responses in a way that builds on more extensive psychiatric experience. Some advanced trainees may gain more post membership from seeing a longer therapy case than in core training as they are more at ease in their professional skin.

Advanced trainee Balint group

An advanced trainee Balint group facilitated by a consultant psychiatrist in psychotherapy and an advanced psychiatry trainee, offered throughout the duration of the placements up to CCT.

What is the Balint group experience for? The aim of the Balint group is to provide a supportive space for doctors in advanced training who are more confident in their psychiatric identity to think about their emotional experience in relation to the mental and emotional disturbance they encounter. The aim is to foster recognition that a therapeutic attitude to reflection on all psychiatric work can be of value in helping the doctor to manage extreme mental states and anxieties. Some advanced trainees may gain more post membership from being in a Balint group than in core training as they are more at ease in their professional skin.

The psychodynamic experience of reflection in a Balint group is more closely congruent with the overall aim of psychotherapy training for psychiatrists, to help them to develop self reflective practice and to address their clinical work through a therapeutic lens, of learning to see the person beyond the problem. Advanced trainees who have begun to experience the problem of the patient creating a space to see the person may in their consultant years join a consultant psychiatrist Balint group or advocate that such a group is needed.
Consultancy and supervision skills courses

Consultancy skills and supervision skills for advanced trainees might be offered in groups facilitated by a consultant psychiatrist in psychotherapy which aims to develop consultancy and supervision skills in multidisciplinary mental health teams. The advanced trainees will be both recipients of consultation and supervised in offering consultation to one another on their cases from a therapeutic perspective.

Consultant Psychiatrist Balint groups

A consultant psychiatrist Balint group which is facilitated by a consultant psychiatrist in psychotherapy and a consultant psychiatrist in any psychiatric sub-specialty which is slow open with a minimum attendance of a year to eighteen months. For such groups to develop it usually requires a cultural context of regular and credible clinical contact between local medical psychotherapists and other consultant psychiatrists.

Reflective practice for complex cases

A reflective practice course for consultant psychiatrists which is facilitated by a consultant psychiatrist in psychotherapy with the aim of developing applied therapeutic skills for work in multidisciplinary teams. The consultant psychiatrists will be both recipients of consultation and supervised in offering consultation to one another on their cases from a therapeutic perspective. Cases seen and consulted on could be a therapeutic component of the case based discussion assessment clinical revalidation in PDP groups.

Strategic changes and ideas arising from the Thinking Cradle to Grave Strategy

Core psychiatry curriculum

At core psychiatry training level a working group has been established by the Curriculum and Assessment Committee to develop amendments in relation to developing reflective practice as a thematic learning outcome. The Medical Psychotherapy FECC is part of this group and actively contributes to its thinking.

Advanced medical psychotherapy curriculum

At advanced medical psychotherapy training level the curriculum changes will build on the new core curriculum ILO 19 on reflective practice including self reflection as an essential element of safe and effective psychiatric clinical practice which was approved by the GMC in July 2013. The ILO 19 development in the advanced medical psychotherapy training curriculum is to be proposed to the GMC in November 2013.

A strengthened statement regarding model congruent personal reflective development will be explicit for medical psychotherapy and while ILO 19 will be in all advanced psychiatry sub-specialties in spiral curriculum form, the knowledge, skills and attitudes of the medical psychotherapist will be distinct.

Dual CCT medical psychotherapy training

Dual training in medical psychotherapy with general adult psychiatry was ratified by the GMC in January 2012.

Dual training is five years in length and can be in an integrated or sequential model. The integrated or concurrent CCT model of dual training combines medical psychotherapy and the other sub-specialty, currently general adult psychiatry, underscoring the template of a new educational relationship which fosters an internal dialogue for the trainee between the two different paradigms of mind.

The blending of different ways of thinking in the context of an external dialogue for the psychiatry and psychotherapy trainers working across two training placements in the same week subverts the tendency to divorce psychotherapy from psychiatry.

Integrated dual training is a challenging model for the trainers and the trainee and while some Schools of Psychiatry offer integrated dual training others will use the sequential CCT dual training model initially.

One of the trainee doubts about dual training is that it potentially creates a two tier system in which single CCT training in medical psychotherapy is seen as inferior to or conversely superior to dual training.

Single CCT medical psychotherapy training

It is important to note that single CCT training in medical psychotherapy is still in the curriculum.
Psychotherapy Survey offered to and recommended by the chair of the College. Some have said well it would be a relief to get this out of the way. Concerns in the College have sought to formalise this Medical Psychotherapy leadership through the curriculum.

It is hoped the GMC requirement can help to draw a line under psychotherapy training in psychiatry does not require a Consultant Psychiatrist in Medical Psychotherapy to lead it. For this line to be drawn this needs to be in the core curriculum. However despite its being in the GMC action plan as a requirement (that is mandatory) and recommended by the chair of the Medical Psychotherapy FECC it was not submitted to the GMC because of funding concerns in the College.

The concerns of the College Curriculum and Assessment Committee chair are that there should be an explicit statement of the financial implications of the requirement of medical psychotherapy leadership in the curriculum as this is a concern NHS Employers have raised. It is hoped that this amendment, currently being discussed between the College Dean and the GMC can be proposed to the GMC in November 2013.

Medical Psychotherapy posts and the mind gap

The appointment of Consultant Psychiatrists in Medical Psychotherapy may be influenced by the UK Psychotherapy Survey and its clear exposition of the psychotherapy training delivery and the essential role of Consultant Psychiatrists in Psychotherapy in organising and leading psychotherapy training.

A strategic tension will lie in the appointment of Consultant Psychiatrists in Medical Psychotherapy solely to deliver psychotherapy training without a clinical context. The acceptance of this would over time erode the specialty of Medical Psychotherapy as without a clinical infrastructure the delivery of psychotherapy training would be taking place in a psychiatric vacuum. This is not an adaptive response to extinction anxiety.

It is essential to maintain and develop psychotherapeutic psychiatry clinically since without this developing clinical context psychotherapy training for psychiatrists becomes a marginal activity which defeats its purpose by reinforcing the peripheral position of psychotherapy in psychiatry.

Without psychotherapy the profession of psychiatry is impoverished; psychotherapy is the poetry to the prose of psychiatry. The loss of a meaningful clinical contribution embodied in the development of psychotherapeutic psychiatry would therefore contribute to the demise of psychiatry as a profession.

Following the GMC requirement for medical psychotherapy leadership filtering through the zeitgeist there are signs across the UK of some deaneries appointing consultant psychiatrists in psychotherapy for the sole purpose of fulfilling the psychotherapy training for core psychiatry trainees.

The survival of Medical Psychotherapy posts solely on the grounds of delivering psychotherapy training would help to write the obituary of psychotherapeutic psychiatry as it will serve to maintain the mind gap between psychotherapy and psychiatry.

The Mind Gap
Dr Henri Rey (1912-2000) was a consultant psychotherapist, a psychiatrist and psychoanalyst, at the Maudsley Psychiatric Hospital in London.

In the foreword to the collection of Rey's papers in the book *Universals of psychoanalysis in the treatment of psychotic and borderline states*, Dr John Steiner wrote the following description of 'the brick mother':

'Henri Rey has a special affection for the Maudsley, which he would refer to as 'the brick mother', and this is partly because of his gratitude for the shelter and opportunity it gave him early in his career. He saw how important the hospital was as a place of safety for patients who were afraid of breaking down, and that it offered a kind of continuity and stability. He also recognised that this kind of 'brick mother' could be cold and unresponsive, but this was often compensated for by his personal warmth and enthusiasm. In this setting, Rey was always reminded of the terrible suffering experienced by psychotic and borderline patients, and he remained distressed by patients for longer and in a deeper way than most of his hardened colleagues. Despite this personal involvement, or perhaps because of it, he was able to think about the problems his patients were facing, and to enlarge his understanding of the mental mechanisms they used.

He is one of the first analysts to have described the anxieties and the thinking of borderline patients, whom he has understood particularly well. He recognises that they find choices so difficult that they inhabit an area between the two alternatives. This is particularly true when issues of identity are involved. The borderline patient feels he is not fully male or female, neither large nor small, neither inside nor outside, but on the border between these states.'


Dr John Steiner is a retired consultant psychotherapist who worked at the Tavistock Clinic in London.

Dr Steiner, like Henri Rey is a psychiatrist and a psychoanalyst; he is a Fellow and Training Analyst of the British Psychoanalytical Society.