CHARLATANS AND 'GOLD STANDARDS': TRAVERSING THE MINEFIELD OF PSYCHIATRIC PSYCHOTHERAPY TRAINING

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BRIDGES TO WHERE?

An innocuous enough looking sentence in A15.6 Explanatory Notes, Medicare Benefits Schedule — 'that the RANZCP has undertaken to establish an appropriate mechanism to enable use of Item 319 by suitably trained psychiatrists' — appears to have led to a flurry of activity. Although psychotherapy is not specifically mentioned in Item 319, the assumption appears to have been made that we are facing the possible future regulation of intensive psychotherapy and psychoanalysis by accreditation of 'suitably trained psychiatrists'. This is a little surprising given that to be eligible for Item 319 a patient must not only be so severely ill that they score a GAF of less than or equal to 50 at the commencement of treatment but they must retain this severely impaired score throughout the treatment to retain eligibility for 319 benefits. Surely, this must exclude many if not most, for example, patients who are candidates for a psychoanalysis, who would be unlikely, on account of the continuing severity of their illness, to either tolerate or benefit from significant regression.

Nevertheless we now have a mountain of paper proposing a Faculty of Psychiatric Psychotherapy. A complex superstructure of compulsory training programmes in psychotherapy, bridging courses, a complex hierarchical administrative system of committees and subcommittees having the power to decide what course content, hours of supervision, possible hours of self-therapy or analysis will qualify a psychiatrist to be included or excluded in the category 'suitably trained'.

The haste towards a Faculty has been further spurred on by the decision of some non-medical psychotherapists and psychoanalysts to bury their differences through some kind of mutual self-accreditation process so that they will be in a stronger position to negotiate with Government for possible statutory recognition as an independent Psychotherapy Profession and receive financial benefits. This is occurring at a time when non-medical psychotherapies and particularly psychoanalysis are under intense scrutiny in terms of scientific validity, relevance to patient care and, most importantly, intense commercial pressure from an increasingly diverse proliferation of competing psychotherapy schools, theories and training programmes. The fact that these schools promulgate quite different theories and espouse conflicting practices and supervision standards, is conveniently buried in a self-serving mutual admiration of 'diversity' of training. However, by reaching agreement on the compulsory time that must be spent engaging in the various courses and supervision (provided naturally by the teachers at these institutions) they have created a captive market of therapists training or teaching trainees — what Hinshelwood [1] has referred to as a kind of 'pyramid selling'. All this being justified on the need to protect the public from untrained charlatans or protecting against the dangers of 'wild analysis'. Here we have a classic confusion between ethical standards, relatively uncontroversial, and training requirements, which are highly debatable.

Motherhood and apple pie pronouncements that we need to upgrade training in psychotherapy or create a Faculty of Psychiatric Psychotherapy sound plausible enough especially in an era of Managed Care where such psychotherapy training is viewed as increasingly obsolete and not affordable. However, the simplistic view that we must tack onto psychiatry a training course that vaguely resembles what non-medical psychotherapists and psychoanalysts believe is 'suitable training', but perhaps 'more so', that is, longer, more intensive supervision, or more theoretical content, is hardly justification for the increased burden of cost that such a psychotherapy training programme will impose on the health system.

Furthermore, by legitimising, by imitation, these non-medical training programmes, we will then place our own College programme in a broad psychotherapy training hierarchy based largely on the length and expense of training. The psychoanalysts, for example, will be able to claim, as they did in the UK [2], that because their training is the longest and most intensive, their training should be regarded as the 'gold standard' and be placed on the top of the training pyramid so that they might regain their once prestigious position in controlling psychotherapy training. However, this begs the question of what relevance,

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importing the highly restrictive, expensive and ideologically driven non-medical training and culture of psychoanalysis, for example, would have for improving patient outcomes.

A compulsory programme of rules, prescriptive practices and accreditation standards, that constitute 'suitable training', if embraced by our College, will inevitably lead to new medico-legal and clinical requirements for psychotherapeutic practice.

In the light of this, there has been a remarkable silence and dearth of any real debate or discussion about what constitutes 'suitable training' for psychiatric psychotherapy. It would appear that these matters are being decided either by trying to imitate the existing non-medical psychotherapy courses, by some kind of political manoeuvring, or by accepting the ideas of a few narrow ideologies. For example, no-one appears to have considered the possible negative effects on patient outcomes of various aspects of formalised compulsory training. 'Suitable training' to what end? Bridging courses to where? [3].

PSYCHOANALYTIC TRAINING ILLUSTRATES THE KIND OF PROBLEMS THAT CAN OCCUR

The major danger of setting up compulsory training, content and supervision requirements — as opposed to compulsory ethical boundaries and rules — is the premature stifling of clinical freedom, open questioning, and scientific, intellectual and philosophical debate about the many uncertainties in understanding the role of psychotherapy in psychiatric treatment. The danger is that we set up courses that are effectively indoctrination into a particular ideology, which create a power structure of authority, rather than an exploratory structure for dialogue and open-ended questioning.

There is indeed broad agreement among experienced psychotherapists that, while there are useful techniques that one accumulates over a career that work for the individual clinician, there is no overarching body of knowledge that has any absolute scientific or philosophical authority. Psychotherapy is highly inter-subjective and the clinical outcome depends far more on the empathic abilities of the therapist (which may be largely innate), the maturity and wisdom of the therapist gained over a lifetime from many sources (including personal experience), the kind and severity of the problems of the patient, the patient's motivation, the particular patient–therapist match, and perhaps to a small degree on the appropriateness of the formal techniques used. Numerous scientific studies have repeatedly supported this view (see below).

Psychoanalytic training illustrates the problems that can occur in so-called training programmes. Szasz [4] has argued that 'while "requirements" regarding training have always been put forward in the name of scientific advances, the steady alterations in the [psychoanalytic] training system, cannot be understood without due attention to certain socio-political considerations.' For example, 'As the novelty of psycho-analytic theories began to wear off and as these theories were increasingly "incorporated" into general psychiatry, both the *exclusiveness* and the *power* of psycho-analysis (as a social organisation) came to reside in matters related to training.'

Balint [5], in a paper commenting on the remarkable increases in length of psychoanalytic training, described psychoanalytic training as follows. 'The whole atmosphere is strongly reminiscent of the primitive initiation ceremonies. On the part of the initiators — the training committee and the training analysts — we observe secretiveness about our esoteric knowledge, dogmatic announcements of our demands and the use of authoritative techniques. On the part of the candidates, i.e. those to be initiated, we observe the willing acceptance of the esoteric fables, submissiveness to dogmatic and authoritative treatment without much protest and too respectful behaviour.'

Compulsory training brings with it power to those in control. There is much within psychoanalytic training that resembles indoctrination or brainwashing. Psychoanalytic training organisations contain strict hierarchies and lack transparency, more resembling churches than academic organisations. The history of psychoanalytic training is one of fragmentation and division, with the notable expulsion of dissident members, the formation of competing 'schools' dividing up the market place by emphasising their differences, and worshipping different founding gurus. Those who disagree with the doctrines are disparagingly referred to as unanalysed or incompletely analysed or deprecated in psychological or pathological terms as 'resistant' or as being 'neurotic'.

These observations are hardly new and explain why psychoanalytic training has remained largely outside of the province of academic institutions. As early as 1927, Dr Fishbein, editor of the Journal of the American Medical Association, wrote [6] 'The Freudian school will not recognize the status of any one in psychoanalysis unless he has himself been through the procedure with Freud or his immediate lieutenant. The great apostle is himself the founder of a school of which he is the despotic head. It is asserted, as it has often been asserted by many charlatans in other fields, that this is to protect the method against quackery. On the other hand, a scientific method is able to stand any type of study or investigation. The psychoanalysts insist, as do all cultists, on an "all or nothing" policy.'

To this day significant dissent is disallowed within the training programmes of psychoanalytic organisations [7].

WHERE IS THE SCIENTIFIC EVIDENCE FOR TRAINING?

Evidence for the effectiveness of psychotherapy (of which there is a great deal) is not the same as evidence for the value of psychotherapy training. Indeed it is quite plausible that a psychotherapy outcome is determined by four major factors: the personality, maturity and empathic ability of the practitioner; the specific characteristics of the personality and illness of the patient; the specific patient–therapist match; and finally the specific techniques used in the treatment. Whether the so-called specific versus non-specific factors are more relevant is a matter of great debate and the evidence for the significance of training is minimal.

For heuristic purposes in considering an overview of the scientific literature regarding the effectiveness of training, one can consider a spectrum. At one end we can place the recent trend towards 'packaged psychotherapies for specific disorders,' that is cognitive, behavioural and directive, and other short term psychotherapies where therapists may follow a printed manual and undergo specific training to learn the rules of the treatment. These treatments are usually aimed at particular symptoms such as phobias and depression. They usually do not require very long periods of training to be practised effectively. At the other end of the spectrum we can place non-directive, long term insight-oriented and supportive psychotherapies which tend to deal with the more complex, chronic, severely ill, and personality disordered patients, and where the developing therapeutic relationship between patient and therapist is more important.

Beutler [8,9], who has conducted the most comprehensive and extensive review of the scientific literature, has concluded that while the research is somewhat methodologically inadequate 'the preponderance of empirical literature on therapist experience and training fails to show a remarkable benefit for experienced and highly trained therapists…'. Beutler [9] points out that 'some therapists are consistently effective while others are quite consistently ineffective, regardless of the type of treatment practiced.' He cites a study [10] which found that 'fully one third of outpatient therapists in training produced as many negative effects as positive ones, independent of the type of therapy utilized or years of training. Other therapists

were uniformly effective with virtually all patients.' In their assessment of the literature Christensen and Jacobson [11], found that most studies did not support differences in effectiveness between trained professional and untrained paraprofessional therapists. Berman and Norton [12] in their analysis of thirty two studies, also found that 'Studies comparing professionals and paraprofessionals have not found substantial differences in the effectiveness of these two groups of therapists.'

Stein and Lambert [13] in their review found some modest but consistent effects for training in patient outcome. They noted that more experienced therapists tended to be able to keep their patients in therapy significantly longer. They found that 'novices can be trained in relatively brief periods of time to provide certain circumscribed, behavioural treatments for specific problems, producing outcomes similar to those found in the literature generally' [14].

There is little known about the potential negative effects of psychotherapy training, although this is an area that has been recommended for research [15]. A longitudinal study of trainees' counselling outcomes [16] found a negative effect from training in family therapy. When post-therapy family satisfaction was measured, it was lower for trainees conducting family therapy after two years of training than after one year of training. One of the speculations [13] about possible explanations for this poor outcome was 'therapists' growing preoccupation with therapy models and "technique" at the expense of personal attributes such as warmth and spontaneity, etc.' At least one study has found a negative effect for supervision. Sandell [17] writes 'Apart from complications created by parallel and reflection processes, the therapist may be caught in confusion, inhibition, evaluation apprehension, and other antieffective states by the fact that he is being supervised.'

In a recent review Lambert [18] found that 'therapist empathy, rather than technique was by far the best predictor of outcome.' He believes that 'Outcome is largely determined by patient variables rather than by the therapist or therapy.' Better outcome is predicted by patient measures such as indexes of severity, chronicity, and complexity of symptoms; motivation; acceptance of personal responsibility for change; and defensive operations. This may have particular relevance for interpreting the outcome of psychiatric psychotherapy where the most complex and severely ill patients are being treated.

There do appear to be differences in what is required for effective training for the short-term versus the long term psychotherapies. When it comes to short-term interventions it appears that 'those with psychodynamic philosophies tended to become less effective...with experience' [9]. It appears it is more difficult to retrain experienced therapists to follow the short-term directive therapies and that 'at least among dynamic therapists, those who initially are the least flexible and empathic may be the easiest to train in the use of manualised interventions' [9]. A body of research is developing to suggest the effectiveness of 'systematic, manual guided training'. However, manualised training may decrease therapists' relationship skills and supportiveness. Henry et al. [19] in their study of a manualised training program, found that to maximise positive effects one should select relatively less experienced therapists as 'therapists with extensive previous supervision are more resistant to training in manual-guided therapy'.

Garfield has written a thoughtful critique [20–22] of so-called empirically 'validated therapies', which generally implies the 'manualization' of therapy, with manuals specifying and standardising treatment and encouraging uniformity by practitioners, such therapies being then amenable to statistical research and able to show positive results. He argues that this kind of research ignores very important therapist and patient variables. Citing Luborsky [23] who 'found the size of the therapists' effects generally overshadowed any differences between different forms of treatment in these investigations.' He argues that instead of trying to reduce therapist variability in research on psychotherapy, we 'should intensively study those therapists who consistently secure the best results and attempt to discover those therapist variables and therapy interactions that appear to be linked to superior outcomes' [22]. He points out the likely importance of such variables as patient–therapist complementarity, and therapist variability based on creative thinking and judgement. He believes that 'For whatever reasons, many people have tended to get emotionally involved and identified with one particular orientation. Consequently, … it is not surprising that evaluations of specific types of psychotherapy become the predominant approach to research on psychotherapy outcome.' [21] Garfield believes more research should be devoted to examining individual therapist differences rather than to which 'school' they belong.

The question of whether personal psychotherapy should be a part of training has been reviewed and the results again found to be inconclusive. Most of the studies reviewed [8] failed to show any relationship between patient outcome and whether the therapists had or had not experienced personal therapy. One study [24] suggested that trainee therapists who had or were receiving psychotherapy may evoke deleterious effects among their clients.

We can conclude that the beneficial effects of psychotherapy are probably highly determined by complex factors relating to individual psychotherapists, the specific patients they are treating and the nature of the therapist–patient match and that there is, at present, little scientific evidence for the usefulness of formalised compulsory training. Short term and directive therapies such as cognitive and behavioural therapies probably can be taught better to relatively inexperienced psychotherapists who are more likely to stick to the manualised scripts.

WHAT ARE THE USEFUL THINGS A FACULTY MIGHT PROVIDE?

In the face of the scientific evidence it is difficult to justify the expense of a Faculty of Psychotherapy. However, if such a Faculty were to go ahead, it is important that it not have a detrimental effect on patient outcome. A helpful Faculty would need to be inclusive, flexible, non-dogmatic, research oriented, open to questioning and containing a strong section of philosophical and theoretical psychiatric psychotherapy to continually examine and question the fundamental underpinnings of our work. We must accept the very high degree of uncertainty inherent in our work. Indeed the training in psychotherapy needs to mirror the practice of psychotherapy which tries to create a safe space in which difficult and threatening questions can be openly examined.

The two greatest external challenges to psychiatric psychotherapy both relate to the loss of concern for the individual in treatment. First, economically imposed time limitations that prevent the development of a genuine long-term therapeutic relationship and, second, the transformation of all psychiatric psychotherapy into a series of contrived, manualised, rigid, behavioural techniques. A useful College Faculty may be able to argue against these developments.

The Faculty needs to be clinically based on the medical needs of our patients and not be modelled on any particular theoretical framework. From this perspective the whole issue of Faculty chapters, such as family, psychodynamic and behavioural, makes little sense. It would be far better to organise seminars, supervision and experiential learning experiences in an integrative way around particular clinical problems and diagnoses. Given the individuality and subjectivity of our work, the training programme should facilitate each trainee developing their own way of working effectively with patients.

How could a Faculty go about doing this?

1. Provide exposure to a wide range of theoretical ideas and clinical approaches that may be useful in treating clinical problems, without any adherence to any particular dogma. An open Faculty would welcome ideas from all sources and subject them to clinical, philosophical, ethical, theoretical and scientific scrutiny.
2. Provide supportive peer, experiential and supervisory experiences for therapists working with clinically difficult and often psychologically demanding patients in an open, questioning environment. The experience in non-medical, particularly psychoanalytic, training programmes is that compulsory requirements and assessment inhibit open and honest discussion. This problem could be addressed by limiting external assessments and focussing more on providing a nurturing educational environment.
3. Provide a political body to fight for the rights of psychiatrists to have sufficient time and resources to treat their patients in a psychotherapeutic way and to resist the current scientistic pull to 'manualisation' of all psychotherapy.
4. Develop both an outstanding research programme and a high quality philosophical and theoretical programme to advance the field of psychiatric psychotherapy without lapsing into unquestioning scientism or unquestioning ideology.
5. Develop a significant programme in ethics to address many of the common and complex ethical dilemmas that arise in the clinical therapeutic relationship.
6. Help integrate psychiatric psychotherapy into the broader range of psychiatric treatments for the best clinical outcome for individual patients.

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