

Establishing psychiatric registrars' competence in psychotherapy: a portfolio based model

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Abstract

During most of the latter part of the last century, South Africa has followed international trends in the training of psychiatrists. Training programmes have become increasingly focused on the neurobiological aspects of psychiatric disorders with less attention being paid to psychotherapy. This is consistent with developments in psychiatric research. In the clinical arena this manifests as a focus on pharmacological and medically based interventions and a resulting relative inattention to non-pharmacological interventions, most especially psychotherapy. In an effort to address this imbalance there has been an international initiative, over the past two decades, to establish an acceptable level of competence in psychotherapy in the training of psychiatrists. A South African programme is needed that can take account of international trends and adapt them for the local context. In order to produce a programme for establishing competence in psychotherapy for psychiatric registrars at the Nelson R. Mandela School of Medicine, the authors examine directives for the development of psychotherapy skills from international regulatory bodies for graduate medical training and their application. Defining and setting preliminary standards for competence is emphasized. A programme based on five core psychotherapy components using a portfolio based model to facilitate learning and assessment of competence in psychotherapy, is proposed.

Keywords: Psychotherapy training; Portfolios; Competence

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Introduction

Psychiatry, one of the first medical specialties to be recognized, literally means "healers of the spirit" and has stood apart from other specialties that minister to the body alone. Psychiatry incorporates relevant knowledge and skills from the behavioural sciences with the biological sciences for the purpose of implementing a comprehensive approach to patient care. Factors that distinguish the psychiatrist from the non-medical mental health worker is the overriding responsibility to help the whole patient, training and expertise in comprehensive (biological, psychological, social) evaluation and diagnosis, and training and expertise in a number of treatment modalities.¹ Acquiring expertise in psychotherapy is

therefore central to the professional development of a psychiatrist to maintain this distinction.

Radical shifts in the systems of explanation or paradigms used by psychiatry to conceptualize mental illness have taken place over the 20th century.² Biological explanations for mental illness have been rapidly replacing, rather than complementing, the social and psychological-analytical models of the mid-part of the century. Concomitantly, the discovery of psychopharmacological agents has ushered in new treatment paradigms which threaten to erode the 'holistic' banner that once distinguished psychiatry from the other specialties. This 'biological boom', together with managed care and the pressure to provide evidence and outcomes based treatments, has significantly influenced the clinical practice of psychiatry. There has been a continuous fascination with biological explanations and interventions for psychiatric disorders resulting in publications concerning psychotherapy and psychoanalysis being sparse.² Similar major forces have shaped psychotherapy training programmes during the past

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two decades viz the burgeoning of neurobiology and its applications to psychiatry, the impact of managed care on psychiatrists' practice styles, and the need to demonstrate accountability in a quantifiable manner.³ Both the intensity and duration of registrars' experiences in psychotherapy has also been noted to have diminished.⁴

Postgraduate training in all medical specialities faces considerable difficulties. These include high service demands competing for 'academic' time, the constant drain of experienced staff to the private or overseas market, staff shortages and reduced time for supervision. However, psychiatric training, which of necessity includes training in psychotherapy, has unique training requirements. Whilst biological psychiatry could be characterized by the principle of linearity (cause and effect) and is goal-oriented, psychotherapy has much more to do with circularity and is process oriented. Both principles are inseparable and training must always consider both of these. The ideal model should ensure appropriate training that honours evidence-based practice and simultaneously affords the opportunity for both formative and summative learning to take place and be assessed. Furthermore, it should be adaptable to local resource constraints whilst embracing the need and challenge to train specialists to practice within a multicultural and multilingual society.

International Trends In Training Psychiatrists In Psychotherapy

The World Health Organisation (WHO), along with the World Psychiatric Association (WPA), in the Atlas series, report that, of the 73 countries surveyed, 'training in psychotherapy' was reported by two thirds of low income countries compared to the almost four fifths of high income countries.⁵ However, this says nothing about the quality or quantity of training received. An interesting comparison is made between psychotherapy training in Switzerland and Uganda. In the former "psychotherapy" occupies a central place in the curriculum. The residency programme stipulates a 3-year training in one of three recognized models and the requirements consist of attending psychotherapeutic courses, attending 125 hours of supervised training and of developing self awareness in psychotherapy." In Uganda, one semester is dedicated to limited psychotherapy training at postgraduate level. In the latter programme registrars are introduced to theories but are not given training in each of them due to the lack of trained professionals.

An examination of international trends revealed that regulatory bodies in other parts of the world (United States, UK, Australia) require psychiatrists to be trained in psychotherapy but did not specify how it should be taught or assessed. As a result, universities are left to design strategies for implementation with minimal direction from regulatory bodies.^{6,7,8}

In 2001, the United States' Residency Review Committee (RRC) regulated that registrars in psychiatry had to be competent in five modes of psychotherapy before they could qualify as psychiatrists.⁹ Whilst competence is stipulated, there are no specifications on how this should be achieved. Various programmes have implemented this in different ways and defining a level of competence appears to be at the core of establishing programmes.¹⁰

The Royal College of Medicine, UK, stipulates five basic requirements for Part One registrars in their psychiatric training. The implementation requires the appointment of a co-ordinator for psychotherapy training on rotational training schemes, who will normally be a consultant psychotherapist. Psychotherapeutic skills are part of the educational contract. Supervision is provided by a consultant psychotherapist with the assistance of specialist practitioners, with whom formal arrangements are made. The use of logbooks is also a requirement and it is mandatory to fulfil specified objectives in order to enter the MRCPsych Part 2 examination. The latter involves a largely theoretical understanding of the description and explanation of various modes of therapy and its application to specific disorders.⁷

The Royal Australia and New Zealand College of Physicians (RANZCP), amongst other requirements, recommend that the trainee should, by the completion of basic training, be able to formulate an individual's psychological issues in terms of basic developmental principles, assess and describe an individual's personality functioning, relationship style, adaptive and maladaptive or defensive behaviours. They should also appropriately integrate the psychological therapies with biological elements and demonstrate an understanding of the psychotherapies in terms of their historical development, theoretical underpinnings, research base and outcomes. During advanced training, trainees on this programme are required to "further develop and integrate psychological aspects of management into clinical practice." One hour a week throughout the two years, for at least 40 weeks of each year of advanced training, should be devoted to the provision of formal psychotherapy (of any modality) to a number of different people. "At least one hour per month must be spent in individual or group supervision of these psychotherapeutic experiences."⁸

The College of Psychiatrists of South Africa (CMSA) recommends that "assessment should occur throughout training, especially for disciplines such as psychotherapy". The responsibility of determining the curriculum and required core knowledge is entrusted to each Department of Psychiatry. Before entering the FC Psych(SA) Part II, candidates have to obtain a Certificate of Training from their department which contains a record of satisfactory psychotherapy training (at least 3 case histories must be documented). Trainees are required to keep logbooks in which psychotherapy case histories and other practical experience is recorded. Trainees are to be supervised by a senior clinical psychologist or psychiatrist who is responsible for ensuring that the trainee fulfils the requirements. The departments of psychiatry are to assume responsibility for this. For admission to the Part II examination the candidate must, amongst other requirements, have submitted a Certificate of Training to the CMSA in which 3 histories of psychotherapy cases and descriptions of practical experience are certified by the head of department as being adequate. The candidate must also present evidence of having gained satisfactory supervision in, amongst other necessary fields, psychotherapy.¹¹

Regulatory bodies' specifications for training in psychotherapy suggest an acknowledgement of the relevance of psychotherapy to the practice of psychiatry. Generally the implicit objective seems to be that an acceptable level of competence should be established. However that degree of

competence is not specified and the concept of competence in psychotherapy warrants some discussion before a programme purporting to produce competent practitioners of psychotherapy can be designed.

Competence In Psychotherapy

The Oxford dictionary describes competence as 'having the necessary skill or knowledge to do something successfully; satisfactory though not outstanding' while proficiency is defined as 'competent or skilled'. This is, however, of limited use in the context of psychotherapy skills. Master therapists are proficient in a particular form of therapy. Proficiency takes years of practice over time whilst trainees on psychiatric programmes may achieve varying degrees of competence.¹⁰ It has been suggested that competence is contextually defined and dimensional rather than dichotomous.¹² "Competence" signifies some degree of familiarity, achievement and proficiency, perhaps in the range of "good enough" It can be described as basic knowledge and sufficient clinical exposure, resulting in the registrar being clinically comfortable with each form of psychotherapy. Simply put, proficiency implies mastery or expertise and competence implies adequacy.

In psychotherapy, it is difficult to define the therapist's precise level of skill since it involves various choices and "micro-procedures" inextricably linked to unique patient factors and interpersonal manoeuvres.¹³

Psychotherapeutic skills are also not easily quantifiable, although efforts are being made to do so following of the RRC specifications.^{11,12} A contributing factor is that many types of psychotherapy are not yet evidence based so that it has not been possible to operationally define what level of skill is "good enough" in these psychotherapies. The issue of what level of skill qualifies a clinician to practice clinically is one that occupies the attention of authors and clinicians who are involved in the training of doctors.^{9,10,13}

Given this background, it is inevitable that those responsible for training registrars in psychotherapy are posed with major challenges. How much training is needed? How should it be done? How should it be assessed? The introduction of the RRC requirements for competence in psychotherapy introduced a flurry of discussion and debate in the US on how to teach registrar psychiatrists to be competent in the five specified forms of psychotherapy in the United States and how to assess that it had been done. In South Africa, future registrars will be required to show competence in five different forms of psychotherapy (psychodynamic, systemic, CBT, group and supportive therapy). The Mc Master University psychotherapy programme, for example, has focused on establishing a level of competence first, intending that future experience will direct the registrar towards specialization and, eventually, proficiency.¹⁰ Formative or intermediate levels that have to be mastered on the way to summative levels should be specified in training, to ensure that the essential formative levels have been attained, leading eventually to competence.¹²

Internationally there has been a move to competence rather than proficiency in the training of psychiatrists.¹² Factors that possibly influence this trend include:

- The recognition that the biological boom in psychiatry has necessitated that more time be devoted to biological aspects of psychiatry in training programmes. Practically

speaking, psychiatrists cannot be experts in a specific form of therapy, requiring years of training, as they were in the past.

- There has been a departure in psychotherapy in general, from long term insight oriented therapies to more brief and evidence based therapies. Psychotherapists generally tend to utilize more than one form of therapy.
- Different forms of psychotherapy have been shown to be effective for different conditions, e.g. Cognitive Behavioural Therapy for depression. It would therefore be prudent for the psychiatrist to be a 'Jack' (competent) of a few psychotherapies rather than a master (proficient) in one.
- As biological aspects of treatment consume increasing amounts of time, all some psychiatrists might choose to want to know about psychotherapy is to recognize which patients would benefit from which type of therapy and when to refer to a specialist psychotherapist.
- An eclectic approach may be more pragmatic and lend itself better to the practice of psychotherapy in a setting of limited human resources and a multicultural client base whose needs may vary considerably.

It would therefore be prudent for programme directors to define; at the outset the expected level of skill required to be considered competent before embarking on labour intensive and time-consuming programmes. Competence is usually specific to delivering a particular treatment. It assumes adherence to specific techniques and a good working alliance. In psychotherapy, this implies a good understanding of theory, the treatment outcome literature, and the maintenance of professional behaviours.¹⁰ As it is not possible for registrars to achieve this level of proficiency within the course of the training programme, considering the demands of training, service load and time constraints, the solution would be to establish a predetermined level of competence (summative competence) that the programme co-ordinators want to achieve, together with benchmarks for achieving it (formative competence).^{14,15,16} Whether this means that, at the end of the programme, the registrar is able to practice psychotherapy to a specified level acceptable to experts in the area, or merely have a theoretical understanding and refer appropriately to an expert, will be determined by the individual programme. Whilst for certain forms of therapy such as CBT, it is relatively easy to structure and determine a level of formative competence, others such as psychodynamic therapy, would prove more challenging.

The training programme could be divided into modules, each dedicated to a particular mode of therapy. At the end of each module a registrar should be able to:

1. Know the indications for each mode of therapy
2. Formulate or conceptualise cases using each form of therapy
3. Meet the formative level requirements set by each expert co-ordinator to achieve competence in the particular form of therapy
4. Develop a therapeutic alliance in each case

Creating the conditions necessary in training to establish a level of competence in psychotherapy may involve including a wide range of teaching methods which impart the theoretical knowledge and opportunities to practice on real patients

whilst being observed and evaluated by experienced practitioners. A favoured method in psychotherapy teaching is watching recordings of master therapists or faculty members practicing the particular form of therapy being taught. Whilst a student's acquisition of elemental skills involved in the practice of psychotherapy may lead to competence, this does not necessarily imply that observing these elemental skills is an effective way of measuring or achieving competence.¹⁷

Assessing Competence

Having defined the desired level of competence, the remaining challenge for any programme is to employ methods of assessment that respect the "spirit" of psychotherapy, that captures both the art and science of the practice, taking into consideration the multidimensional, multi-faceted, sometimes nebulous nature of the psychotherapeutic context and relationship. A variety of methods can be used to assess competence. These include 360-degree questionnaires, patient surveys, OSCEs, observation of real or simulated patient interaction and portfolios.¹⁸ The goal of assessment in medical education remains the development of reliable methods of assessing student performance which, as well as having predictive value for subsequent clinical competence, also has a formative educational role. One option may be to base the assessment of competence on the demonstration of basic knowledge and sufficient clinical exposure for the trainee to begin to feel comfortable with psychotherapy.³ Of all the available methods that can be used to assess the level of competence attained by registrars in psychotherapy training, portfolios conform to this goal most authentically.¹⁹

Portfolios

"A collection of material, made by a professional that records, and reflects on key events and processes in that professional's career".¹⁷ The focus in portfolio compilation is to collect material that illustrates that learning has taken place and not merely that evidence has been gathered. To this end it is necessary that the students show that they have engaged with material and reflected on the content as well as having engaged in self reflection during the process of learning.

Portfolios lend themselves well to training in psychotherapy. Portfolio based learning is a method of encouraging reflective learning for professionals and although still in its infancy as a tool for professional development, in many ways may be considered the ultimate educational tool for good practice in adult learning.²⁰ The learner takes responsibility for the portfolio's creation, maintenance and presentation for assessment. It is based on a model of self-directed learning where the learning derived from any activity is determined more by the learner than the person who designed the activity. This calls for creativity, initiative and self awareness on the part of the learner, attributes that are particularly relevant to training as a psychotherapist.

Portfolios can contain any or all of the following:

- Clinical case records,
- Process notes of therapy sessions
- Self-assessment material
- Patient feedback,
- A reflective diary/journal
- Schedules of formal lectures/tutorials/workshops

attended/literature-books studied

- Notes from supervision sessions
- Notes on routine or unusual clinical encounters that offered windows for learning
- Audio-visual recordings of therapy session

The material in a portfolio can be used in several ways:

1. As a method of personal development and a way of tracking progress. Material collected would include a reflective journal to which the learner could commit thoughts and feelings. While the portfolio is the practical and intellectual property of the learner, an effective network of tutors and mentors will be important in determining the effectiveness and success of the system.
2. As learning tools to stimulate discussion and to plan future learning. While a reflective journal can be therapeutic and a guiding tool, real and challenging reflection requires the involvement of another person viz a mentor, tutor or trainer to provide a framework for the support of the learner and the learning process. This is typically called a learning portfolio.
3. As a formal/summative assessment tool, portfolios are attractive and allow for the assessment of the application of theory as well as practical skills. The requirements and contents of the portfolio would however have to be tailored to meet the purpose for which it is to be used.²¹

The benefits of using portfolios in adult learning and assessment is that autonomous and reflective learning based on real experience and practice which helps the learner make the connection between theory and practice, is recognised and encouraged. As an educational tool portfolios are highly flexible and can accommodate a range of learning styles. Portfolios allow for assessment within a framework of clear criteria and learning objectives. Learning from different sources can be considered. Portfolios can also provide a process for both summative and formative assessment and a model for lifelong learning. The educational rationale for using portfolios is that programmes should be interactive, include reflective components and be related to experience.^{20,21} Portfolio based learning incorporates all of these components. Adults enter into a learning context with a background of learning based on their own experiences. Arguably, the need to integrate the personal experiences of the learner with the learning process is essential and unique to psychotherapy training and will be discussed later.

Portfolios encourage students' interaction with supervisors, with their educational material through the reflective journal and, with their clients. Portfolios offer a mix of deep and surface approaches to learning. Surface approaches adopt rote learning of facts and their reproduction when required. Deep learning is characterised by learners trying to understand underlying principles, ideas and concepts and to interpret these in ways that have personal meaning. Portfolio based learning can incorporate all the key characteristics that facilitate and promote deep learning through recognizing that a learner's motivation is intrinsic, actively involving learners in their own learning, allowing opportunities for exploratory conversations and approaching knowledge as a series of integrated wholes and related to other knowledge, rather than presented in small separate wholes.²⁰

Portfolios in Psychotherapy Training

The strengths and merits of a portfolio based learning model lends itself particularly well to the challenges posed by psychotherapy training. The practice of psychotherapy is multidimensional and demands a lateral rather than vertical thinking approach from the practitioner. Leaps in thinking that do not follow the traditional vertical logical processes of understanding need to take place. These processes are not easily observable and even more complicated to assess. The assessment of competence in psychotherapy should be based on multiple sources and multiple methods to compensate for the tendency in supervision to minimize problems and emphasise successes. Multiple sources and methods of assessment may also be a solution to the problems of assessing the enigmatic nature of some of the issues in psychotherapy.¹⁰ For example: "At what point has the therapeutic alliance been adequately established?" A portfolio is also one of the best tools for combining teaching with assessing continuity of care concerns that are central to psychotherapy.^{10,19}

The content of the portfolios does not have to be standardized since the purpose is to demonstrate individual learning gains relative to individual goals. This is ideally suited to the context and conditions under which psychotherapeutic skills are acquired. Each individual case that registrars encounter will have a high degree of distinctiveness as compared to cases in other medical specialities as the combination of psychosocial circumstances in each patient is unique. Any form of assessment that does not account for this is likely to encounter problems. Portfolio compilation requires not only that the person performs the work in question but also explains why the work is done in that particular manner.¹³ To use the language of psychotherapy the trainee is not only required to present the content of what has been learned but to describe the processes involved.

The teaching and learning benefits of using portfolios is as follows¹³:

- Recording is not restricted to knowledge of the facts of the case but includes how the registrar grappled with the understanding the relationship between the persons/patient's contextualized problems and specific psychotherapeutic theories, along with their associated technical treatment strategies
- Registrars would demonstrate that they selected and conducted the course of treatment according to their assessments and understandings
- As a supplement to the portfolio, registrars could be asked to analyse video tapes of the different forms of therapy as a means of sifting out those more discerning students from those who are unable to pick up on nuances and complexities of thought.

Reflective Practices In Psychotherapy Portfolios

The human aspect is central to psychotherapy. It is essential that a competent psychotherapist engage in self exploration to adequately appreciate the patient's condition and empathise with the patient's experience. Therapists must be able to be conscious of their own life experiences, both positive and negative, in order to be able to relate to what patients experience. Assessing this skill in aspiring therapists is

challenging and it has been suggested that its' measurement lies in the area of therapeutic alliance building and basic counselling skills, both of which are common to most forms of psychotherapy.²²

Therapists should be willing to remain open to their own growth if their clients are to believe in them and the therapeutic process. The maintenance of a reflective journal can be a useful tool contributing towards the personal as well as professional growth of the student. To ensure that the journal serves its desired purpose, ground rules should be established at the outset as to ownership and access. The learner should be allowed to control who sees the journal so as not to limit the degree of personal revelation and hence defeat the ends of the exercise. The learner has the prerogative to choose what material she wishes to discuss and disclose. The journal need not be extensive, as time constraints would ensure the failure of the exercise. It does however require some discipline in committing thoughts to paper and would often entail a few minutes of jotting down after contact with a patient. The exercise encourages learners to reflect on what they are doing, question why they are doing it, identify difficulties and rewards and help in planning the way forward. Journals also offer the opportunity to "bridge" between sessions, something that busy clinical practices do not allow time for. These journals, while tracking the learning process, simultaneously track the personal growth and development of the learner.²⁰ This process has the additional benefit of allowing the therapist to inculcate a habit of being an 'external observer/critic' of the therapeutic interaction- an important step towards the development of a meta-cognition which is an important skill in the practice of psychotherapy.

Portfolios as Assessment Tools

The teaching and training of psychotherapy pose unique challenges. Consequently the assessment is not easily managed through traditional methods. Assessment is an essential component of any educational and training programme and should fulfil several purposes. Some of these are to provide feedback to and motivate learners to consolidate learning, to help learners to apply abstract principles to practical contexts, to classify or grade progress, to give teachers feedback on how effective they are at promoting learning and to provide statistics for internal and external agencies.²³

The strength of portfolios lies in their capacity to provide feedback to learners, in helping them to define their strengths and weaknesses, in providing evidence of achievement towards set learning objectives and in motivating learners and facilitate a positive attitude to lifelong learning.²⁰ Using portfolios allows students to focus on individual qualities and receive direction from supervisors on this in the context of their unique learning. There is significant potential for idiosyncratic learning and skill acquisition. There is more intensive interaction between teachers and students. The parallels between the therapist-patient and teacher-learner encounters in themselves add an added dimension to the benefits of portfolio based learning. The teaching process and methods have been highlighted as being important in ultimately influencing professional behaviours.²⁴ Reflective ability, apart from its central significance in the context of the practice of psychotherapy, is increasingly being identified as a

PORTFOLIOS CONTRIBUTION TO ASSESSMENT²¹

1. They allow for the assessment of learning outcomes including those not easily assessed by other methods viz. personal growth, self-directed learning, reflective ability, self assessment and professionalism. These are outcomes that have particular significance for the training of psychotherapists.
2. They provide for the collection of evidence of performance from a range of sources.
3. They provide evidence of student development over time as opposed to getting a 'snapshot' at a point in time as traditional assessments usually yield.
4. They allow assessment of progress towards the learning outcomes by using chronological work samples collected at different points of time.
5. They lend themselves to formative and summative assessment.

key component of medical professionalism.²¹ Portfolio work assists the development of complex skills required for clinical work and encourages a holistic and integrative approach to medical practice.²⁵

Formative assessment allows learners to set their own learning goals, determine how they will be met and gather evidence on whether and how they have been met. Feedback is arrived at through self-appraisal or through scheduled meetings with teachers. Conversely, with summative assessment someone other than the learner assesses the presented portfolio. The portfolio would have to then be measured against predetermined learning goals or at least around a stipulated broad framework.

The University of Kwa-Zulu Natal (UKZN) Psychotherapy Training Programme

The approach proposed is essentially portfolio based. This is a departure from the CMSA proposal which requires the registrar to maintain a logbook and collect expert/consultant signatures to confirm "that basic therapeutic skills are mastered adequately" and that the student has "participated adequately" on courses in the different forms of psychotherapy". The concept of a logbook is an attempt towards formative assessment but does not, in the opinion of the authors, quite cover the needs of psychotherapy training in the form proposed by the CMSA. Logbooks are a recording of the occurrence of an event as confirmed by an expert but does not document the process of the acquisition of knowledge and skills. The latter is critical in psychotherapy as the process of learning is as important, if not more so, than the outcome in this context. Arguably more is learned from discovering what does not work as opposed to what does work. The identification and negotiation of "failures" in the process of learning to become a psychotherapist would be captured in a reflective journal or in feedback sessions with the supervisor. These are defining moments in the journey of learning, which logbooks, in their proposed format will not capture. Logbooks are restrictive, as they prescribe limits. They do not allow for the student to explore their personal experiences within the learning process. A focus on 'collecting signatures' can suppress or even discourage creativity, flexibility, initiative and spontaneity- attributes that are desirable in a competent therapist.

The UKZN programme has just been introduced and is in

its first year of implementation. The programme commences with Part One registrars being taught theoretical concepts whilst part two registrars concentrate on practical application. At the beginning of the practical component of the course, registrars are introduced to the concept of portfolios and their application in the context of training in psychotherapy. Five psychotherapeutic modules are introduced within the course of an 18 month to two year period. "Basic Counselling Skills" is the first module and incorporates micro-counselling techniques and establishing the therapeutic alliance. This module was included as its content forms the basis for all types of psychotherapy. Module two, "Supportive therapy," builds on skills encountered in Module 1 and extends these to incorporate various situations and conditions under which they can be applied. "Cognitive Behavioural Therapy", "Family and Group Therapy" and "Psychodynamic Psychotherapy" are the remaining three modules and include theoretical foundations and practical application of each of these modes of therapy.

At the beginning of each module a workshop is presented by a psychotherapist/s with experience in the particular form. Compulsory pre-workshop readings are provided, and theoretical teaching at the workshop is kept to a minimum. In the latter three modules students watch videos of master therapists or experienced psychotherapists practice the techniques and then have the opportunity to practice in the group setting with peers. Practical exercises are given by the psychotherapist/facilitator and observed, with feedback given by both peers and the psychotherapist. During the workshop, questions and areas of doubt are clarified and students are given the opportunity to practice the approach and techniques with colleagues and under the supervision of the facilitating psychotherapist. In some cases, group work in the session includes formulation of practice cases to help bridge the gap between theory and practice.

At the end of each module the registrar should be able to:

1. Develop a therapeutic alliance
2. Know the indications for each mode of therapy
3. Formulate or conceptualise cases using each form of therapy
4. Meet the formative level requirements set by each expert co-ordinator to achieve competence in the particular form of therapy

Whilst some forms of therapy such as Cognitive Behaviour Therapy are relatively easy to structure and determine the required level of formative competence for, other such as Psychodynamic Therapy prove more challenging.²⁶ The co-ordinators of individual modules will stipulate the levels of formative competence required.

After the workshop registrars are expected to begin practicing the mode of psychotherapy they have just been introduced to and compile a portfolio which illustrates their personal development within the mode.

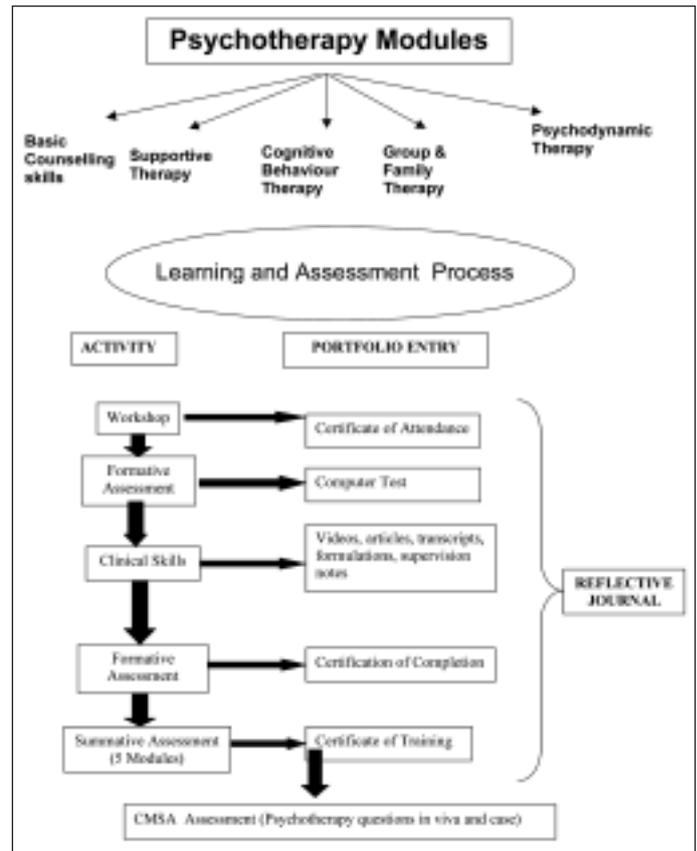
The certificate of attendance at the module workshop is the first item to be included in the portfolio. During the module the facilitator/psychotherapist would have given the registrars direction as to the basic requirements of the portfolio. For example in the "Basic Counselling Skills" module the registrar will be required to provide evidence that a therapeutic alliance has been established in a specified number of cases or that

s/he is able to paraphrase, summarise and reflect correctly and appropriately. Evidence in the form of transcripts or appropriately edited videos will form the mainstay of this evidence with literature, reflective journals, and personal analysis of the material providing support.

The programme is still in its inception and resources have yet to be fully established so registrars are not yet required to obtain formal supervision during their practice. Registrars on the programme work in training hospitals where senior clinical psychologists and psychiatrists who are experienced psychotherapists may be approached for ad hoc supervision. Alternatively the registrar may make arrangements to receive supervision from a private source provided it is a senior psychiatrist or psychologist, who has an acceptable level of competence in that particular form of therapy. Registrars are encouraged to facilitate and document the process of their personal experiences and development as a psychotherapist by keeping a reflective journal, the significance of which was discussed earlier.

Once the programme is fully established the registrar will be assigned supervisors for the duration of the module. They will also be offered an opportunity for a formative assessment before the contents of the portfolio are presented for final summative assessment. It will be the registrars prerogative as to when this will occur and registrars will apply to sit before a formative assessment committee consisting of at least two psychotherapists, one of whom is competent in the form of therapy being assessed. During this assessment the registrar's progress in attaining the basic experience requirements of the module will be reviewed and s/he will be offered direction on how to bridge the gaps evident in the portfolio. Advice may also be offered on how work done could best be represented in the portfolio to illustrate the attainment of basic requirements. The summative assessment verifies that the basic requirements have been attained and that recommendations made at the formative assessment have been followed. The summative assessment is conducted in a similar form to the formative assessment with two psychotherapists (one an expert in the psychotherapy being assessed) on the committee who review the portfolio with the registrar. At this point the registrar may be declared competent in the form of psychotherapy being assessed or be asked to repeat the module. If the registrar is declared competent a Certificate of Training is awarded rendering the registrar eligible for the exit examination. Here there is the option for the registrar to be questioned on psychotherapeutic issues in the viva or clinical component.

We propose the following assessment framework. The portfolio should contain a log of compulsory observed clinical skills, set coursework (seminars, workshops, readings) over a two year period (after completing the Part I programme), and a series of reflective case studies and case material (transcripts, audiovisual recordings) and reports based on the student's own experiences. Formative assessments are held periodically, once per therapy type. The portfolio is assessed by two examiners and marked according to a defined list of curriculum outcomes and criteria. The student has an oral examination based on the portfolio and in particular the reflective cases. A final mark is then given. This mixed economy allows both subjective and objective data to be examined, and is driven by set curriculum outcomes.



Challenges & Opportunities

Currently the portfolio in the UKZN programme takes the form of a learning portfolio to document personal development and track progress as well as to stimulate thought and discussion and plan future learning. Problems with this system emanate from:

1. The relatively comprehensive level of psychotherapy training proposed by this model is not a requirement for the College of Medicine examinations to qualify as a psychiatrist. Therefore, despite it offering the opportunity for registrars to obtain a substantial degree of competence in psychotherapy they will not be motivated to pursue it especially in the face of the biological requirements of the course and the demanding clinical loads they manage. Portfolios require a substantial amount of effort to create and maintain and if there is no imperative to do so it is unlikely to be done. As portfolios encourage self-directed learning, the greater effort lies with the learner. While students will naturally balk at any extra workload, the exercise depends on faculty support for its' successful implementation. Starter workshops, while initially labour intensive, will after the first run, only require them to be repeated at regular intervals. Computer based self administered tests would address issues of establishing a competent theoretical foundation prior to initiating psychotherapy.
2. Currently there are not enough psychotherapists adequately trained in the specific forms of psychotherapy to serve as supervisors/facilitators. If the programme is implemented nationally driven by CMSA requirements, it might be possible to network with experts from other institutions. Partnerships with therapists in the private

- sector for the purposes of supervision will ensure that those in the public/academic centres are not overwhelmed with demands for supervision. The possibility of group supervision confers the benefit of learning from others' experiences at the expense of several private sessions.
3. Paradigm shift in learning vs. appropriateness/effectiveness. The entire programme represents a shift from didactic to outcomes/learner based education. Whilst didactic type training for professionals has been criticized, it has been the dominant method for training doctors. The number of competent professionals in the medical community is testament to its success to some degree at least. Learner based learning and the use of portfolios, although novel, has not yet been proven to fill the gaps left from didactic teaching alone. However initial reports of success and the fact that it appeals to clinicians' sensibilities lends weight to its merit.
 4. On initial inspection the programme may seem labour intensive and time consuming. However once the basic structure is in place, the programme is essentially self supportive. Trainees obtain substantiating material for their portfolios in the course of their clinical work. Consultants act as supervisors and supervisor contact and feedback is recorded in the portfolio.
 5. The programme requires a relatively significant amount of supervisor contact. It might be argued that human resources in training facilities are already stretched to the limit and this programme places an added burden. However this may be alleviated by using public private partnerships with private practitioners supervising on a sessional basis or group supervision with one supervisor supervising a group of registrars.
 6. Design evaluation procedures. The current proposal makes use of learning portfolios to merely document students' learning and not to assess progress against predetermined standards. However to implement the programme more effectively, basic predetermined standards or criteria (levels of competency) would need to be set, by which students can track their progress and examiners can determine whether the students meet the desired level of competency.

Conclusion

Portfolios offer a prodigious option as learning and assessment tools for training of psychiatric registrars in psychotherapy. They are especially relevant in the multicultural and resource strained environment of South African postgraduate medical training.

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