Psychotherapy Competencies: Development and Implementation

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New requirements by the Psychiatry Residency Review Committee of the Accreditation Council for Graduate Medical Education maintain that residents must be competent in five specified psychotherapies. This shift toward evidence-based education and assessment highlights psychotherapy as an integral part of a psychiatrist’s training and identity, while introducing accountability of training programs, faculty, and individual residents. Training directors must now find the resources in faculty, patients, and residency teaching time to teach, supervise and assess residents so they graduate with competency. The American Association of Directors of Residency Training (AADPRT) appointed a Task Force on Competency to assist training directors with the new requirements. The Task Force, through the establishment of five workgroups, has written sample competencies for each required psychotherapy: brief, cognitive behavioral, psychodynamic, supportive and combined psychotherapy and psychopharmacology. In this article, the authors describe the historical context of the new requirements, and the goals, process and issues that arose in the development of the sample competencies. (Academic Psychiatry 2003; 27:149–153)

The Psychiatry Residency Review Committee (RRC) issued new regulations that stipulate, effective January 1, 2001, residency programs must demonstrate that residents are competent in five specified psychotherapies: brief, cognitive behavioral, psychodynamic, supportive and combined psychotherapy and psychopharmacology (1). These new regulations, an outgrowth of the Outcomes Project of the Accreditation Council for Graduate Medical Education (ACGME) (2), are part of the growing shift toward evidence-based medical education and public accountability (3,4). In the Outcomes Project, the ACGME mandated that all medical specialties ensure that its residents develop competency in six core areas: patient care, medical knowledge, interpersonal and communication skills, practice-based learning and improvement, professionalism, and systems-based practice. Only psychiatry has additional requirements for competency in the five specified types of psychotherapy.

Psychotherapy training has gradually eroded over the past two decades. Biological psychiatry and new technologies offered greater understanding of psychiatric disorders and the brain while promising rapid remission of disease. The pharmaceutical industry attained significant control over the direction and funding of clinical psychiatric research through large-scale drug studies. The soaring cost of healthcare, stigma of mental illness, and competition from less expensive providers led managed care to further diminish the role of psychotherapy in the definition of a psychiatrist (5,6). Specifically, the managed care movement systematically argued for fewer psychia-

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trists and a re-definition of the role of psychiatrist as “consultant” for diagnostic evaluations and medication management. Its demand for limited lengths of treatment, brief visits, and reduced reimbursement for psychotherapy, in conjunction with decreased federal funding for residency education, has impacted the way residents are trained. Meanwhile, psychoanalysts, formerly the prototypical clinician teachers and chairs in academic medical centers, became relics of the past in many training centers, losing their esteemed place in residency education.

Erosion of psychotherapy training results in residency graduates who may be unskilled in conducting psychotherapy and unaware of deficiencies in their understanding of a biopsychosocial model. Senior examiners at the psychiatry oral board examinations, themselves well trained in psychotherapy, often lament this change as they examine board candidates who do not understand that symptoms may have arisen in the context of life events or relationships which have particular meanings to the patient. Residencies vary widely in psychotherapy education. Some programs and geographic areas have no experts in a particular modality, or at least none on faculty. In an informal 2001 survey of psychodynamic psychotherapy training in residency, didactic course hours ranged from 24 hours to 200, treatment hours from 100 to 650, and supervision hours from 50 to 400 hours per resident (Mellman, unpublished). In contrast, Wallerstein reported up to 3,000 hours during residency training devoted to learning psychotherapy shortly after World War II (7).

How Was Psychotherapy Taught?

The adage in medical school is, “See one, do one, teach one.” Psychotherapy training has traditionally followed an apprenticeship model. “Seeing” included undertaking one’s own personal psychotherapy and observing senior experts interview patients and conduct psychotherapies, “doing” meant spending hours treating patients and receiving one-on-one supervision, and “teaching” began during residency or afterwards, often amidst further psychotherapy training. Several factors have contributed to the gradual decrease in psychotherapy training. First, until recently, residency requirements for accreditation by the RRC included timed rotations and exposure to particular diagnoses, groups of patients, and treatment modalities. Residents could meet these requirements passively by completing rotations, showing up for sessions with patients, and attending classes and supervision. Second, as psychotherapy teaching and supervision gradually diminished in importance and as lengths of stay decreased, residents were only exposed to the treatment modalities available on their rotations. Opportunities for conducting psychotherapy disappeared from most inpatient units, and outpatient psychotherapy training has never been uniform. Third, since the psychotherapy modalities taught in any depth varied across residencies, the lack of uniform standards in psychotherapy left psychotherapy teaching to the discretion of each program. In many programs, specific types of psychotherapy were amalgamated and lost any differentiation. Rotation sites often were determined by the source of funding for the resident line or position, sometimes further diminishing psychotherapy exposure. Finally, even in areas of the country where postresidency psychoanalytic training used to be common, residents no longer routinely enter personal psychotherapy or psychoanalysis. In many programs faculty identifying themselves as psychopharmacologists and psychotherapists lived often in separate worlds. Few residency programs fully addressed details of combined treatment, for example, considering how medication might impact on psychotherapy, or how taking medication affects the treatment relationship. Although supervisory reports for psychotherapy trainees were required, the specific teaching goals were up to each program and often not comprehensively specified. Using a food analogy, psychotherapeutic foods were sampled by residents, but a balanced diet and attention to comprehensive nutrition was not necessarily guaranteed.

Renewed Interest in Psychotherapy Training

In 1994, the American Association of Directors of Psychotherapy Training (AADPRT) established a Task Force on Psychotherapy to address the diminished place of psychotherapy education in residency. Over 6 years, six initial participants grew to over 80 as interest in psychotherapy training increased, and members participated in a survey of essential psychotherapy skills in residents (Goldberg et al unpublished). These results were endorsed by AADPRT as important skills for residents. In 1996, the American Psy-
chiatric Association (APA) established the Commission on Psychotherapy by Psychiatrists (COPP) to focus on psychotherapy education and revitalize psychotherapy. Members of COPP have published data on psychotherapy efficacy (8), teaching (9,10,11), and supervision (12), and conducted several psychotherapy education programs for residency training directors and educators.

**AADPRT Task Force on Competency**

When the ACGME announced the outcome project in 1999, AADPRT established a Task Force on Competency. Its mandate was to assist the field in implementing and assessing the core competencies and five psychotherapy competencies. Once the initial mission of developing sample core competencies for the field was completed in 2000, the Task Force began to address psychotherapy competencies. AADPRT and Task Force leaders raised several questions. Who should develop psychotherapy competencies-individual programs, a national organization, or a coalition? Should the competencies be a “gold standard” endorsed by national organizations such as AADPRT, or samples to guide training directors? How reliable and valid are the current assessment methods that are used, including supervisor reports from process notes, audio and videotapes, and direct observation? Could new assessment methods be developed? If so, who might fund their development?

Since AADPRT is an organization of training directors with substantial expertise in residency training and recognizes that differences exist among programs in size, location, resources and emphasis, the Task Force chose to develop sample competencies for the field. These were intended to serve as guides to program directors and could be revised by each program to meet its specific needs.

Further questions emerged. What is the definition of competency? Should the threshold for competency be set at low levels which most residents could readily meet? Should the threshold be set higher so that competency has increased specificity and is more meaningful? Can differences in competency be specified for PGY 2’s, 3’s and 4’s? How does the “competency” of a residency graduate compare with that of experienced clinicians who have practiced for 10 years? How comprehensive should the competencies be? For example, should residents be able to identify and manage all types of transference, or only those that jeopardize treatment? To what extent should residents be competent in guided discovery and bridging between sessions in cognitive behavioral therapy? Must all competencies be met for graduation, or only a majority? If psychotherapy experts were consulted, would they realistically understand a resident’s capability or impose even higher standards of expertise? Questions emerged regarding teaching and assessment by faculty. To what extent would all supervisory faculty be able to use the same standards of assessment reliably? To what extent would programs lacking faculty expertise and other resources balk at these competencies? To what extent do programs have adequate resources for remediation? Will programs unable to demonstrate competence fail accreditation and close?

After wrestling with these questions, AADPRT and the Task Force leadership decided to develop workgroups to write competencies for each of the required psychotherapies. Most of the workgroup members were to be training directors with specific interests and expertise in psychotherapy education. Psychotherapy experts and residents were also to participate. The APA Task Force on Competency, with representatives from major psychiatric organizations involved in education and accreditation, offered support and recommended consultation from COPP for psychotherapy expertise. One expert from COPP was invited into each workgroup and asked to write an initial set of competencies for the assigned modality. The psychodynamic psychotherapy workgroup already had three psychoanalyst members to help write the initial draft. Authors were instructed to write one section each on knowledge, skills and attitudes, and reminded to be cognizant that residents are not experts. Task Force leaders determined that assessment methods would be addressed at another time.

The completed first drafts of psychotherapy competencies were then sent by e-mail to each workgroup member for comments and revision. Task Force co-chairs incorporated the revisions and provided further editing to insure uniformity of language and comprehensiveness. Next, each workgroup member was sent copies of all five revised sets of competencies by e-mail, and asked for further comments. Additional revisions were made. Final meetings of all workgroups were planned for the AADPRT 2001 meeting in Seattle where final changes were to be
made. The Seattle earthquake prevented some members from attending, but those not present faxed in their comments. The members in attendance met for lengthy discussion and reached consensus about the scope of the competencies, thresholds to set, and degree of comprehensiveness for all five psychotherapies.

**SOCIOCULTURAL ISSUES**

Sociocultural issues are imbedded in all therapeutic relationships, and certainly in psychotherapies. Though quite important, they are easily ignored or mishandled through personal bias, countertransference and ignorance. To explore understanding of the sociocultural issues related to the core and psychotherapy competencies, the Center for Mental Health Services and APA held an invitational conference on Cultural Competence in June of 2001. AADPRT leaders participated in the conference, which shed further light on how sociocultural issues impact patients and therapists engaged in psychotherapy. The goals of psychotherapy, establishing a therapeutic alliance, and decisions regarding whom the therapist involves in the treatment are all impacted by sociocultural issues. Content themes that emerge in therapy, and transferences and countertransferences, particularly those concerning authority, deference, assertiveness, and gender are also affected by sociocultural factors. Furthermore, balancing the importance of family vs. individual values is also influenced by sociocultural issues in patients and therapists. In response to attending this conference, Task Force co-chairs further revised the sample competencies to include sociocultural issues before sending final drafts of the sample competencies to the AADPRT Executive Council for approval. The sample competencies were approved and distributed to all AADPRT members in December 2001. (See sample competencies at end of this article.)

**PROBLEMS FOR TRAINING PROGRAMS**

The announcement of the new RRC Essentials for psychotherapy competencies generated significant anxiety among training directors, who quickly grasped the difficulties that would arise in meeting these challenges. Implementing both general and psychotherapy competencies places new demands on training directors and their faculties. First, all clinical and academic components of the program must be specified in writing, in terms of knowledge, skills and attitudes for all general and psychotherapy competencies. Such descriptions become the official goals and objectives of the residency curriculum, which need to be evaluated systematically, and whose outcomes are to be demonstrated to the RRC at the time of site visits. Educational mandates of programs are often determined by departmental chairs in conjunction with their training directors and education committees. How will departments find the resources to fulfill these new requirements? Teaching time in the curriculum is already thinly divided between a myriad of required, important and competing topics. Now programs face a triple threat: They must re-define what they are already doing in terms of the competencies; add specific, systematic training in the five psychotherapies; and devise reliable and valid assessment measures for all activities. These are time-consuming activities to be imposed on faculty who are already stretched to their limits. In addition to specifying and evaluating these competencies, training directors and faculty are now mandated to provide and document remediation of deficits where outcome measures indicate deficiencies in competency. Such remediation will require additional resources from faculty.

Accountability creates liability for all parties involved: programs, faculty, training directors and their departments. The new RRC Essentials require training directors to write summary documents for all graduates indicating that they have met the program requirements, are ethically and professionally sound, and are competent to practice independently. What if a resident is found to be incompetent in psychotherapy, and remediation attempts fail? Must such a resident fail the program? What happens to the brilliant resident researcher who never intends to practice psychotherapy and who never attains competence in psychotherapy? If a residency graduates a resident and certifies competence in psychotherapy and the resident is subsequently sued for incompetence by a patient, to what extent might the residency and training director be held liable?

Where will resources such as salary or faculty come from if a resident needs remediation? Should residents requiring remediation be expected to pay for these resources themselves?
THE FUTURE

Although the initial task of writing psychotherapies was complex, more difficult tasks lie ahead. Training directors have just begun to implement the language of competency in their teaching and supervisory goals and to revise their evaluation methods and forms to reflect the new competencies. Old methods of assessment including direct observation, process notes, audiotaaped and videotaped interviews, and chart reviews are still the major methods used, and updated versions of these methods are emerging. Remediation for deficient performance is now required. A few new methods of psychotherapy assessment have developed. Mullen, Rieder and Glick developed the multiple-choice Columbia Psychotherapy Test for psychodynamic psychotherapy and have demonstrated sound psychometric properties (Mullen, unpublished). The Cognitive Behavioral Therapy Supervision Checklist by Wright, Sudak, Beck and Bienenfield will also be available shortly (Wright, unpublished). Developing novel valid and reliable assessment methods is costly and time-consuming but additional methods are needed.

Meanwhile, some training programs have already benefited from the focus on outcome. Training directors have new leverage to require resources from their departments. Since many chairs and faculty members are not aware of the magnitude of the new RRC requirements, training directors need to educate them about the new requirements and work to develop resources for training and evaluation. The intended goal of educational improvement is one we can all share.

References

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