PASSING THE PSYCHOTHERAPY WRITTEN CASE
Passing the Psychotherapy Written Case (PWC)

Overview

- PWC in the era of the CBFP
- EPA’s & WBA’s
- PWC: 3 Stage Formative Component
- Trends in passing rates
- PWC: Summative Component
  -> Preliminary considerations
  -> Choosing a psychodynamic model
  -> Using the 7 College assessment domains
- Bringing it all together
The Psychotherapy Written Case (PWC) in the era of CBFP

The (2012) CBFP is a more outcome & competency orientated framework based on CANMEDS Model for the Medical Expert

- Reinforces need for a psychological understanding of all our patients
- Reinforces the Psychotherapy Written Case central role in psychotherapy training
- Uses EPA’s & WBA’s in psychotherapy training
- Uses the Formative Case Discussion Assessment component
The PWC in the era of CBFP Standards

Completion of the PWC is not a barrier to entering Stage 3 of training (average submission after 24 months in training) but is required for entry for Psychotherapy AT Certificate

Will be assessed at Junior Consultant Standard

Competence of trainee as a therapist is not the major focus of assessment

PWC marking pro-forma is aligned with CBFP Developmental Descriptors (see list on RANZCP website)
Entrustable Professional Activities (EPA’s) & Workplace Based Assessments (WBA’s)

- EPA’s & WBA’s have been introduced as an integral part of the CBFP
- To aid trainees with structure, guidance and tools that help in both formative and summative components of the assessment process
- Requires a number of new rules, forms and processes
EPA’s

- EPA’s are mandatory *summative* assessments.
- They consist of specialised tasks that trainees must perform competently in order to progress to the next stage of training.
- Each 6 month rotation requires completion of 2 EPA’s.
EPA’s

- There are 3 categories of EPA’s over 3 Stages of Training
  - General
  - Psychotherapy (x3 over Stage Two & Three, x10 in Stage Three)
  - Specialist Rotation (CL, Child, Addiction, Old Age, Forensic etc)

Fellowship (FELL) EPA’s can be attained in any area of practice rotation (“Foundational”)

Area of practice (AOP) EPA’s can only be attained in the relevant area of practice (“Advanced”)

EPA’s through Basic, Proficient & Advanced Stages of training

Stage 1
BASIC
• 4 General (2 Mandatory) EPA’s

Stage 2
PROFICIENT
• 4 General Psychiatry EPA’s
• 2/3 Psychotherapy EPA’s
  • Supportive Psychotherapy
  • Managing Therapeutic Alliance
  • CBT for Anxiety
• 24 Specialist Rotation based EPA’s

Stage 3
ADVANCED
• Additional General Psychiatry EPA’s
• Additional Psychotherapy EPA’s (4 FELL & 6 AOP)
  • Use of Supervision (FELL)
  • Assessment & Planning (FELL)
  • Management of Psychotherapy (FELL)
  • Research Skills (FELL)
• Presentation Skills
• Supervisory Skills
**ST2-PSY-EPA2 – Therapeutic alliance**

<table>
<thead>
<tr>
<th>Area of practice</th>
<th>Psychotherapy</th>
<th>EPA identification</th>
<th>ST2-PSY-EPA2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage of training</td>
<td>Stage 2 – Proficient</td>
<td>Version</td>
<td>v0.4 (BOE-approved 08/11/12)</td>
</tr>
</tbody>
</table>

The following EPA will be entrusted when your supervisor is confident that you can be trusted to perform the activity described at the required standard without more than distant (reactive) supervision. Your supervisor feels confident that you know when to ask for additional help and that you can be trusted to appropriately seek assistance in a timely manner.

**Title**

| Psychodynamically informed patient encounters and managing the therapeutic alliance. |

**Description**

Maximum 150 words

The trainee can create and manage a therapeutic alliance with patients including those who are challenging or resistant. The trainee will be able to recognise points of conflict and disjunction and take steps to repair these. These steps will be informed by a familiarity with the evidence base in managing the therapeutic alliance.

**Fellowship competencies**

<table>
<thead>
<tr>
<th>ME</th>
<th>5</th>
</tr>
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<tr>
<td>COM</td>
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<tr>
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<tr>
<td>MAN</td>
<td></td>
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<tr>
<td>HA</td>
<td></td>
</tr>
<tr>
<td>SCH</td>
<td>1,</td>
</tr>
<tr>
<td>PROF</td>
<td>1, 2, 3</td>
</tr>
</tbody>
</table>

**Knowledge, skills and attitude required**

The following lists are neither exhaustive nor prescriptive.

**Ability to apply an adequate knowledge base**

- Positive correlates of therapeutic alliance quality, for example:
  - client characteristics such as psychological mindedness, expectation for change and attachment quality
  - therapist characteristics and behaviours such as warmth, flexibility, honest, respectful, trustworthy, confident, interested and higher maternal care (good attachment).
- Negative correlates of therapeutic alliance quality, for example:
  - client characteristics such as avoidance, interpersonal difficulties, depressive thoughts
  - therapist characteristics such as rigidity, highly critical attitudes, being distant, disconnected and indifferent.
- Basic understanding of defence mechanisms including those used by distressed patients.
- The impact of transference and countertransference on the clinical encounter.

**Skills**
Using WBA’s

- WBA’s are a formative assessment tool that has been introduced as part of the CBPF to provide greater structure to the supervision experience.

- 4 WBA tools are approved for use in the CBFP.

- Each WBA tool specifies a number of options on which to focus the assessment.
Case Based Discussion

Observed Clinical Activity
Initial assess

Professional Presentation

Mini Clinical Evaluation
20 min clinical encounter

4 WBA TOOLS
How are EPA’s & WBA’s linked?

- WBA’s provide a mechanism for structured feedback in the formative assessment of competence in typical work settings.

- Supervisors use WBA tools, together with other information, to assess whether a trainee can attain a particular EPA.

- A minimum of 3 WBA’s must be used in the assessment of each EPA.

- Bi-National Committee will be publishing summary booklet in near future.
WBA’S
Via 4 Prescribed Tools
(PROVIDES STRUCTURE TO SUPERVISION)
= FORMATIVE ASSESS

Choose/Use a Tool
1. Case Based Discussion
2. Mini Clinical Evaluation
3. Observed Clinical Activity
4. Professional Presentation

EPA’S
General, Psychotherapy, Specialist
= SUMMATIVE ASSESS

FELLOWSHIP COMPETENCIES

LEARNING OUTCOMES
(PRES CriBEs MINIMUM EXPECTATIONS)
The Psychotherapy Written Case in the era of CBFP

- **FORMATIVE ASSESS**
  - (X3 Case Discussions)

- **SUMMATIVE ASSESS**
  - (Case Write-up)
  - 7 Domains

PSYCHOTHERAPY WRITTEN CASE
The PWC in the era of CBFP

Formative Component

- Trainees must participate in 3 (formative) case discussions with their psychotherapy supervisor during the therapy process.

- Psychotherapy case discussion form to be submitted for each of the 3 phases.

- Encourages reflection on treatment progress and provides opportunity to receive constructive feedback in order to draft the case out as you go.

- Shapes out early, middle and late phase by facilitating/structuring discussions with supervisors:
  - Highlights/explores developmental milestones in the therapy.

- Do prep work and bring a draft.
CASE DISCUSSION FOCUS

Early Phase

- Case selection
- Suitability of chosen modality
- Assessment/MSE examination
- Initial formulation
- Understanding theoretical frameworks/therapies
- Treatment Planning
CASE DISCUSSION FOCUS

Middle Phase

- Therapeutic progress & process issues
- Key episodes
- Reflect on nature of the therapeutic relationship
- Treatment dilemmas/emerging issues (transference, boundaries, termination)
- Understanding and application of theoretical framework
CASE DISCUSSION FOCUS

Late Phase

- Reformulation
- Termination
- Evaluation of the therapy
- Specific learning points from the experience
- Review of appropriateness of chosen therapeutic model
- Reflection on supervision
Using the formative Case Discussion Assessment component

Early Phase
CASE DISCUSSION 1

Middle Phase
CASE DISCUSSION 2

Late Phase
CASE DISCUSSION 3

3 Pillars of the PWC
Purpose of the Formative Case Discussion Assessment component

IMPROVE SUPERVISION

PROCESS
via
Structure
Feedback
Guidance

IMPROVE SUPERVISION

EXPERIENCE & EFFECTIVENESS

IMPROVE PWC PASS RATES

PSYCHOLOGICAL METHODS COMPETENCY
"We weren't what I would call a 'touchy-feely' family"
What are the overall pass trends?
- Pre 2004 pass rate ~ 90%, since then ~ 75% → 50%

Which sections fail?
- Assessment/MSE, Formulation & Management probably worst
Pass Rates (all cases) since 2000

- Psychotherapy
- All cases
- Other cases pre 2004, then first presentation from 2004
Table 12 Psychological Case Submission % pass rate, by geographic distribution/year: 2005 to 2010

<table>
<thead>
<tr>
<th>Year</th>
<th>ACT</th>
<th>NSW</th>
<th>NT</th>
<th>QLD</th>
<th>SA</th>
<th>TAS</th>
<th>VIC</th>
<th>WA</th>
<th>AUST</th>
<th>NZ</th>
<th>College Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>60%</td>
<td>77%</td>
<td>0%</td>
<td>70%</td>
<td>79%</td>
<td>0%</td>
<td>73%</td>
<td>67%</td>
<td>73%</td>
<td>80%</td>
<td>74%</td>
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<tr>
<td>2006</td>
<td>0%</td>
<td>71%</td>
<td>100%</td>
<td>83%</td>
<td>69%</td>
<td>0%</td>
<td>77%</td>
<td>80%</td>
<td>75%</td>
<td>72%</td>
<td>74%</td>
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<tr>
<td>2007</td>
<td>100%</td>
<td>72%</td>
<td>0%</td>
<td>80%</td>
<td>75%</td>
<td>100%</td>
<td>64%</td>
<td>44%</td>
<td>71%</td>
<td>67%</td>
<td>70%</td>
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<tr>
<td>2008</td>
<td>67%</td>
<td>68%</td>
<td>0%</td>
<td>82%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
<td>75%</td>
<td>77%</td>
<td>72%</td>
<td>77%</td>
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<tr>
<td>2009</td>
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<td>67%</td>
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<td>74%</td>
<td>70%</td>
<td>75%</td>
<td>71%</td>
<td>73%</td>
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<td>2010</td>
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<td>100%</td>
<td>91%</td>
<td>86%</td>
<td>100%</td>
<td>79%</td>
<td>75%</td>
<td>78%</td>
<td>78%</td>
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<tr>
<td>2011</td>
<td>-</td>
<td>58%</td>
<td>-</td>
<td>67%</td>
<td>87%</td>
<td>0%</td>
<td>87%</td>
<td>83%</td>
<td>73%</td>
<td>67%</td>
<td>73%</td>
</tr>
</tbody>
</table>

Figure 7 Case history 2005-2011 overall % pass rates for Australia and New Zealand
<table>
<thead>
<tr>
<th></th>
<th>1st Submission</th>
<th>2nd Submission</th>
<th>3rd Submission</th>
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</thead>
<tbody>
<tr>
<td><strong>n</strong></td>
<td><strong>%</strong></td>
<td><strong>n</strong></td>
<td><strong>%</strong></td>
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<tr>
<td>2005</td>
<td>149</td>
<td>73%</td>
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<td>2007</td>
<td>82</td>
<td>68%</td>
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<td>2008</td>
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<td>103</td>
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</tr>
<tr>
<td>2011</td>
<td>71</td>
<td>69%</td>
<td>15</td>
</tr>
</tbody>
</table>

Based on the average pass rates by attempt across the case history submissions from 2005 to 2011:

- 71% of all Trainees pass the First presentation case at their first attempt.
- 71% pass the Psychological Case at their first attempt.
Which Section Fails?

Unsatisfactory ratings for Psychotherapy Case History marking
*
*March 2006 to Nov 2008*

Percentage of cases

Date of submissions

- Initial Assessment and Mental State Examination
- Adequate Formulation
- Management Plan
- Clinical Progress and Communication/Liaison
- Discussion
Written English

English Standards in Psychotherapy Case Histories
March 2006 to Nov 2008

- Adequate English standards
- Inadequate English standards

Date of submissions

Percentage of submissions
Pattern in 2012 cohort  
(n=11)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Satisfactory Rate (%)</th>
<th>Unsatisfactory Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment/MSE</td>
<td>9</td>
<td>91</td>
</tr>
<tr>
<td>Formulation</td>
<td>36</td>
<td>64</td>
</tr>
<tr>
<td>Management</td>
<td>45</td>
<td>55</td>
</tr>
<tr>
<td>Clinical Progress</td>
<td>55</td>
<td>45</td>
</tr>
<tr>
<td>Supervision</td>
<td>91</td>
<td>9</td>
</tr>
<tr>
<td>Communication</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>Discussion</td>
<td>73</td>
<td>27</td>
</tr>
</tbody>
</table>
“BASICALLY, MR. WILSON, WHAT I SEEM TO BE HEARING YOU SAY IS ‘HELP’!”
The PWC in the era of the CBFP

Summative Component

- Largely unchanged
  - its purpose and basic principles remains intact
The PWC in the era of the CBFP
Summative Component

- Reinforces integral role of competency in psychological methods for all Psychiatrists (and relevance for all patients)

- Skills not only pertinent for those planning to work as psychotherapists but as an integral aspect of a Psychiatrist’s expertise necessary in:
  - The general setting or private practice
  - The hospital environment (including C-L psychiatry)
The PWC in the era of the CBFP

Summative Component

- Reinforces the PWC as the main method through which psychotherapy skills are assessed

- Only component of CBFP in which the trainee’s capacity to prepare & submit a formal report is assessed
  - Necessary in communicating with referring doctors or in constructing medico-legal reports
The Purpose of the PWC

KEY CAPACITIES

Conduct psychological therapy

Integrate theoretical & clinical knowledge in a discussion

Reflect on patient relationship & supervision experience

Communicate in writing their assessment, formulation, management
Relevant Regulations (Trainees)

Regulation 6.2 (ii) of the RANZCP Regulations for Basic Training and Advanced Training for Fellowship states:

Your basic training is assessed as follows:

2 Case Histories of people managed under supervision, as outlined below:
   a) A person, presenting for the first time to the mental health service, whom you have personally managed
   b) A person(s) in whom the predominant mode of intervention has been psychological.

Relevant Regulations (Exemption Candidates)

Regulation 13.1 (ii) of the RANZCP Training and Assessment Regulations states:

You will be assessed as follows:

Unless granted exemptions by the Committee for Exemptions, two Case Histories of people managed under supervision, as outlined below:
   a) A person, presenting for the first time to the mental health service, whom you have personally managed
   b) A person(s) in whom the predominant mode of intervention has been psychological.

Remediation

Regulation 6.2 (vi) (Trainees) and Regulation 13.1 (vi) (Exemption Candidates) of the RANZCP Training and Assessment Regulations states:

Remediation for Multiple Failures of Assessment

Before applying to sit the written or clinical examination or to submit a Case History for the third and every second subsequent attempt thereafter, you must complete a remediation program of duration as outlined in the remediation policy (trainees see link 83, exemption candidates see link 83a), to the satisfaction of the Fellowships Board. In the case of the clinical examinations, this will result in your being ineligible to apply for the next scheduled examination.
Preliminary Considerations

Selection of Patient

-> Long case is not the same as long-term psychodynamic psychotherapy (ie time limited)
-> Good assessment crucial & identify a dynamic focus
-> Modest expectations of change
Preliminary Considerations
Orientate to College requirements early on

- Refer to RANZCP PWC Mark Sheet and Link 45 on College website
- Remember de-identification, confidentiality, consent
- Consider keeping separate process notes or note book with milestones to act as guidelines
- Use “early phase” formative case discussion to set off on right path
- Drafting essential
Preliminary Considerations
Choosing a Psychodynamic Modality

- Psychodynamic psychotherapy uncovers the unconscious patterns of object relations (interpersonal relationships/attachment), conflicts and desires that cause symptoms such as anxiety and depression.

- Modalities
  - Freud & Ego Psychology
  - Klein & Object Relations Theory
  - Kohut & Self Psychology
  - Bowlby & Attachment Theory
  - Postmodern Schools (Intersubjectivity, Relational)
Preliminary Considerations
Choosing a Psychodynamic Modality

Despite profound transformation since Freud, core principles derived from psychoanalysis remain:
- Frame and boundary setting
- A developmental perspective
- Psychic determinism
- Complex meanings of symptoms, behaviours and motivations
- The unconscious
- The relationship
- Transference/counter-transference
- Resistance
- Working through
Preliminary Considerations
Choosing a Psychodynamic Modality

- Multiple modes of therapeutic action that varies from patient to patient
- Continued emphasis on the 2 person nature of the relationship in therapy
- Trainee needs to demonstrate a link between patient’s needs and the modality chosen

Choosing a Psychodynamic Modality
Qualitative & quantitative factors

- Choice of modality can also be guided by severity of disorder and level of engagement that the patient is capable of

- Coherence, relational & psychosocial functioning, affect regulation

- Philip Graham and Leo van Biene’s “Hierarchy of Engagement” model based on the Hughlings Jackson Hierarchy of Consciousness (The Self in Conversation, Vol VI, Editor Pauline Nolan, 2007)

- Nancy McWilliams/PDM “P Axis” takes into account:
  1. Level of personality organisation
     (healthy->neurotic->borderline)
  2. Personality patterns and then temperamental, thematic, affective, cognitive and defensive patterns
EXPANDING COLLABRATIVE INTERSUBJECTIVITY
(NEW FORMS OF RELATEDNESS)

ELABORATING OF DEFENSIVE CONFIGURATIONS
(INTERPRETATION)

IDENTIFYING & TRANSFORMING TRAUMATIC SYSTEMS

FOSTERING OF THE PERSONAL
(REFLECTION, MENTALISATION)

PROVISION OF SAFETY
Choosing a Psychodynamic Modality

MULTIPLE THERAPEUTIC MODES LIKELY:
2 FUNDAMENTAL PILLARS

FOSTERING INSIGHT
- Awareness of repetitive pattern, conflicts & defences
- Coherent self-view
- Better judgement
- Acceptance
- Cognitive restructuring

THERAPEUTIC RELATIONSHIP ITSELF
- Containment
- Internalising therapist’s capacity to mentalise/self-reflect
- Internalisation process modifies representations of self & others etched in childhood
“You don’t say much, but I’m told it’s the therapeutic relationship that counts.”
The Summative Assessment Component of the PWC
The 7 College Assessment Domains

The knowledge, skills and attitudes gained through the process of therapy are then communicated/reflected in the written case.

The written case is then assessed within 7 College Assessment Domains (reflected in the structure of the PWC Marking Sheet).

Familiarising yourself with the structure of 7 Assessment Domains is critical in passing the summative component of the PWC.

Attending to structure then frees you up for flexibility & exploration.
The Summative Assessment Component of the PWC
The 7 College Assessment Domains
Case History Subcommittee

**Psychotherapy Written Case**

Marking sheet

<table>
<thead>
<tr>
<th>Case number:</th>
<th>Examiner number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Candidate number:</td>
<td>Examine number:</td>
</tr>
<tr>
<td>Date of submission:</td>
<td>Submission number:</td>
</tr>
</tbody>
</table>

Please note that the patient consent, word count and other administrative requirements of this submission conform to the guidelines set out in the Psychotherapy Written Case Policy and Procedure.

Examiners, please rate the following aspects of the Psychotherapy Written Case by indicating your assessment in the appropriate box.

### De-Identification

<table>
<thead>
<tr>
<th>Does this Psychotherapy Written Case meet the de-identification requirements (as detailed in point 8.2 of the Psychotherapy Written Case Policy and Procedure)?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the answer to the above is 'No', the case report is to be failed and returned unmarked with no feedback provided.</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

### Presentation

<table>
<thead>
<tr>
<th>Is the content presented according to the requirements as described in point 8.3 of the Psychotherapy Written Case Policy and Procedure?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the standard of written English conform to the guidelines as described in point 8.3 of the Psychotherapy Written Case Policy and Procedure?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>The case report needs a substantial rewrite to provide clarity. Because of the serious deficits in language and grammar, the case report is unable to be adequately appraised in its current state. Limited feedback is provided but there may be matters of concern that only become apparent once the case report is rewritten.</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
The following domains are to be articulated at the standard of a junior consultant:

<table>
<thead>
<tr>
<th>Assessment (including mental state examination and initial formulation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider the following (if relevant to this case) in assessing this domain.</td>
</tr>
</tbody>
</table>

The following criteria are to be met at the proficient standard:

| A thorough, comprehensive and detailed psychiatric history in the standard format including discussion of the referral, history of presenting complaint, past psychiatric history, as relevant. |
| Detailed personal and developmental histories in order to substantiate the psychological formulation and management plan proposed. |
| A thorough and comprehensive mental state examination with emphasis tailored to the person. The emphasis should be upon those aspects of mental status that are meaningful to the process of psychotherapy while giving a level of detail in other areas of mental status appropriate to the circumstances. |
| Consideration of the physical health of the person is expected, although it is acknowledged that this task may have been undertaken by the general practitioner. |
| The issues around the collection of any further information including physical investigations. |
| A diagnosis and differential diagnosis using a recognised classificatory system. |
| An initial formulation should demonstrate the trainee’s understanding of why this person presented with this illness at this time, rather than merely an explanation of the illness. Careful attention should be paid to include significant organic factors/illness. |

- □ Satisfactory  □ Not satisfactory

The following criteria are to be met at the junior consultant standard:

| Sophisticated understanding of the immediate and long-term risks of the individual that include considerations of history and mental state examination and the impact of treatment. |
| Critical appraisal of components of the assessment, mental state examination and diagnostic conclusions and reflection on learnings. |

- □ Satisfactory  □ Not satisfactory

Management plan

Consider the following (if relevant to this case) in assessing this domain.

| The management plan is clearly informed by the formulation and considers all of the relevant biological, psychological, social, spiritual and cultural issues. |
| If other health professionals are involved, for example as case managers or medication prescribers, this should be detailed and the issues around this fully explored and discussed. This may be particularly pertinent when there are significant organic factors/illnesses. |
| Justification of the psychological therapeutic model used. This should include a discussion of the way in which therapy was negotiated with the patient, other modalities that were considered and the reasons for their rejection, potential risks of therapy, goals and expectations of the patient and the therapist, awareness of any limitations of the model used and the suitability of the type of therapy for the patient. |
| Hypotheses are provided regarding the potential difficulties with the therapeutic alliance and barriers to psychotherapy, including potential problems arising during care. |

- □ Satisfactory  □ Not satisfactory
Clinical progress
Consider the following in assessing this domain.

A review of the process of psychotherapy with a clear description of the psychological processes that were observed and experienced. These should be explained using a theoretical concept appropriate to the therapeutic style employed.

Discussion of the relationship between the patient and the trainee, as therapist, with regard to the therapeutic model being used.

Evidence of the trainee’s self-awareness, capacity for reflection and appropriate self-criticism, awareness of limitations to expertise and appropriate seeking of support.

A summary of the therapy. There is no single method for describing a course of therapy; however, the capacity to prioritise and identify the key episodes in the therapy should be demonstrated.

Discussion of termination, either actual or anticipated. This should include how termination was explained to and negotiated with the patient. If relevant, comment on the appropriateness of termination of therapy.

Issues of boundaries and ethical dilemmas are identified and responded to.

The language used is technically sophisticated and psychological terms are not mis-used.

If the use of videoconference for a number of psychotherapy sessions was approved, there should be a discussion of the use of this technology and any effect that it may have had on the therapy.

☐ Satisfactory  ☐ Not satisfactory

Reformulation
Consider the following in assessing this domain.

A sophisticated psychological formulation that reflects increased understanding of the person as a result of the therapy. The extent and complexity of the reformulation will vary with the psychotherapy modality used. The trainee should reflect on the extent and nature of the changes from initial formulation. The reformulation should include vulnerability and resilience factors.

☐ Satisfactory  ☐ Not satisfactory

Supervision
Consider the following (if relevant to this case) in assessing this domain.

Description of the role of the psychotherapy supervisor in the trainee’s learning, including the supervisor’s role in the examination of the psychotherapy process and the contributions of the trainee and patient to this process.

If the psychotherapy supervisor was not the consultant psychiatrist involved with the patient, the role of both the consultant psychiatrist and the supervisor should be described.

Critically appraises components of the supervisory relationship, the limitations of the supervisory process and reflects on the learnings for their own general supervision practice. (The competence of the trainee as a psychotherapy supervisor is not the focus of this criterion.)

If the psychotherapy supervision was provided as group supervision and/or via telephone or videoconference, any effects of this type of supervision should be described.
**Communication/liaison**
Consider the following (if relevant to this case) in assessing this domain.

Outline of communication with other professionals who are or will be working with the person undergoing therapy.

Discussion of issues that may arise with respect to the therapy and therapeutic relationship as a result of communication with other professionals.

☐ Satisfactory ☐ Not satisfactory

**Discussion**
Consider the following (if relevant to this case) in assessing this domain.

Evaluation of the therapy and its significance for the person.

Reflection on the mode of therapy undertaken and its appropriateness and usefulness for the person. The reflection should place the therapy in the context of the theory underpinning the model of therapy.

The discussion should be reflective and, as appropriate, critical of the existing theoretical knowledge and model of therapy.

Demonstration of the trainee's learning as a result of the therapeutic experience with the person.

☐ Satisfactory ☐ Not satisfactory

Examiners please note:
To achieve a pass in the Psychotherapy Written Case, trainees must meet the de-identification and presentation requirements and achieve a 'satisfactory' grade in all aspects of the marking domains.

**The result for this Psychotherapy Written Case is** ☐ Pass ☐ Fail
De-identification & Presentation

Importance of written English & clarity
Presentation
Basic Principles in Writing-up the PWC

- **Structure**
  - Organise data & presenting it in a logical manner
  - Communication is key: Coherence of thoughts & written language
  - Professional English (the expected standard is that of a formal report)
  - Attention to spelling, grammar, layout & editing (over-use of computer spell-checks)
  - Candidates fail on written English even those for whom English is their first language
  - Obvious gross repetitiveness
  - Consistency with names, ages, dates
  - Encourage having it proof read by a 2\textsuperscript{rd} supervisor, DoT, colleague, 3\textsuperscript{rd} party!
Presentation
Basic Principles in Writing-up the PWC

**Content**

- A story about the patient and their clinical involvement in a process that evolves over time
- Capture & convey the essence of the patient & the therapeutic relationship as it unfolds
- Demonstrate the ability to make a sophisticated psychodynamic formulation
  - Demonstrate knowledge of psychotherapeutic principles and theoretical underpinnings
  - Discuss/reflect the experience and role of supervision
Assessment

- Main problem area in Summative Assessment Component
- 7/9 criteria require “proficient standard” rather than junior consultant standard
- Trainees must include comprehensive psychiatric history in standard format
  - Psychiatric history often lacking “clinical” acuity (a narrative but omitting symptoms of anxiety, mood etc)
  - This is a *psychiatric* psychotherapy case
  - See HETI resource
- Personal/developmental history must be detailed enough to substantiate formulation & management plan
Assessment

- Comprehensive MSE relevant to the process of psychotherapy with that patient
  - MSE often brief, unelaborated as patients viewed as “normal” relative to hospital patients
  - Need to demonstrate observational MSE skills (not “Speech: No Formal Thought Disorder identified”)
  - Inadequate risk assessment

- Should include physical health and investigations
  - Often not included

- Collection of additional information

- Include any organic factors

- Diagnosis, DD using recognised classificatory system
  - Diagnosis and DD poorly justified
Assessment

Initial Formulation
- Developed at the time of initiating therapy
- Explaining why this person presented in this way at this time
  - Not addressed

2 new criteria emphasising deficits in past cases
- Understanding the risks/impact of treatment
- Critical appraisal & reflection
Management Plan

- Demonstrating relevant bio-psycho-social, spiritual/cultural issues
  - Biological and socio-cultural issues not considered
  - Discussion of ongoing biological treatments (eg medication) omitted

- Clearly informed by the formulation?

- Involvement of other health professionals?
Management Plan

- Justification of psychotherapy *usage*
  - Inadequate exploration of goals and expectations of patient/therapist and way in which therapy was negotiated with patient

- Justification of the psychological *model* used
  - Consideration of other modalities, potential risks and limitations of model used, not discussed
  - Stick to one model for coherence (universality not pastiche)

Consider potential difficulties arising (new addition)
Clinical Progress

- Review of the psychological processes experienced using an appropriate theoretical model
  - Inadequate discussion of experience of working with chosen modality (i.e., therapy described but not integrated with the therapeutic model employed)

- Relationship with patient
  - Essence of therapeutic relationship not conveyed (candidate depicts themselves as passive observer rather than active participant)
Clinical Progress

- Self reflection, limitations and appropriate self criticism of trainee
  - Lack of self reflection/self awareness

- Summary with a capacity to prioritise and identify key episodes in therapy
  - Poor prioritisation of material (e.g., lengthy description of early sessions but then last 20 sessions dealt with briefly)

- Reformulation
  - Often missing hence now given separate section

- Termination
  - No discussion of termination issues (particularly where therapy was ongoing)
Clinical Progress

3 New Criteria added

- Issues of boundaries & ethical dilemmas
- Sophisticated use of psychological language
- Use of videoconference technology
Reformulation

Reflect increasing knowledge/experience of the patient and the process of therapy
  - Little evidence of re-formulation

Supervision

- Was the role of psychotherapy supervision adequately explored (interaction and processes)?

Communication/Liaison

- Communication with other health professionals and impact on therapeutic relationship
  - Only mentioned if a central event/issue
Discussion

- Evaluation of the therapy and its significance

- Reflection on the theoretical model used and its usefulness/appropriateness
  - Critique/shortcomings of therapy or modality used often missing (i.e., therapy appropriateness/usefulness)

- Reflection/critique of the existing theoretical knowledge base
  - Reflection particularly poor if therapy did not go well or patient selection was poor
Other Resources

- Supervisor, DoT, Committee for Examinations members
- HETI Complete Clinical Assessment
- Selzer & Ellen’s “Formulation for beginners” article
- RANZCP website including EPA Handbook and Forms, Psychodynamic Psychotherapy Reading List
- South Western Sydney Psychiatry Training Network (SSWPTN) website -> swslhd.nsw.gov.au (Hierarchy of Engagement article)
- McWilliams N. Psychoanalytic Diagnosis. Guilford Press.
3 CASE DISCUSSIONS HIGHLIGHTING IMPORTANT MILESTONES

- PASSED THE LONG CASE

COHESIVE STORY OF THE THERAPY JOURNEY

- AWARENESS OF COMMON PITFALLS
- ORIENTATE TOWARDS 7 COLLEGE ASSESSMENT DOMAINS
- INTEGRATE ACADEMIC & CLINICAL KNOWLEDGE WITH PERSONAL EXPERIENCE

CLEAR WRITTEN COMMUNICATION
“No, I'm not interested in exploring the meaning of my existence; I just want to know whether I actually exist.”