Requirements of the Psychotherapy Written Case (extract – NOT the whole RANZCP policy)

The Psychotherapy Written Case assessment includes both the provision of psychotherapy and the writing and submission of a case report.

1.1 Standard

The Psychotherapy Written Case will be assessed at the standard of a junior consultant (as described by the assessment domains).

Trainees may begin the psychotherapy in Stage 1. The competence of the trainee as a therapist is not the major focus of the assessment. The trainee is expected to maturely reflect on all aspects of the therapy (integrating theoretical and clinical knowledge) at the standard of a junior consultant in the written report.

1.2 Learning goals

The learning goals of the Psychotherapy Written Case are to develop the trainee's ability to:

- conduct psychological therapy
- acquire knowledge of psychotherapeutic principles and practices
- integrate psychiatric/medical and psychotherapeutic perspectives in the practice of medical psychotherapy
- integrate theoretical and clinical knowledge
- formulate a case where psychodynamic factors are prominent
- communicate in professional English to the standard of a formal report, which implies attention to grammar, spelling and lack of repetitiveness
- organise data and present it in a written report in a logical and coherent manner (with appropriate attention to the structure to promote reader understanding)
- capture and convey the essence of the patient together with the essence of the therapeutic relationship
- reflect and identify the nature of the engagement between the therapist (the trainee) and the patient
- reflect on the role of, and relationship with, the psychotherapy supervisor.

2. The psychotherapy

In order to successfully complete the Psychotherapy Written Case, trainees must treat a person, under supervision, using therapy informed by psychodynamic principles for at least 40 sessions (each session lasting approximately 1 hour). The psychotherapy should last for at least 6–12 months with at least one session weekly to achieve the necessary experience for the demonstration and discussion of the required psychotherapeutic principles and practices.

In many instances, more than the minimum 40 sessions will be needed to achieve the goals of the Psychotherapy Written Case and the therapy may continue beyond 40 sessions and/or the time of writing up the case. This decision should be made in discussion with the patient, psychotherapy and psychiatrist supervisor(s) (where different) with regard to the patient's needs.

All requirements of this policy and procedure must be adhered to throughout the entire psychotherapy, including any sessions in excess of the minimum 40.

2.1 Knowledge, skills and attitudes gained through the therapy

Trainee competence in conducting therapy over 40 or more sessions is demonstrated through the knowledge, skills and attitudes gained.

The competencies to be gained might broadly be expected to include, but are not limited to, the following:

Knowledge

- Acquiring knowledge of psychotherapeutic principles and practices.
- Understanding that symptoms, behaviours and motivations often have complex meanings.
- Understanding the impact of life cycle issues.
- The indications and contraindications for psychodynamically informed therapy.

Skills

- Ability to build and monitor a therapeutic alliance (over a longer term than is often possible in usual trainee rotations) including managing disruptions and problems.
- Ability to engage a patient in exploring life history in-depth, including relationships, fears, traumas and losses.
- Ability to create and maintain a safe therapeutic environment for the patient.
- Ability to refine and improve on listening and empathy skills.
- Ability to use self-reflection, clarification and interpretation to enhance progress of treatment.
- Ability to manage both the early assessment and the termination phases.
- Ability to make use of ongoing supervision.

Attitudes

- Empathic, respectful, open, collaborative attitude and ability to tolerate ambiguity.
- Sensitive to sociocultural issues that arise during therapy.
- Ability to display confidence in the psychodynamic process.
- Genuine.
- Non-judgmental.
- Patient-centred.
- Professional (for example, privacy and confidentiality, attend sessions in timely manner, arrange follow up, manage interruptions).
- Ethical (for example, maintenance of appropriate therapy notes, informed consent, appropriate boundary maintenance).

3. Supervision

All psychotherapy supervisors must be accredited by the Auckland Psychiatric Training Committee and be appropriately skilled and experienced to supervise psychotherapy. To organise acreditation, contact the local Director of Training (in Auckland, Dr Plunkett).

3.1 Supervision during the psychotherapy

The process of supervision must begin before therapy actually starts. The psychotherapy supervisor must be involved in the selection of a patient, who must be suitable for (at least) 40 sessions of psychotherapy.

As outlined in point 6, trainees must participate in three (formative) Psychotherapy Case Discussions with their psychotherapy supervisor during the therapy process.

In addition to their three formative Psychotherapy Case Discussions, trainees must have regular supervision sessions with their psychotherapy supervisor to allow mutual examination of both the psychotherapy process and the contributions of the trainee and the patient to this process.

Individual supervision on a weekly basis is ideal. If this is not possible, supervision should be at least fortnightly. Group supervision can be used as an alternative to individual supervision as long as each trainee involved takes part in all discussions. In relation to group supervision, the following criteria should be met:

- groups should not exceed 5 trainees
- meetings should be ideally weekly or at least fortnightly
- meetings should be 1–2 hours
- each trainee's case should be discussed at least at every second session.

It is the trainee's responsibility to provide regular communication of progress and significant developments in the psychotherapy of the patient to the psychotherapy supervisor (and psychiatrist supervisor where different).

3.2 Supervisor requirements

The psychotherapy supervisor is required to:

- supervise the trainee's clinical care of the patient within the clinical governance structure of the health facility
    - However, if the psychotherapy supervisor:
        - is not a psychiatrist; or
        - does not work for the service where the patient is registered; or
        - is accessed via telephone or videoconference;

      then the trainee must ensure that their clinical care of the patient is supervised by a College-accredited psychiatrist supervisor who has oversight and clinical governance of the patient's treatment in the health facility where the patient is registered.
    - It is recommended that there is communication between the psychiatrist supervisor and psychotherapy supervisor at the start of therapy and if/when the trainee transfers to another service to delineate the extent of responsibility or co-management (if any), of the patient.
- engage in three formative Psychotherapy Case Discussions with the trainee during the course of psychotherapy as outlined in point 6 and in the Psychotherapy Case Discussion Protocol
- attest that the Psychotherapy Written Case accurately reflects the presentation of the patient and the management as carried out by the trainee
- view all related written communication, for example, discharge summaries, and confirm they are satisfactory as professional communication.

The psychotherapy supervisor must confirm the above by signing the Psychotherapy Written Case Submission Form.

The psychotherapy supervisor must be familiar with the style and content requirements of the written case report.

3.3 Psychotherapy supervision via telephone or videoconference

(see the full Regulation re this)

4. Selection of patient

Any psychotherapy patient seen by a trainee must be managed with appropriate clinical governance arrangements in place and registered as an open case at an appropriate health facility linked to an accredited training program. The trainee should be in a training post in the same location; however, this may not be possible due to trainee or patient movement over the course of treatment.

- A trainee who is treating a patient who is registered with a different health facility than the one through which the trainee is employed must discuss the clinical governance arrangements with their supervisor and Director of Training. Trainees must ensure that they receive documented approval for the continuation of treatment by the health facility with which the patient is registered. Trainees should also ensure that indemnity arrangements with the facility remain in place.

The psychotherapy supervisor must be involved in the selection of a patient, who must be suitable for (at least) 40 sessions of psychotherapy.

If a trainee is unsure as to whether the selected patient is a suitable choice for the Psychotherapy Written Case, their Director of Training (DOT) should be included in discussions with their psychotherapy supervisor. A trainee who has further questions can contact the CFT via the Training Department at the College head office.

4.1 Patient consent form

Trainees must obtain consent from their patient and have the prescribed Patient Consent Form signed before therapy begins.

- Trainees who select a child or adolescent patient must obtain consent from patient's legal guardian before therapy begins in the first instance. Trainees must also take into consideration the legal requirements in relation to treatment of minors.
- In the case of multiple supervisors (if the trainee's accredited psychotherapy supervisor and accredited psychiatrist supervisor are different people), valid consent should include informing the patient of the roles of both supervisors and clarifying the clinical governance arrangements.
- A trainee who has received prospective approval from the CFT to conduct a portion of the psychotherapy sessions via videoconference must obtain specific consent from the patient for videoconference sessions, in line with Appendix 1.

The Patient Consent Form is to be sighted and confirmed on the Psychotherapy Written Case Submission Form by the trainee's psychotherapy supervisor.

The trainee is responsible for the safe-keeping of the Patient Consent Form as per local record management policies, which usually require documentation of the patient's consent to be filed in the patient's formal case file held at the health facility. A copy of the Patient Consent Form should also be kept by the trainee.

Additionally, all legal and ethical consents required by the relevant health facility should be addressed by the trainee.

4.2 Use of a child or adolescent patient

While there is no restriction on selecting a child or adolescent patient for the Psychotherapy Written Case, the marking requirements can be very difficult to fulfil when the patient is a very young child because of the need to tailor the therapeutic relationship to the appropriate stage of the child's development and the level of sophistication required to describe the psychotherapy process.

Trainees who have selected a child or adolescent patient should reflect age appropriate considerations in their assessment and management of the patient (see the 'assessment' and 'management plan' assessment domains outlined in point 10).

4.3 Requests to conduct psychotherapy sessions via videoconference (Refer to Appendix 1)

(see the full Regulation re this)

5. Provision of therapy

The trainee must be the sole therapist/practitioner of psychological intervention for the case.

The psychotherapy will generally be undertaken while the trainee is in a College-accredited training post due to the clinical supervision required (i.e. not while a trainee is on an approved break in training or has otherwise interrupted their training). Any variation will require prospective approval by the CFT. Applications must be made in writing and submitted via the Training Department at the College head office.

The patient should be seen in appropriate office facilities within normal working hours, for both trainee and patient safety.

The patient needs to be aware of how to access emergency or after-hours support. This information should be clearly documented.

5.1 Documentation

The trainee must make an entry in the health facility case notes for each attendance by the patient. Such entries should contain statements of facts concerning the history and management of the psychotherapy patient, including risk management. Whilst seeing a patient for psychotherapy treatment, the trainee is responsible for keeping this clinical file up to date with progress notes, medication details and risk assessment accurately recorded. Upon termination of the therapy with the trainee, the details of follow-up arrangements for care should be clearly documented in the health facility case notes.

5.1.1 Separate training notes

In addition to the health facility record, trainees may, with the permission of the patient and the facility involved, keep separate notes or audiotapes for training purposes on their sessions with their psychotherapy patients to discuss with their psychotherapy supervisor.

These training notes may contain the trainee's subjective impressions and interpretations of their patient. In practice, most psychodynamic psychotherapy treatment under supervision occurs with the use of this separate set of training notes. The training notes are also used for reference in writing up psychotherapy cases in training. The notes must be de-identified and kept in a secure place. These notes should not replicate or be a substitute for good clinical notes and records, which would form part of the patient's clinical file.

The trainee should document in the health facility case file where these training notes can be accessed. The trainee and patient need to be aware that, although these training notes belong to the trainee, these notes could also be accessed by the patient in some

circumstances and/or subpoenaed if required by a court of law. They should be retained and not destroyed for the legally required time period in the jurisdiction in which the trainee operates, which in most cases will be 7 years.

6. Formative assessment – Psychotherapy Case Discussion

During the psychotherapy process, trainees must participate in three formative Psychotherapy Case Discussions about the patient whose therapy will be written up for assessment purposes with their psychotherapy supervisor to encourage reflection on the patient's treatment progress and to provide opportunities for qualitative feedback.

The Psychotherapy Case Discussions should occur during the early, middle and late phases of the psychotherapy and should focus on pivotal points or milestones in the therapy process (such as case selection, formulation and termination) as these points are critical to meeting the standard for the written case report, or on treatment dilemmas and/or emerging issues (such as gift giving, erotic transference, boundary issues, etc.).

For each Psychotherapy Case Discussion, the Psychotherapy Case Discussion Form will be completed by the supervisor, together with the trainee. Trainees must retain the three completed forms and submit them to the Case History Subcommittee via the College head office with their written case report.

Guidance on Psychotherapy Case Discussions can be found in the Psychotherapy Case Discussion Protocol available on the Psychotherapy Written Case page of the College website.

Note: the Psychotherapy Case Discussion is a different assessment with different requirements to the Case-based Discussion (CbD) Workplace-based Assessment (WBA) used throughout training.

7. Termination

Termination of therapy should be planned by the trainee with the patient and supervisor(s), and should be managed to avoid an abrupt end to treatment and with regard to the patient's needs. The patient should be given clear details of the follow-up arrangements for care following termination of therapy with the trainee. These details should be clearly communicated with all members of the treating team, and clearly documented in the case notes of the health facility with which the patient is registered.

7.1 Termination prior to 40 sessions

There may be unusual and exceptional cases where therapy is terminated just before the planned 40 sessions. Trainees must submit a request to waive the 40 session requirement to the CFT via the College head office. Trainees should include supporting documentation from their psychotherapy supervisor and/or DOT with their requests. The CFT will consider these requests on a case-by-case basis.

Trainees for whom the 40 session requirement is waived must attach written evidence showing that the CFT waived their 40 session requirement to their Psychotherapy Written Case Submission Form. Trainees in this circumstance must still include adequate and convincing discussion in their write-up to demonstrate the required psychotherapeutic principles and practices.

8. The written case

Trainees must write and submit a case report that details their assessment and subsequent management of a person through the use of psychological methods over at least 40 sessions. This written report forms the summative assessment component of the Psychotherapy Written Case. The Psychotherapy Written Case must be a formal report.

8.1 Length

The Psychotherapy Written Case must be 8000–10,000 words in length. The word count commences from the start of the case (introduction/demographics/synopsis) through to the end of the case (discussion/conclusion).

Written cases found to be outside the prescribed range will be returned by the College unmarked. The total word count should appear on the cover page.

The word count will **include**: all headings, footnotes, and appendices.

- Explanatory footnotes are not to be included in the reference list; rather they must occur at the appropriate point in the text and be included in the word count.

The word count will **exclude**: the de-identification disclaimer, cover sheet (which should include the de-identification disclaimer), index/table of contents and references/bibliography. Figures and diagrams are also excluded from the word count.

Trainees are advised to include their references in a separate reference list/bibliography at the end of the report and to use superscript numbers in the body of the case, as these can be excluded from the word count.

8.2 De-identification and confidentiality

All data which could potentially identify the patient must be removed from the case report, including from all appendices and acknowledgments.

As part of de-identification, the name of the trainee submitting the case must not appear anywhere within the text of the case report (nor the name of any College Fellow or other staff involved in any aspect of the case).

The first time a pseudonym is used, it must have an asterisk (*) after it, indicating that it is a pseudonym. Each case report must contain a de-identification disclaimer (and statement concerning the use of asterisks) on the cover sheet, stating that all data identifying the patient has been removed.

It is not sufficient to simply use a pseudonym for patients, their families and the submitting trainee. The following must also be de-identified:

- locations, including the patient's city/town of residence
- names of mental health services, hospitals and hospital units
- dates of admission
- names of College Fellows, supervisors, other staff and trainees
- identifying data included with X-rays, children's drawings, copies of letters and/or other information included with the case report including any appendices or attachments.

Where individually relevant, the country of origin and occupation of the patient must also be modified, that is, where circumstances are so unique or unusual as to allow easy identification.

- Trainees are strongly advised to avoid high-profile cases.
- It is recognised that at times altering ethnicity, country of origin, occupation or a significant identifying aspect of the patient, or the respective genders of the trainee and/or patient, can potentially detract from the richness and essence of the case. Trainees are advised to seek their supervisor's input to determine whether such alterations are necessary to avoid potential breaches of patient confidentiality and to refer to principle four of the RANZCP Code of Ethics. The trainee should document this rationale in their case.

The de-identification disclaimer is not included in the word count.

8.2.1 Failure for identification

Case reports that include data which, in the opinion of the examiner, leads to the identification of the patient or the trainee, will be returned to the trainee as failed.

A case that has been failed on these grounds will not be marked and the only feedback the trainee will receive will appear in the 'De-identification' section of the Psychotherapy Written Case marking sheet. (On the next submission, a new Psychotherapy Written Case Submission Form and fee will be required.)

8.2.2 Examples of de-identification disclaimers

'In accordance with Psychotherapy Written Case Policy and Procedure (11.1), all data which could potentially identify the patient, their family and other individuals has been removed from this case report. The locations, names of hospitals, supervisors and dates of assessment have been modified and replaced with a pseudonym marked by an asterisk (e.g. Jane*) the first time they appear in the text.'

'Pseudonyms are used for all names in this case report and are marked with an asterisk (e.g. Jane*). All data that could potentially identify the patient has been removed from this case to ensure confidentiality.'

8.2.3 Proofreading following de-identification

Trainees are reminded to carefully proofread their case report following de-identification. Inconsistent ages, dates or names make it difficult to understand the timeline of events within the case and can distract from the true essence of the case.

8.3 Presentation

If the examiners are of the opinion that the case does not meet the standard of a formal report, it will be failed.

Trainees should present their written case report according to the following requirements:

a) The case report is well presented with a clear layout.
   - Professional English is used with appropriate spelling and grammar.
   - The font must be 12 point font.
   - The font used is to be consistent throughout the case, for example Arial or Times New Roman.
   - The report must be double-spaced.
   - Pages must be numbered and should be printed double sided when possible.

b) The data is organised and presented in a logical and coherent manner.

c) All references cited in the text are listed at the end of the report in an accepted reference style that uses superscript numbers in the body of the case, e.g. Vancouver style. (This is to ensure the word count can be verified).

d) The report has been carefully proofread (by supervisor and/or third party, as well as by the trainee).
   - It is recommended that trainees seek advice in relation to the style of expression, use of language, structure and organisation of content, which could be provided by a colleague or a professional editor. In relation to the specific clinical content/clarity of clinical concepts, trainees should consult their supervisor or another clinician.
   - Trainees are reminded that they are required to submit work that is their own independent undertaking. The Case History Subcommittee encourages and supports the formative process that occurs when trainees and

supervisors/Directors of Training review draft case submissions. Careful proofreading by a third party is recommended; however, for a professional editor or supervisor/Director of Training to substantially modify the content of the case report would be considered unauthorised collaboration.

- Trainees are reminded to adhere to the de-identification and confidentiality requirements for the case report before seeking advice from a third party non-clinician.

e) Each case report must be bound securely, for example, spiral binding. Cases that are not bound securely will be returned unmarked.

- The Psychotherapy Written Case Submission Form is not to be bound within the case.
- Stapling, the use of bulldog clips, paper clips, ringed binders or tube or metal file fasteners, (i.e.: no hole punching) are insufficient.

9. Submission of the Psychotherapy Written Case

Trainees must be actively training or on an approved break in training in order to be eligible to submit their Psychotherapy Written Case. Trainees who have interrupted their training without approval for a break in training are considered to be not in training as per the Leave and Interruptions to Training Policy (23.1), and are not eligible to complete or submit their Psychotherapy Written Case during that time. A trainee's status will be assessed in line with the relevant final submission date as per the published examination timetable.

Trainees must submit their Psychotherapy Written Case to the Case History Subcommittee via the College head office. The Psychotherapy Written Case may be submitted at any time; however, the Case History Subcommittee will mark cases and release results in designated time periods with the final submission dates specified on the College website. The Case History Subcommittee will delegate the marking of individual cases to suitably experienced Fellows.

When submitting a Psychotherapy Written Case, trainees must complete the Psychotherapy Written Case Submission Form and forward the hard copy together with the bound case history to the College by 5pm, Melbourne time on the published submission date, together with their printed case report, electronic copy (on CD), their three completed Psychotherapy Case Discussion Forms, a hard copy of their current medical registration and the prescribed fee. Applications will not be accepted via any other method.

- Submissions received after the submission date will not be accepted under any circumstances and will be held over until the next submission date; however, submissions that are postmarked before submission closing will be accepted.
- Case reports will not be processed without the electronic copy, payment or signed Psychotherapy Case Discussion Forms and Psychotherapy Written Case Submission Form. In these instances, the case report will be returned by the College unmarked.
- The trainee's name is not to appear anywhere on the case. The trainee's name must only be recorded on the Psychotherapy Written Case Submission Form and on the CD itself. Cases found to have the trainee's name on them will be returned unmarked by the College; however, the College is not responsible for ensuring the return of identifiable case reports before they are sent to the examiners.

  Note: If within the text of the case report, there is data which in the opinion of the examiner might identify the trainee, it will be returned to the trainee as failed as outlined in point 8.2.1.

Trainees who are applying for special consideration should follow the overarching requirements of the Special Consideration Policy (18.2).

9.1 Electronic copy

A Microsoft Word version (not PDF) of the Psychotherapy Written Case must be saved to a CD and submitted with the printed case. It is the trainee's responsibility to ensure files are correctly saved to the disc. Applications without correctly saved files will be considered incomplete and will not be accepted.

- The word count stated by the trainee on the Psychotherapy Written Case Submission Form will be verified.
- The case report should be saved as one file, not as separate files (cover page, table of contents, case, and references).
- The CD must be labelled with the trainee's name, pseudonym used in case and date of submission.

10. Summative assessment domains

The following domains summarise key elements that should be addressed in the written report and that will be assessed (see the Psychotherapy Written Case marking sheet for further guidance). Whilst each domain is required to be covered and the case is marked accordingly, the relative importance of material and hence content will vary according to the case.

10.1 Assessment (including mental state examination and initial formulation)

- 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.

The above criteria will be assessed at the proficient standard as the competence of the trainee as a therapist is not the major focus of the assessment (see point 1.1). The below criteria (and all further domains) will be assessed at the junior consultant standard. This distinction is set out in the Psychotherapy Written Case marking sheet.

- 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.

Trainees who choose a child or adolescent case are reminded to reflect age appropriate considerations in their assessment of the patient.

10.2 Management plan

- 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.

Trainees who choose a child or adolescent case are reminded to reflect age appropriate considerations in their management of the patient.

10.3 Clinical progress

- 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.

10.4 Reformulation

- 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.

10.5 Supervision

- 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.

10.6 Communication/liaison

- 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.

10.7 Discussion

- 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.

(for additional details including marking and remediation for failed cases see the full Regulations)