Psychiatric Bulletin (1990), **14**, 363–372

Correspondence

Training matters

DEAR SIRS

I am pleased at the interest taken by Dr Veale in psychotherapy training and find his paper stimulating and provocative (*Psychiatric Bulletin*, April 1990, **14**, 217–219).

He has two main theses – first, that training in behavioural and cognitive approaches is inadequate, and secondly this is due to "vested interest", implying a powerful elite deliberately depriving trainees of such experience. His answer is to develop a separate training structure and new consultant posts redesignated from either general psychiatry or psychotherapy.

Ten years ago I would have agreed with most of his points but the situation has been gradually changing over recent years. He is perhaps unaware of this, not being a psychotherapy senior registrar. Sadly, he seems to be re-enacting the previous sterile argument between psychotherapists of different orientations. My own experience is that there has been a gradual rapprochement and the development of mutual respect.

There are a number of factors contributing to this development. The concern about the vast changes in the NHS has tended to unite professionals across the board. The dynamic therapists have come to recognise the need for clinical evaluation and audit, having tended to turn a blind eye to this area for many years. Often they have had to learn such skills from more behavioural or academic colleagues. No-one would disagree that behavioural and cognitive approaches are better than dynamic work with certain disorders and certain patients. The move away from radical behaviourism towards cognitive models has narrowed the distinction from dynamic approaches, although it still exists.

Dr Veale is correct, however, in seeing the core trainings that have developed as being heavily biased towards approaches based on modern psychoanalytic ideas; they not only apply to intensive therapy, but increasingly in the field of brief and/or focal therapies, and in group therapy. This is not a conspiracy, it is market forces. Most consultant psychotherapists, and their senior registrars, do seek to develop expertise in this area. One's continued extensive work with a few selected, disturbed patients, provides the continuous intellectual and personal challenge to inform and enrich the more applied work.

The task of those of us overseeing such training is to ensure that such 'depth' of training is balanced by a 'breadth' of experiences and approaches. It is essential for all senior registrars in psychotherapy to have good supervised experiences of the range of modalities described in the handbook, including behaviour therapy.

He asks why there are not trainings centred in behavioural work. The same is said for family therapy. It is extremely difficult for trainings to develop when the main trainers would be from other disciplines or other specialties. In most settings psychologists are required to teach behaviour therapy and child and adolescent psychiatrists to teach family therapy. He is, therefore, correct about the need for consultant psychotherapists to have skills in these areas in order to teach them to the next generation.

Where are these consultants to come from? In practice most consultants working with behaviour therapy tend to remain within general psychiatry and indeed general psychiatrists are usually supportive about the need for such skills. When consultant psychotherapists retire there is often a debate about replacement with someone with a more behavioural orientation. Part of the dilemma about the provision of services is that in most settings there may be one consultant psychotherapist providing dynamic work and some half dozen psychologists providing behavioural work so that in terms of the needs of the service it becomes hard to justify. This situation may be changing in that a number of clinical psychologists are increasingly becoming interested in psychodynamic work.

Psychotherapy is a very small specialty within mental illness. My personal view is that it would surely be invidious to split it even further and have consultant behaviour therapists, consultant dynamic therapists, consultant group therapists, consultant family therapists, etc. We should all be able to ensure that the patient receives the optimal treatment for his difficulty (given the restraints of available resources) and if we cannot provide that ourselves we should be alert where to refer the patient on.

Coming to the question of the JCHPT handbook, which appears to have caused some offence, I should like to reassure Dr Veale that it is indeed in the process of revision. It is recognised that the present handbook is fairly limited about what would constitute primarily behavioural training. This is under review by the committee although will not unfortunately be ready for the new handbook. Should a training scheme with manpower approval and funding for a senior registrar in psychotherapy post seek educational approval for training with a majoral behavioural component, balanced by other approaches, I

would foresee little difficulty in fulfilling our criteria for approval.

In conclusion I welcome continuing constructive debate on these matters.

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Research in psychiatry

DEAR SIRS

Professor Crisp (*Psychiatric Bulletin*, March 1990, **14**, 163–168) is hopeful that his statement on 'The case for teaching and research experience and education within basic specialised training (registrar grade) in psychiatry' will be of interest. It may produce some controversy within the College. He makes a good case for research and teaching but I think it would be undesirable if all psychiatrists were expected to do research. In support of his case he notes that doctor means 'teacher'. By contrast, I would argue that research is not essential to the psychiatrist's job of treating psychological disorders.

I think the misunderstanding may have arisen because of the notion that research has advanced psychiatry. Is it true? Is psychiatry a science? What is a social science? These are questions that need research but are far too philosophical for most current psychiatric research.

Of course, research can be of value to psychiatry. Such education and training should be available in all training schemes. My case is that trainees should be allowed to choose whether they want to do research, and not be expected to do so as part of a career in psychiatry.

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Models of care for AIDS dementia

DEAR SIRS

Although it was flattering to see our Bow Group Memorandum being given such an extensive review by Professor Chris Thompson (*Psychiatric Bulletin*, February 1990, **14**, 126), I was somewhat disconcerted at the way his critique involved such a dismissive approach and rubbishing tone on my efforts to raise the public debate on an issue which seems to have obtained little currency or discussion elsewhere; namely the need to provide long-term institutional care for AIDS dementia patients at the end of this decade. I am quite robust enough to fully accept that some of my figures may be incorrect as they are based on averaging or interpolating some of the ranges of AIDS prevalence figures published in the Cox report, and furthermore my paper predates both the recent more optimistic predictions emanating from the Department of Health as well as the Dutch trial alluded to which suggests that Zidovudine will considerably alleviate the neuropsychiatric morbidity of AIDS, although this study makes no allowance for the possible emergence of Zidovudine-resistant HIV strains. As to the 4th International Conference on AIDS figures which were quoted, I drew upon two selected abstracts. The first is Abstract No 8565 done in Stockholm by Alexis, B. and Wetherberg, L. *et al* who examined 50 HIV infected patients with MRI and neuropsychological tests and found about 75% of the HIV infected homosexual men had frontal, parietal or occipital cortical atrophy with 70% having impairment of fine motor function with neuropsychological testing. The next Abstract is 8566 by Boccellani, A., Dilley, J. W. *et al* of San Francisco General Hospital on 46 hospitalised subjects with the first episode of *P. carinii* (i.e. the onset of AIDS). They found impairment in 78% on 6 of 10 neuropsychological tests. "These results support previous findings of a large incidence of cognitive pathology in patients with AIDS".

However I would like to take issue with a number of inaccuracies and points raised. I still maintain that AIDS patients if psychiatrically disturbed would be best kept in separate facilities even if physically ill, as in my experience general physicians are seldom happy to manage confused or disturbed patients as they find them too disruptive and are unfamiliar or unwilling to employ the Mental Health Act if this is required. The alternative, I suggest would not be an "ill-equipped mental hospital", as I clearly point out in our paper that any possible AIDS dementia unit would require very special joint care approaches between psychiatrists, infectious disease physicians, and genito-urinary physicians, and thus would require all the requisite funding and modifications to ensure adequate and modern medical care.

I also take particular issue with the very insensitive and critical attitude of Professor Thompson to our long-stay hospitals. I have spent a considerable amount of time as a junior psychiatrist at a long-stay mental asylum and was not aware of working in "an unmanageable sprawling complex in which individuality of all but the most disturbed was submerged among the faceless masses of the mentally ill". Frankly, this frontal attack on our long-stay hospitals does a disservice to their dedicated staff and patients whose morale is already at a nadir faced with the prospects of imminent closure and an uncertain future with social services managed community care.