Senior registrar in psychotherapy

DEAR SIRS

As one of Dr Ryle's SR level trainees in psychotherapy I was pleased to see his views in print (*Psychiatric Bulletin*, January 1992, **16**, 30–32). I found myself agreeing with much of what he had to say but I should like to add something of my personal experience in my peer group as a trainee.

Dr Ryle stresses the importance of an involvement in research yet with notable exceptions only a few of my SR colleagues seem to be actively involved in much research. Few attend the Society for Psychotherapy Research conference each year and possibly even fewer went to the first IPA conference on research in London last year. When I discuss research with them there often seems to be a combination of disinterest in and disinformation about the nature, and practical use of many of the tools valuable in psychotherapy research; tools like numeric methods, audiotaping or questionnaires. The disinterest and disinformation serve to reinforce a distrust of these methods which is not based on a balanced appraisal of either their benefits or their disadvantages. Many give lip service to research but, in connection with my interest in research, I have been asked on more than one occasion why it is that I am training to become a psychotherapist rather than a general psychiatrist which it is implied would be more suitable.

The attitude of the SR body to cognitive and behavioural approaches is also problematic. Such methods are often acknowledged as potentially beneficial in "removing symptoms", especially if a psychodynamic approach has been ruled out for some reason. It is also accepted that SRs need to learn how to identify suitable cases. However, there is little interest in learning how to do these treatments, this component of training where it exists being regarded as, at best, a worthy chore. Actually being keen on doing such treatments may be treated as an indication of being unfeeling, out of touch with the unconscious or no more skilled than any psychiatrist who talks to patients.

This leads me to a personal worry. I have an impression that debate has polarised into one conducted between only psychodynamic and cognitive behavioural therapists. Often some kind of divisional system is proposed with consultants chosen to represent either pure cognitive or pure psychodynamic approaches. While I am reassured that currently the view is that the specialist section should not be split, I find myself worrying that ancient hostilities and different approaches to training will, when combined with an exclusive focus on only two pure lines of treatment, avert *de jure* separation but perpetuate it *de facto*.

My experience of my peer group provides me with worrying evidence for this. A principal component of my training so far has been in an approach which combines cognitive and analytic perspectives in a single method of working. Yet often talking with my peers about this it is difficult to get the integrative focus across. I find myself talking to a person who, knowing my interest in cognitive approaches, assumes I must therefore be disinterested in and ignorant of psychodynamic ones.

Purists are vital. They promote excellence but a danger is that they may become rigid and be contemptuous of or patronising towards integrated approaches. I would be sad if the outcome of debate in the College was a victory for purists of whatever sort and this is because one of my chief training experiences has been in the values of integration.

CHESS DENMAN

Guy's Hospital
London SE1

DEAR SIRS

Having received a three-and-a-half year psychotherapy training outside London, I was interested to read Anthony Ryle's criticisms. I agree that for a senior registrar to undertake an analytic training on top of a full-time NHS post is likely to preclude social or family life and that the concentration on psychoanalytic thought to the exclusion of real life is likely to be detrimental rather than helpful to prowess as a psychotherapist. I was shocked to meet such a senior registrar last year and discover the sacrifice of time, energy and money that her training involved. If there is little chance of achieving a consultant post in London without an analytic training, this must surely be mistaken. Of course, senior registrars should be free to choose the type of psychotherapy training they wish but we need consultants with a variety of outlooks. To date, the Royal College guidelines have not catered for those who prefer to specialise in behavioural and cognitive therapies, although this is under consideration.

Dr Ryle criticises the overemphasis on seeing long-term patients during training. As there will always be patients who need several years therapy, long-term work should form part of training. But experience of other modes of psychotherapy is vital given that, as consultants, we may be more involved in recommending patients to appropriate modes of therapy than treating them. Most of us are gifted at particular forms of psychotherapy and should develop our skills by concentrating on these while knowing enough about other approaches to be able to point our patients in the right direction, and to value colleagues who work in a different manner. Psychoanalytic institutes, and some psychotherapy training, encourage adherence to one particular set of beliefs at the expense of other training as though ignoring the famous Luborsky finding that all therapies were equal.

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