Many of the psychiatric disorders with which we are confronted defy methods of treatment based on pure biological science – eg. somatoform disorders, or personality disorders. Most patients will not want psychoanalysis, but psychodynamic issues such as transference and countertransference will be unavoidable in any therapeutic relationship. These concepts might not be easily adapted to an MCQ answer but a good understanding of them may help avoid therapeutic disasters. From a broader viewpoint, psychoanalysis, particularly Lacanian analysis, has had an immeasurable impact on philosophy, literary theory, feminism, and political theory, and if we lose psychoanalysis we may also lose the richness that these disciplines add to our study of human subjectivity. Clearly, methods of teaching psychodynamic theory must be subjected to rigorous discussion. However, for psychiatry to abandon psychoanalysis could lead to a stagnation in our approach to knowledge and science.

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References
1. Trigwell PJ, Curran S, Milton J. Training in psychodynamic psychotherapy: the psychiatric trainee's perspective. Ir J Psychol Med 1995; 12 (2): 57-9.
2. Clare A. Commentary on 'Training in psychodynamic psychotherapy: the psychiatric trainee's perspective'. Ir J Psychol Med 1995; 12 (2): 59-60.
3. Lacan J. Function and field of speech and language in psychoanalysis (1953). In: Ecrits. London: Routledge, 1977.
4. Lacan J. Les quatres concepts fondamentaux de la psychanalyse. Paris: Seuil, 1973.
5. Lacan J. L'Envers de la psychanalyse. Paris: Seuil, 1991.
6. Lacan J. The direction of the treatment and the principles of its power (1958). In: Ecrits. London: Routledge, 1977.

Training in psychodynamic psychotherapy: Quo Vadis?

Sir – The article by Trigwell *et al*,[1] and the subsequent separate commentary by Clare[2] should stimulate further debate on training in psychodynamic psychotherapy for psychiatric registrars. Trigwell *et al*, highlighted their "subjective difficulties" in adjusting to such training. What follows is another subjective impression, but this time from the "other side of the fence".

Trigwell *et a*l, began by noting that in the US there has been a dramatic reduction in the time "devoted to the learning and practice of psychoanalytic psychotherapy" – from 50% in the decades following World War II, to as little as 2.5% nowadays. (However, these figures are somewhat confusing as the authors confound psychoanalytic with psychodynamic psychotherapy). What Trigwell et al, did not mention was that in the US the practice of psychoanalysis was exclusively restricted to medical doctors up to about a decade ago. In recent times American clinical psychologists have begun to take over the provision of a broad range of psychotherapies. Concurrently, psychiatric training in the US has become more biological and technological in orientation.

Fortunately, on the continent of Europe, this split between the biological and the psychological approaches has rarely been as striking as in the US. Nevertheless, psychiatry in Ireland has been increasingly leaning towards the 'American model'. This may be due, in part, to the fact that Irish doctors, for historic, cultural and linguistic reasons, tend to go to the US for postgraduate experience and training – to a degree rarely found in other European countries.

Within American psychiatry, concurrent with the move from psychodynamic psychotherapy to a more bio-technological approach, there has been a sharp decrease in the duration of inpatient hospital stay.[3] The 'time is money' attitude has put considerable pressure on traditional forms of psychodynamic psychotherapy, where it has always been argued that it takes time to achieve something worthwhile – such as substantial emotional and behavioural transformation.

This brings us back to psychotherapy training. Broader and more inclusive training from the beginning may help to deal with the inter-disciplinary problems to which Trigwell *et al*, referred. Trigwell *et al*, also complained that psychodynamic theories were presented as dogmatic 'truths', 'certainties', and 'discoveries'. I agree that it is more helpful to present psychodynamic theories as hypotheses and psychological constructs.[4] But psychodynamic theories are not the only ones which have been charged with the accusation of dogmatic presentation. Psychiatry too has at times been taught from the position of positivist factual certitude and is often examined by multiple choice questions which assume, with realist confidence, that *the* answer is beyond debate. A century from now shall we be as critical of current psychiatry for being relatively 'unscientific', in the fuller sense of the word, as we are today of Freud's writings of a century or so ago? Should, or can, psychotherapy really follow the steady drift away from the 'Art of Medicine' towards the (biological) 'Science of Medicine', ie. towards medical materialism?

It may well be that an exclusively biological grounding makes the acquisition of a psychodynamic perspective difficult. I can empathise with the complaints of the three psychiatric registrars undergoing training in psychodynamic psychotherapy. With my own original background in genetics I had similar initial difficulties in comprehending and feeling comfortable with the more elusive psychological constructs. The problem here is that one is addressing different domains – with biology focussing on the external and objective, and psychodynamics being primarily concerned with describing the process of construction of internal subjective reality. Both must be considered in dealing with the human condition.

Some serious attempts have been made to teach, and conduct research into cognitive behavioural psychotherapy along objective scientific lines.[5] However, whilst this is welcomed and promising, research into the dynamic psychotherapies is most unlikely to attract anything like the same level of funding as pharmacotherapy, or to attain such levels of scientific rigor as to assuage its critics. This is because, as already alluded to, psychodynamic psychotherapies mainly address the internal world of convert experience, which includes our memories, emotions and defences. Neither this subjective domain, nor the "inputs" of psychotherapists are as readily quantifiable as the fixed dosages of pharmacotherapy. Thus the insights emergent from the practice of dynamic psychotherapy are fragile in two directions – namely they are difficult either to prove or refute!

This lack of scientific scrutiny makes psychotherapy open to the charge of being 'like a religion',[1] an accusation with which I am not entirely uncomfortable.[6] Who has not heard patients make claims of beneficial emotional transformations based on their personal experiences with faith and spirituality? Such anecdotal claims have received empirical support.[7] Nevertheless, I should be unhappy at the thought of psychotherapy being taught as an orthodox dogma in the spirit of medieval fundamentalism!; but have little difficulty with the notion that a developing rich inner life, through rendering meaning, may be beneficially transmutative and adaptive in terms of our relationships with self and others.

Psychodynamic psychotherapy has also been perceived as adding no more than 'good literature'. Those familiar with the history of literature will know that it, like philosophy (including Oriental philosophy) has yielded extremely incisive insights into the human condition. This is not to argue that psychotherapy should be thought like literature. However, it must be acknowledged that a good literary style allows for more sophisticated portrayals of experience, yielding a counterweight to the reductionistic tendency in much scientific writing.

Since cognitive-behavioural therapies tend to focus on conscious behaviour and experience, there is less of an obstacle here to teaching them in the mode of the empirical sciences. Studying handbooks on behavioural therapy rarely poses serious problems for students. Problems do arise, however, when trying to teach those forms of therapy whose main focus is beyond the level of appearances; for example, on the inter-psychic 'space' (as in systemic family therapy), or at the lower levels of cogni-

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tive awareness (as in psycho-dynamic psychotherapy). Reading books alone will not suffice in learning to become a good practitioner here. Metaphorically speaking, what is called for is a degree of experiential 'immersion'. The difference between 'knowing about' from books and lectures on the one hand, and actual 'immersion' on the other, is rather akin to reading about Japan as opposed to going there and learning to speak Japanese! The latter approach creates a new experiential viewpoint together with a language (jargon) for talking about it. Having more than one point of view gives perspective. 'He who only knows England does not know England very well'! Trainee psychotherapists are thought how to listen attentively, observe, analyse and reflect more so than 'doing'. We are essentially the same as those whom we wish to help. Thus it is useful to also look at ourselves in terms of our defences and so forth.

The experiential aspect of teaching psychodynamic psychotherapy is incorporated into the tripod approach to becoming a practitioner namely: 1) Formal study (reading and lectures), 2) Personal therapy (individual and/or group) and 3) Supervision of practice. Other schools of psychotherapy are increasingly adopting this tripod approach. The more complementary perspectives we learn the better. Therefore, it is advisable for clinical psychologists and social workers, working in psychiatric hospitals to learn the language and constructs of psychiatry. Likewise, trainee psychiatrists would do well to continue to learn how to view the world through psychological and sociological 'lenses'. Thus I hope that psychiatric trainees in Ireland, under pressure with an ever-expanding curriculum, do not lose sight of the value of training in the dynamic psychotherapies.

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References
1. Trigwell PJ, Curran S, Milton J, Rowe C. Training in psychodynamic psychotherapy: The psychiatric trainee's perspective. Trish Journal of Psychol Medicine 1995; 12 (2): 57-9.
2. Clare AW. Commentary on "Training in Psychodynamic Psychotherapy: The psychiatric trainee's perspective". Ir J Pychol Med 1995; 12(2): 59-60.
3. Leibenluft E, Tasman A, Green SA. Less time to do more: psychotherapy on the short-term in-patient unit. American Psychiatric Press: Washington, DC, 1993.
4. Winter DA. Personal conduct psychology in clinical practice. Routledge, London, 1992.
5. Bergin C, Garfield S. The handbook of pychotherapy research. Wiley: London, 1944.
6. DelMonte MM. Silence and emptiness in the service of healing. Br J Pychotherapy 1995; 11(3): 368-78.
7. Neelman J, Persaud R. Why do psychiatrists neglect religion ? Br J MedPsychol 1995; 68 ()2): 169-78.

Commentary on 'Training in Psychodynamic psychotherapy: the psychiatric trainees perspective'

Sir – I would like the opportunity to reply to Prof Clare's comments. He has made some strong criticisms of myself as a psychotherapy tutor and in addition I was not given the opportunity of seeing his criticisms before publication.

I suspect that Prof Clare's somewhat aggressive commentary is intended to promote correspondence on the topic of psychotherapy training for junior psychiatrists and I fully support this aim. However, despite his strong re-statement of the trainees' comments about their dissatisfactions with psychotherapy teaching, he has missed the point that this trainer and trainees have at least a good enough understanding and working relationship to write an article together expressing different views. It arose out of a supervision group in which th three trainees were given the opportunity to talk about the difficulties of learning psychotherapy. Does a dogmatist commonly facilitate this sort of discussion?

Prof Clare did not notice the trainees' comment that they have gone on to incorporate their psychotherapy training in their general psychiatric practice. Their experience of psychotherapy teaching was in many respects helpful, despite it's shortcomings. Their dissatisfactions were taken on board by their tutors and they went back and revisited ideas that they initially felt antagonistic towards.

Is Prof Clare suggesting that multidisciplinary training is to be discouraged? There are difficulties in multidisciplinary teaching, but the outcome is usually that in the long run trainees say they have learned a lot about the perspectives of different disciplines and this benefits their working relationships.

I am sure Prof Clare does not think that the seminar format for teaching, which is designed to encourage discussion, is a bad idea. One of the reasons given by the trainees, for finding this difficult, was that it was unfamiliar. Doctors are used to being taught 'facts' both from their medical undergraduate teaching and later at postgraduate level. This does make it harder to adapt to a subject which is concerned with the history of ideas, concepts and with models of the mind. This context needs to be given consideration by psychotherapy trainers and teachers so that the different way of thinking entailed is clearly indicated. Moreover, the differences between factual knowledge, theories that relate to an understanding of human nature and opinion need to be distinguished. How to apply these theories usefully in thinking about patients in a psychiatric setting should be a central concern to teachers.

I was surprised that Prof Clare misunderstood my suggestion that trainees should look critically at research into psychotherapy practice and at the scientific literature (for instance, that related to memory storage and retrieval, and to the importance of attachment in relation to child development and to adult life). As well as ideas of psychoanalysis, this is also important to the study of psychotherapy. However, my comments were abbreviated in the interests of producing a brief article and I see my meaning was not clear.

'Negative reactions' are not always the same as 'negative attitudes'. Negative reactions in my book refer to doubts, disappointments and anxieties which need to be addressed but which are also important aspects of learning. Negative attitudes include the wish to denigrate and dismiss without any thoughtfulness. I did not think this was the case with this group of trainees. The trainees' fear that their objections are going to be analysed and in a critical fashion is another area that needs to be faced by psychotherapy trainers.

Perhaps my reply will be interpreted by some readers as a fundamentalist defending his corner. The anti-psychotherapy dogmatists may think so. It is not intended as such, but rather as an attempt to put an important question about how psychotherapy should be taught to trainee psychiatrists back into the arena of sensible debate. It seems to me that Prof Clare and I may well be on the same side. Some understanding of psychoanalytic ideas is essential for the educated and thoughtful psychiatrist. In addition, teaching about the range of psychotherapy approaches (psychodynamic, cognitive behavioural, systemic) how and when to apply them is also essential even if the psychiatric trainee does not intend to develop a special interest in this area. There are a number of reasons why it is difficult to teach psychotherapy successfully and helpfully in the context of a general psychiatric training and these need to be addressed thoughtfully and constructively.

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The Tukes of York

Sir – In Prof Breathnach's enlightening article on the Tukes of York, he refers to my great great grandfather, Dr John Eustace (1791-1871), a Dublin friend and physician who knew Daniel Tuke and modelled his hospital, Hampstead, on the moral treatments at the Retreat York. However, John Eustace became

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