

## Personal columns

### Senior registrar in psychotherapy

A. RYLE, St Thomas' Hospital, London SE1 7EH

Higher professional training is designed to produce consultants and in general this aim is achieved by combining the increasing practice of consultant-like activities (clinical, teaching, administration) with the opportunity to consolidate basic skills and knowledge and to undertake research. This combination of the practical and the intellectual is regulated by clinically and academically responsible professional bodies. While the same principles apply in psychotherapy, there are a number of special features.

Lacking respectable medical parentage, and subjected to much prejudice, psychotherapy was slow to win acceptance as a part of the National Health Service and as a necessary strand in psychiatric training. Psychotherapy had been kept alive largely by psychoanalytic organisations and it was from this source that the teachers and new consultants were mostly drawn. This predominance is now maintained and in many ways is increasing, despite the emergence in recent decades of cognitive, behavioural and integrated approaches to therapy. As a result, the current training of senior registrars is heavily influenced by the training evolved for psychoanalysts, with an emphasis on long term treatments of patients, with higher value placed on treating patients more than once weekly, and with the expectation that trainees will undergo a full personal analysis. In London at least, there is in addition a powerful implicit (at times explicit), pressure to seek analysis with one of the main institutes and there is little chance, it seems, of a London consultant post unless the applicant has added to his or her NHS training a parallel training with one of the Institutes. I believe this trend is unfortunate and should be given carefully consideration by the profession.

In this discussion I am speaking personally from the viewpoint of one of the last consultants to be appointed in London who had not undergone the formal training now deemed appropriate. It is, I think, natural that I tend to think that it was a good thing that I was appointed and therefore believe that the kind of door which let me in should be left open. I hope that the reader, while recognising this possible bias, will also attend to the arguments put forward here. These arguments do not dispute the major con-

tribution made to psychotherapy by psychoanalytic idea, and by many individual psychoanalysts, but they do suggest that the training of psychotherapists and the consultant psychotherapist establishment should reflect a spectrum of ideas and practices, and must not be in the exclusive control of the psychoanalytic institutes. As a corollary to this, it is clearly important that the College Specialist Sub-Committee should reflect this spectrum of views also.

#### *The work of the consultant psychotherapist*

Most of the first consultant psychotherapists in the NHS were attached to the psychoanalytic enclaves of the Tavistock Clinic or the Cassel Hospital or to teaching hospital departments often created in the same mould. They were oriented towards training and paid rather little attention to research or to questions of service provision. With the increase in posts and the reluctance of most analytically trained consultants to stray into the analytic wilderness that stretched from Potters Bar to Edinburgh, some new appointments were filled with relatively eclectic incumbents, bringing, perhaps, a touch of hybrid vigour. Moreover, in these non-metropolitan areas, the pressure to provide a service to a catchment area similar to that provided by other specialities was more clearly visible. With current demands for cost-effectiveness and audit, this requirement to take seriously a responsibility to populations (rather than to those patients who get treated) is likely to increase, correctly in my view. The consultant of the future will have to cut his or her therapeutic coat to match his or her cloth. Simple calculations will tell us that 100 hours of therapist time can treat one patient twice weekly for a year, or two patients once weekly, or six patients for four months each. To run this service he or she will need to be good at working with therapists with a range of skills and trainings. Although holding, no doubt, particular preferences as regards psychotherapy theory and practice, the future consultant cannot afford to travel on faith alone, and proper evaluation and research will be needed to establish what practice is effective and to justify

the decision to use the more expensive and time-consuming approaches. In the rest of this article I will consider how far and at what cost present trends in training are likely to prepare the senior registrar for this pattern of work.

### *Matching training to practice*

In general, training in an activity involves practising it. Currently, senior registrars will gain some experience in most of the activities listed above, but the emphasis on long term work and on parallel psychoanalytic training gives the highest status to an activity which they will never practise (unless they choose, having trained in the NHS, to work in it part-time only, which is a common but, from the viewpoint of the NHS, an uneconomic outcome). Only if one believes that the personal experience of psychoanalysis and practice in it produce universally able human beings and clinicians would this seem to be a sensible approach, and there is little enough in the way of evidence to support that view. The implicit belief that the frequency of personal analysis required by a training is an indication of its quality is no better grounded. Even if one were to accept that psychoanalytic training enhances the effectiveness of psychotherapists to a remarkable degree, in ways not achievable by other forms of training, the costs of such training must be borne in mind. These include the hostility to brief forms of psychodynamic therapy displayed by the psychoanalytic establishment, the intellectual isolation of psychoanalytic thinking and the very poor track record in respect of research. I believe that the ideas that have been generated from psychoanalytic work are crucial to psychotherapists but I believe that they are vigorous enough to face competition. I believe that the practice of psychotherapy is different from that of psychoanalysis and that the training should be different. Non-psychoanalytic ideas and methods have made major contributions which no psychotherapist can afford to ignore. If debate between, and integration of, competing approaches are to flourish, we need a training that encourages questioning rather than conformity, and a consultant body containing protagonists of psychoanalytic, cognitive behavioural and other views, with, I would hope, a particular encouragement of those committed to integration and research.

### *The personal cost of training*

The psychotherapy senior registrar is at a time of life when marriage or stable cohabitation, having children and taking out mortgages are normal activities. The narrowness of British education and the high demands of medical training mean that few will have

attended seriously to literature, art or music and few will have sustained minimally healthy involvement in physical recreation. To add to SR training in the NHS a parallel analytic training involving 15–20 hours per week means days starting at 7 a.m. with personal analysis and ending at 8 or 9 p.m. with training cases; this can hardly be compatible with good relationships with partners or children, let alone with the broader experience of life which might contribute to the kind of maturity one would hope to find in a therapist. Add to this the financial cost of analytic training and one can foresee a time when only single minded zealots with private means will present themselves for training.

### *The requirement for personal therapy*

Despite the failure of Macaskill (1988) to find any evidence for the effect of personal therapy on the work of psychotherapists, it seems appropriate that personal motivation should be explored and personal awareness enhanced, given the intense exposure to others and the need to avoid collusive responses faced by therapists. However, it is in my view outrageous that the particular ideology and institution of the person giving the trainee therapy should be prescribed by the training body. Yet in effect this is now the case. There is absolutely no evidence to demonstrate the superiority of any particular school or frequency or duration of analysis over another. Provided trainees experience an adequate minimum exposure to therapy (preferably including both individual and group experience), the choice of with whom, how often and for how long should be left to the trainee, its adequacy being approved by the trainer according to agreed guidelines. I have known of two individuals in the past two years whom analytic training institutions have instructed to stop ongoing therapies in order to change to approved analysts, no consideration being given, apparently, to the stage of the therapy, and no consultation with the existing therapist (myself as one example) taking place.

### *Selection and validation*

The pressure to choose from a restricted range of analysts for one's personal therapy and the pressure, at any rate in London, to seek parallel psychoanalytic training, mean that decisions about consultant selection and validation are increasingly in the hands of the institutes, which are bodies devoted essentially to psychoanalytic training and which have no public accountability. Their history makes them weighted in the direction of private practice and their structures and methods tend to produce intellectual conformity and unconcern for other psychological

theories. In other specialities, in which there is a much clearer consensus about theory and practice, validation is in the hands of practitioners organised professionally, not according to belief. In the absence of such a consensus, psychotherapy requires the preservation of the right to debate and dissent as well as the maintenance of professional standards. There must be no confusion between what is professional and what is ideologically approved.

### *NHS changes and the future of psychotherapy*

At this time of change, traditional assumptions and patterns of work are likely to be questioned. One change which is certain to occur is the greater involvement of clinical psychologists in the provision of psychological treatments. The recent BPS booklet (November 1990) entitled *Psychological Therapy Services: The Need for Organisational Change* advocates a service co-ordinating a wide range of psychological therapies and makes a cogent case for the role of clinical psychologists in such a service. Compared to clinical psychologists with specialist therapeutic skills, medical consultant psychotherapists have a special role in relation to the training of psychiatrists and in liaison work but cannot claim greater authority in other areas such as research and administration. I believe that it would be wise to ensure that the training of consultant psychotherapists generates a broad, service-oriented attitude and a range of skills equivalent to that recommended in the BPS policy statement. It is better to be in healthy competition with a view to co-operation than to risk being marginalised as the practitioners of only one (lengthy and poorly researched) therapeutic method.

### *Conclusion*

I believe that SRs in psychotherapy should be trained by exposure to its various forms, in order to prepare them for the range of skills called for in NHS practice. Psychodynamic ideas derived from psychoanalysis will undoubtedly form a major part of their training, and longer term work with more disturbed patients should be part of their experience, but I see no reason

why "the intensive treatment of a few patients seen several times a week over a long time", (JCHPT Guidelines, 1991) should be a central component. There should be a central commitment to short term, group, couple and family work, but there is no evidence that intensive long term work is a good or necessary preparation for this. Personal therapy should be approved but should be determined by the trainees' preference and should not be restricted to any particular school or ideology. While some might choose recognised training analysts with a view to later analytic training, such training should normally be postponed to the time when the consultant contract can be trimmed to allow time for it. The choice of personal therapy should not influence selection for consultant posts. The consultant body should include representatives of a wide range of approaches. Psychotherapy is a field where there is more uncertainty and debate than in any other sub-speciality, and less research. For this reason properly conducted research in psychotherapy, either before SR training or during it, should carry considerable weight in the selection of consultants, for only through the introduction of informed debate and careful evaluation can the practice and conceptual development of the field be assured.

### *References*

- THE BRITISH PSYCHOLOGICAL SOCIETY (1990) *Psychological Therapy Services: The Need for Organisational Change*. Leicester: BPS.
- MACASKILL, N. D. (1988) Personal therapy in the training of a psychotherapist: is it effective? *British Journal of Psychotherapy*, **4**, 219–226.

Dr Ryle raises points of great interest and concern to the College. Such matters have been raised by others in recent months and the President has set up a small working group, which I am to Chair, on the position on behavioural and cognitive psychotherapy within the College.

It would be very helpful to hear the views of Members through the correspondence column.

DR FIONA CALDICOTT  
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