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