activities, for example giving lectures to primary care groups.

Conclusion

My findings mirrored a previous study whose aim was to pick up 'at risk' women and work preventatively. They found the majority of referrals to a new obstetric liaison service were for women with psychiatric symptoms during pregnancy (Appleby *et al*, 1989). The wide spectrum of psychiatric disorders referred was noted in another study (Dunsis & Smith, 1996), and this was replicated in my experience.

It was clear from my experience that there was a demand for a service for women with psychiatric problems associated with childbirth. Because of the pressure on the general psychiatric service, colleagues were keen to pass on their cases so that my available time was soon used up. This did therefore not allow me time to develop efficient systems for referral and management or to then see the extra referrals this would have produced.

Towards the end of the year, the health authority developed a contract for specialist perinatal services covering the area. This service will develop more formalised provisions and include an in-patient facility as well as outreach community-based services.

The limited and temporary service I was able to offer was well received by other professionals and by patients. I always discussed cases with referrers who felt my input was valuable, but it was not possible to more formally monitor outcomes. It provided me with good experience of the variety of psychiatric conditions presenting during and after pregnancy. The number of referrals I received during this period fell far short of the expected morbidity. However, to have further advertised my service would have led to an unmanageable workload for the time available. It is evident that in an area with this number of births and its consequent level of psychiatric morbidity, it would not be possible, within two special interest sessions, to develop a more formalised or comprehensive system.

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Bridging the psychotherapy divide

Mary T. Monaghan and Stirling Moorey

Aims and method All consultant psychotherapists should be sufficiently familiar with the three major branches of psychotherapy, to appropriately match therapy with their assessment of the patients' needs. This requires that specialist registrars training in psychotherapy acquire skills in psychodynamic/interpersonal, cognitive-behavioural and systems-based therapies.

Results While acknowledging the benefit for the trainee of being familiar with more than one model of

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psychotherapy the practicalities of incorporating different models in to training is likely to be problematic, at least initially, for both trainees and trainers.

Clinical implications In this article the experience of a senior registrar who completed a training in psychoanalyticpsychotherapy prior to gaining experience in cognitive-behaviour therapy is examined from the perspective of both the trainee and cognitive-behavioural trainer.

Specialist registrar training in psychotherapy should enable the trainee to assess and treat patients making use of each of the three major branches of psychotherapy practised within the National Health Service (NHS): cognitive–behavioural, psychodynamic/interpersonal and systems-based therapy. This will allow the trainee to match therapy with the patient's needs, thus providing the most appropriate treatment for the patient. Most trainees will wish to specialise in one branch and acquire sufficient expertise in that model to allow them to teach and supervise as well as assess and treat patients. In an attempt to facilitate specialist registrar psychotherapy training within the NHS the Royal College of Psychiatrists has specified that trainees spend 700 of the 900 hours of supervised practice allocated for training in their preferred branch of psychotherapy and 200 hours in the other two branches (Royal College of Psychiatrists, 1995). The College will accept a more eclectic training but acknowledges that most trainees will not wish this and that most training institutions are unlikely to be able to provide it. It is at specialist registrar level that trainees will attempt to integrate models of psychotherapy to a level where they are competent practitioners. This is likely to result in difficulties for both trainee and trainer at whatever stage of training the alternative models are introduced.

In this paper the experiences of a senior registrar undertaking 100 hours of supervised cognitive–behavioural therapy (CBT) towards the end of a four-year psychoanalytic training and that of her CBT trainer will be examined.

Trainee's experience

As a flexible senior registrar training in the pre-Calman era I was offered a six-year contract in which to complete my special responsibility training in psychotherapy. During the first four years I attended an advanced training course in adult psychoanalytic psychotherapy, the thrust of which was a four-times weekly personal analysis which continued throughout the duration of training. In my third year, I made arrangements to attend a weekly CBT supervision group but was unable because of time constraints to treat a patient using CBT at that time. This experience allowed me a space in which to think about similarities and differences between CBT and psychoanalytical psychotherapy. For personal reasons towards the end of my fourth year I transferred my flexible training post to North-West Thames and at this stage of training did start to assess and treat patients cognitive–behaviourally under supervision.

The tools that I as a cognitive–behaviour therapist was expected to use were very different from the psychoanalytic tools I had acquired. I felt deskilled and suspected that my communication with the patients while being technically correct was stereotyped, dry and sterile. To my surprise all of my patients survived the experience. I discussed the problems I was experiencing with my supervisor who showed understanding of the issues I was raising. He encouraged me not to attempt to follow the 'rules' attached to CBT in a rigid way but rather to allow myself more flexibility within the sessions. As I gained experience I was gradually able to integrate psychodynamic understanding with the more formal experimental method used in CBT. I discovered that my understanding of the transference relationship between the patient and myself could often be restructured to provide the patient with an explanation of the schemata or basic assumptions underlying his manifest behaviour and faulty cognitions. By the end of therapy with some of the more disturbed personality-disordered patients that I had treated by CBT I suspected that there had not simply been a symptomatic shift but also a dynamic shift. Indeed I thought that some patients who on initial assessment would not have been suitable for psychoanalytic work would now benefit from this, which in the longer term could result in personality change.

Discussion (trainee)

While recognising that some cognitive therapists do not accept the concept of 'the unconscious' and would provide a behavioural explanation for the formation of schemata, they would I think agree that making a patient aware of the basic assumptions underlying his cognitions was an essential part of the cognitive–behavioural model when working with more disturbed patients. Schematic explanations like psychoanalytic interpretations result in the patient becoming aware of a part of himself that he has not previously recognised. The psychoanalyst would view this concept in terms of making the unconscious conscious and thereby allowing the patient choice in regard to his future

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behaviour, a choice that did not previously exist. CBT, which has as its basis the experimental method, would look for changes in the manifest behaviour of the patient to empirically validate the treatment.

Trainer's experience

While it is clearly the role of a CBT supervisor to ensure that his trainees establish good practice, there is sometimes a danger that supervision can become rigid and overprescriptive. Someone coming to CBT for the first time can feel overwhelmed by how busy it is. When the trainee is more familiar with a style of therapy which is less directive they can feel constricted and pressurised. My own approach has been to try to work with the strengths which the trainee brings to therapy and help them to develop their own way of doing CBT. This will include personal skills and also theoretical and technical skills brought from previous training.

It is often our experience as cognitive therapists that psychodynamic therapists find it harder than most to learn CBT. As well as difficulties with the structure of therapy, the whole therapeutic relationship is different. Rather than waiting for themes to emerge, we tell them to be active from the first session, identifying problems and establishing goals for symptom relief. In standard cognitive therapy, therapist and patient talk about 50% of the time each, and rather than open, emotion-based inquiry we use closed, factual questions to help reveal the distortions in the patient's thinking. The relationship is collaborative in a very different way from a psychodynamic therapy. Therapist and patient work alongside each other on a problem that is externalised, rather than focus on the relationship as the vehicle for change. All this can seem to miss the point for therapists who see continuous examples of transference go unnoticed in a cognitive therapy session.

My trainee's experience of her initial attempts feeling stereotyped and false is a common one. It is perhaps inevitable that when we are learning a new skill we have to practise it in a rule-bound way. A novice cognitive therapist's session appears highly structured, whereas a session by an experienced cognitive therapist seems to flow. Trainees can be tyrannised by technique, a persecution that is encouraged by some of the more cook-book descriptions of CBT. Real cognitive therapy is much more alive and dynamic than this stereotype. It places great emphasis on conceptualisation as a road map for therapy. In supervising my trainee I set out to help her to translate her understandings of what has happened in the transference with her patients into cognitive language. I am sure that the trainee's ability to deal with transference issues helped her to successfully treat by CBT patients who in less skilled hands would have made progress during therapy but relapsed soon after.

Discussion (trainer)

This is an example of how an experienced psychodynamic therapist was able to learn CBT techniques and integrate them within a theoretical understanding that did not violate her previous model of the mind. This was not achieved without a struggle, during which she felt confused and deskilled for some weeks of her placement. This is not surprising if we think about the process of changing our schemas about therapy. By the time a specialist registrar decides to specialise as a psychotherapist, he or she will already have espoused a particular form of psychotherapy. To embark on a psychotherapy training requires a strong belief in the 'truth' of our own brand of therapy and we will have a tendency to seek confirmatory information for its applicability and efficacy. In the past, most therapists have remained 'brand loyal' to a fault. The College is now asking specialist registrars to learn more than one form of therapy, with an assumption that this is relatively easy. I suspect that dedicated psychotherapists will find this eclecticism difficult to embrace. It is possible for a psychoanalyst to do 100 hours of CBT (or vice versa) as a penance, without changing their belief in the one true faith. But to really learn about another form of psychotherapy we need to be able to both assimilate it within our existing schema of therapy, and modify our schema in the light of this new information and experience. Little attention has been given to how trainees might be supported in this, but we hope that this article will stimulate some thought and debate about the issue.

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