need long-term therapy, and offering a general service with a range of therapies can be cost-effective for a Health Maintenance Organisation (Bennett & Wisneski, 1979).

Andrews' argument seems hostile and hasty. It continues the division between psychodynamic psychotherapy and cognitive therapy and that between psychodynamic psychotherapy and research. Both divisions have been profoundly unfruitful for the growth of knowledge and mutual respect. For this reason, among others, his argument is regrettable.

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SIR: Andrews' call (*Journal*, April 1993, **162**, 447–451) for greater valuation and teaching of 'good clinical care' is as encouraging as his implicit dismissal of dynamic psychotherapy as 'inessential' is tendentious. Dynamic psychotherapy is essential to good clinical care as he depicts it, requiring an appreciation of the principles of overdetermination, defense-mechanisms, and of the inevitability of transference and countertransference within the therapeutic relationship. I have described a similar approach as supportive analytic therapy (Holmes, 1992).

Andrews makes a valid point in his call for controlled studies of analytic psychotherapy, but surely overstates his case in his efforts to discredit the dynamic approach in comparison with cognitive therapy. Effect sizes may generally be greater with cognitive-behavioural approaches, but nonetheless his own study (Andrews & Harvey, 1981) showed an impressive effect size of 0.74 for dynamic therapies. He fails to discuss the limitations of meta-analysis, or to mention Horowitz *et al*'s attempts to tease out the differential indications of dynamic and behavioural approaches, showing, for example, how in the psychotherapy of abnormal grief, inhibited patients did better with an expressive approach while less mature patients benefited from a behavioural one (Horowitz *et al*, 1984).

Andrews' arithmetic purports to show that, by using dynamic psychotherapy, 15% of psychiatrists are only able to treat 0.5% of the patients, and raises an important point about manpower, but this again reveals his bias. Many of the patients treated in psychotherapy departments suffer from severe personality disorders, and, despite their statistical infrequency, often consume huge amounts of ineffective, non-psychodynamic time and resources. Rosser *et al* (1987) showed that long-term, in-patient dynamic therapy with such patients can be effective and cost-effective, if 'offset costs' such as medical salaries, drug bills, and welfare payments are included in the equation. Andrews' concern with the 'safety' of psychotherapy, and his awareness of the dangers of therapist abuse are laudable, but his insinuation that dynamic therapy is less safe than other forms of psychotherapy is based on no firm evidence, and can only be regarded as a slur that fits the overall polemic of his piece.

We are entering an era of creative collaboration between the psychotherapies. Cognitive therapists are beginning to work with transference and countertransference, and dynamic therapists are increasingly abandoning dogma for observation while rating, evaluating, and researching their methods. Ryle's (1991) 'cognitive analytic therapy' is an example of a time-limited dynamic therapy, appropriate for 'third-party funding', that illustrates this new spirit of cooperation. If Andrews' aim was to provoke debate it is to be welcomed, but if to revive old antagonisms and destructiveness, he does a disservice to our discipline.

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