Case 1. Became distressed, recollecting her termination of pregnancy, and disclosed CSA. During the following sessions she became progressively more disinhibited and eventually hypomanic. This culminated in her doing karate kicks while saying, "You are so perfect, with your job, husband and baby asking me how I felt about my termination, I could have killed you". When I acknowledged her anger she accepted admission.

Case 2. Announced that she wanted to get pregnant too, "so we can have our babies together" and had been having unprotected intercourse. We were able to explore her wish to become pregnant, to keeping the therapy alive inside her and to identify with me, while on the other hand attacking me, by withdrawing from a drug trial she was participating in.

Case 3. Had recently disclosed CSA to her family. My pregnancy coincided with the breakup of her marriage. Earlier treatment had ended due to her therapist's pregnancy. She became depressed and suicidal, saying "I'm not important to you, you have a life and family of your own", and required admission.

Case 4. Had been abused by her brother. After hearing of my pregnancy she returned her medication saying that news of my pregnancy had cured her. She did, however, admit to being angry, "with men, it's all their fault", saying that as I had my baby to worry about I should not waste time on her. Despite interpreting her anger, she continued her "flight into health". On my return from maternity leave she represented.

My pregnancy, by reminding patients of their damaged sexuality, made them envious of my life and marriage. I was perceived as abandoning them, as perhaps their mothers did in not protecting them from abuse, leading them to demonstrate their needinesss. A physician's pregnancy may be particularly traumatic for patients who have been abused.

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Need for support in developing clinical skills

DEAR SIRS

I greatly enjoyed the article 'The Doctor Patient Relationship and Psychiatric Out-patients' (Timimi, *Psychiatric Bulletin*, June 1991, **16**, 425–427). The author reminds us that no matter how straightforward or "biomedical" a clinical problem may appear, we ignore the subtleties of transference and counter-transference at our peril. This message is particulary refreshing at a time when psychodynamic principles and their advocates are so often displaced by the hegemony of biological psychiatry.

I was, however, concerned by the style in which this piece was written, and in particular the repeated implication that the author had arrived at these clinical insights in isolation. While accepting that Dr Timimi may be a gifted as well as a perceptive psychiatrist, the piece makes no mention of colleagues, either junior or senior. With the exception of an intuitive "flash" (as described by Balint) the author fails to identify the sources of any of the interpretations employed. The use of a private, rather than a work, address at the top of the paper further suggests a clinician working alone.

As psychiatric trainees we are under great pressure to undertake service commitments, initiate research, prepare for exams and apply for career posts, all in the space of a few years. In the midst of this we also seek to develop clinical skills which are necessarily very different from those of our medical colleagues. Above all we must learn to listen to our patients in the manner exemplified by Dr Timimi. It is highly misleading, and potentially dangerous, to suggest, however subliminally, that these skills can be arrived at intuitively or without supervision. Life for a psychiatric trainee is hard enough without being made to feel that one should be able to arrive at psychodynamic formulations unaided.

To develop clinical skills trainees require both peer support and the sort of supervision which incorporates both didacticism and an attention to interpersonal issues in the doctor-patient relationship. Without supervision such matters are likely to be overlooked; at worst they may lead to dangerous or pathological acting out on the part of both doctor and patient.

Dr Timimi is right to re-assert the case for psychodynamic thought in the routine care of 'general' psychiatric out-patients. All trainees must be encouraged to think about their relationships with patients, including both the positive and negative feelings evoked. To do so may result in anxiety and a sense of vulnerability: for this experience to be bearable and therapeutically productive there must be considerable support. That this support is occasionally not forthcoming (or worse still not sought) is inexcusable; that a fellow trainee should suggest that it is unnecessary is highly regrettable.

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