analytic therapy" without being explicit that these were agreed quality standards to be present in any practice of CAT. Furthermore, there seemed to be no agreed level of expertise expected of the therapists; however, the impression was given that implicit standards and practice were operating.

The link between supervision, (as would be practised in the normal course of good psychotherapy), and audit was not clarified. We were therefore left wondering if the analysis of audio tapes was routinely used as part of supervision or whether it has been introduced sporadically and specifically for the purpose of audit. No comment was made about the potential difficulties in audio taping therapy sessions, and its effect on the process of therapy.

We felt that this paper raised more questions than it answered. Our recommendation would be that it could have been more valuable as a descriptive account of the process of setting up this kind of audit of psychotherapy, acknowledging its limitations and difficulties, rather than the quasiscientific inquiry it became.

MEG KERR, J. BIRTLE, F. ROLDAN, J. APPLEFORD, J. EVANS, R. SARGEANT, C. KENWOOD, J. RAMSDALE and L. CHESTER, *Uffculme Clinic, Queensbridge Road, Moseley, Birmingham B13 8QD*

Sir: On criticising my work Kerr *et al* raise issues of considerable importance in psychotherapy research. They take exception to what they see as subjective and evaluative judgments made in my audit, and presented in a "quasi-scientific" format, citing for example, the use of the term "definitive interpretations". This is odd as the term "definite" interpretations is closely defined (point 1 in Table 1). They also criticise a comment about "communicative misfires" even though this is clearly signposted as an impression.

The suggestion that clinical material should have been presented was prevented by space constraints although this would not guarantee greater objectivity because of biasing effects of selection, recall and description. Taping could eliminate some bias but Kerr *et al* have reservations about the effects of taping on therapy and take me to task for failing to discuss this. The matter does need discussion, most importantly in the area of ethical and practical criteria for gaining informed consent to taping in a way which respects psychodynamic and power issues. But in my experience the chief anxieties, problems and resistances to taping arise in the therapists not the patients.

I was sad my paper might have given the impression that supervision was not a regular, mandatory part of the practice of CAT and that the authors implied that the therapy done at Guy's was not good. Neither is true.

I was astonished that Kerr *et al* felt it a criticism that my paper raised more questions than it answered. I take this as an (unintended) compliment. The chief point of my paper was to report how (more by luck than by judgement) an audit I had done which had certain features did change practice (whether for the better remains to be evaluated). I suggested that success in this respect resulted from how our evaluations managed to be both close to and distant from the concerns of clinicians and supervisors. If this feature made for "quasiscience" then at least in audit terms it seems to have worked.

F. DENMAN, *24 Lawrence Street, Chelsea, London SW3 5NF*

The same old scene?

Sir: Lewis (1991) states having a publication (and not simply being involved in some research project) is important in getting to interview. Post-membership appears to be the optimum time for this as examinations no longer loom on the horizon.

Most books on research regard the process as starting with the formation of new hypotheses and then the subsequent generation of methods to test them. Flanigan (1992) showed that 14.9% of papers in the *British Journal of Psychiatry* had a junior author. This included the senior registrar grade. Lewis was concerned with the progression of registrars to the senior registrar grade. For registrars the situation is still poor: (excluding non-UK authors) there were 258 authors present in the January to June 1993 issues of the Journal. Of these 17 (6.5%) were registrars, and were almost (bar one) exclusively present in original papers (7 out of 158 – 4.4%) and brief reports (9 out of 44 – 20.4%). There were no papers of original research with sole authorship.

The trend is therefore unchanged for registrars. Since brief reports continue to be the only realistic, but still sparse, method of obtaining publication it shows that publication does not equate with research. If Lewis' hypothesis still holds then the determining factor for interview is not the generation of new hypotheses and testing them (pure research), nor really the testing of other professionals' ideas (passive research normally involving the laborious administration of innumerable rating scales), but is actually dependent on which patients you see. Essentially career progression is determined, not by having experience of seeing thousands of mentally ill and learning to manage them, but more by the one case of an Eskimo

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