THE TEACHING OF PSYCHOTHERAPY

By

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FOR the past twenty years we have been studying methods of teaching and their effectiveness in changing the behaviour of medical students and doctors. At the Massachusetts General Hospital our work was concerned primarily with teaching psychotherapy to medical students, residents and younger physicians. During these years we have practised and taught many kinds of psychotherapy, including situational therapy, relationship therapy such as catharsis, support, reassurance, suggestion and persuasion, and the various types of insight therapy from the verbalization and understanding of simple correlations to more extensive Freudian psychoanalysis. The patients we treated in Boston were primarily those with psychoneuroses and psychosomatic disturbances. In these groups of patients insight therapy was the method of choice. It was only when insight therapy was impracticable or too disturbing to the patient that other methods such as relationship therapy were used. During these years we used insight therapy whenever possible, often with limited effectiveness. The treatment for any given hospital admission required from 20 to 40 interviews, occasionally more. It was our practice to use the vis-à-vis interview method.

Since we are to discuss the teaching of psychotherapy I should like to describe in a little greater detail the type of therapy we were trying to teach. Obviously we were interested in teaching methods of diagnosis and of formulating the psychodynamics in our patients—but our major emphasis was on procedures of interviewing that we adapted and found useful in insight therapy (1).

This form of insight therapy owes much to psychoanalysis, both in scope and in technical procedures. As in psychoanalysis, the therapy relies on an effective doctor-patient relationship for the production of material for interpretation and assimilation. The material is made up of behaviour, talk, intonation, gestures and feelings; it includes the whole gamut of verbal and non-verbal reactions. The ultimate goal of insight therapy that we practise may be limited to a less fundamental rearrangement and enhancement of the personality than in psychoanalysis. When used in relatively brief psychotherapy, it seldom exposes the phantasies and memories that are most deeply repressed. As a rule, transference material and dream material are not used to the extent that they are in psychoanalysis. But there is nothing to prevent goal-directed procedures from being applied in a longer and more extensive treatment. And indeed, we have so applied them. In such cases, the patterns of the patient are followed in greater detail through the use of dream and transference material, relying constantly on the fundamental principles that we find helpful in insight therapy. These principles are the development and utilization of an effective doctor-patient relation, the use of goal-directed planning and management, the focusing of material, and the use of minimal activity.

https://doi.org/10.1192/bjp.104.435.504 Published online by Cambridge University Press

It is our experience that these procedures can be taught and that students can learn to apply them starting with their first patient. The teaching method that we find most effective consists of reading verbatim interviews of a current case in which the remarks of the doctor as well as the patient are recorded. In these supervisory conferences the methods of interviewing and management are formulated and discussed in reference to the situation as it is presented. Dynamic formulations of the patient's productions are elaborated, but the emphasis is on procedures—what to do. Teaching is most productive when the students actively participate in these discussions. The student learns that the very elements in his own behaviour which make for success in the conventional social situation may be precisely contra-indicated in psychiatric interviews used for insight therapy.

The four guiding principles that we have found useful in insight therapy have been referred to above. The enumeration of specific principles in a field as fluid as psychotherapy may seem arbitrary and even challenging, but it is our impression that experienced therapists will recognize much in common between these principles and the rationale of their own working procedures. These working guides could be useful for other forms of psychotherapy. The extent to which such guides would include these four principles can be determined only by study and evaluation.

In collaboration with Dr. Florence Powdermaker these principles have been presented in a series of films on psychotherapeutic interviewing (2), which I am sure many of you have seen.

The method of teaching was as follows: when a new patient was admitted to the service for treatment he was assigned to an assistant resident or to a fourth year medical student. After a brief history had been taken, the physical and laboratory examinations and a mental status examination had been completed, the resident would meet with the instructor individually or with a small group of residents and students. A tentative diagnosis was made, the type of therapy was decided upon and immediate and ultimate goals were set up for the treatment. Usually the immediate goal in the area of material was a detailed description of the current symptoms or problem. The purpose of this was to enable the patient to describe in detail his symptoms and the setting in which they occurred. The resident was urged to write down the verbatim remarks of the patient, to write down his own comments as the interview proceeded—as accurately as possible. At the next supervisory session, which was preferably the next day, the resident would present his material. He would state his goal and read the verbatim interview, being sure to include his own remarks as well as those of the patient.

The interview is usually first scrutinized as interaction material; the resident's interventions and the patient's material are discussed in detail. The questions dealt primarily with the appropriateness of the resident's interventions and their effectiveness in reaching his stated goal. The inexperienced therapist is usually unable to set up meaningful goals; he also has difficulty in proceeding systematically toward achieving his goals even if he can state them. He is usually not clear about his goals, follows the patient's leads and for many reasons—usually unbeknown to himself—goes off at a tangent. The discussion of this aspect of the interview points out just how the patient's productions are influenced by the behaviour and interventions of the therapist.

After a few interchanges have been discussed and have been appraised in terms of goal achievement the material is reconsidered in detail as to its content. The resident and the group are asked to scrutinize the interview material to

note the sequences of associations, to determine whether it is possible to see trends and patterns in the verbal material—and whatever non-verbal material is available. Once such a trend or pattern is unearthed an attempt is made to determine whether this pattern repeats itself in the material and whether it is in any way similar to patterns seen or inferred from the material of the patient as obtained in the history. As the resident acquires more skill and technical facility he is able more readily to set up reasonable goals, to become more skilful in working towards them, and to become more flexible in changing goals. He becomes more sensitive in appraising the subtleties of the patient's material and his own role as a participant in the doctor-patient interaction. During the early stages of the work with a given resident the entire supervisory session may be spent in discussing two or three interventions, and in setting up the goals of the next interview. After several supervisory periods it is possible to cover an entire interview or the major part of an interview in a single session. Later on usually less time is spent on technical matters relating to interviewing and more time becomes available for understanding the content and meaning of the material. As the resident becomes more experienced it becomes possible to discuss every other or every third interview. In the supervisory meeting the instructor encourages the resident to bring up his own questions and problems. The purpose of the discussion is to solve the problems. The role of the instructor is to keep the discussion alive—to point it up if necessary and to do this with the minimum amount of talk on his part—in order to stimulate the maximum discussion on the part of the group.

The advantage of group supervision is that many students can learn from the work of one student. We have also found it practical and even wise to supervise a mixed group of students—two or three medical students, two or three first-year residents and two or three more advanced residents. Since the technical methods are the same and are consistent it is possible for the more experienced students to teach the less experienced students. The more advanced doctor may be reporting on some earlier material—let us say, he is correlating a childhood experience with his patient's current problem; the less experienced therapist may then present material in the current experience of his patient. The medical student may present his problem of getting the patient to communicate the details of his patient's current illness. The methods of creating a therapeutic setting, the methods of helping the patient talk about his current problem, the methods of helping the patient struggle with earlier material—are essentially the same at all levels of therapeutic work.

There is one additional point I should like to make. Many educators—notably A. N. Whitehead (3) have felt that one of the major university functions is the stimulation of imagination. "The justification for a university is that it preserves the connection between knowledge and the zest of life, by uniting the young and old in the imaginative consideration of learning. The atmosphere of excitement, arising from imaginative considerations, transforms knowledge. A fact is no longer a bare fact—it is invested with many of its possibilities. It is no longer a burden on the memory; it is energizing as the poet of our dreams and as the architect of our purposes." In conducting the group sessions we try to break down the barriers between the students and the teacher. The group members—with the exception of the resident who has responsibility for the patient—are free from responsibility and have no responsibility for immediate action—one of the requirements Whitehead believes essential for the discipline of imagination.

I hope you will pardon my spending so much time on the details of the

method. The differences between this type of teaching and the conventional type are often difficult to see—yet the difference lies precisely in the details—and I believe that these differences are crucial.

The teaching method itself is primarily that of discussion, in which the instructor participates as little as possible. His job is that of a catalyst—occasionally that of a resource person. He sees to it that pertinent topics get into the discussion and that they are kept alive and left open-ended. Occasionally he shifts to a more didactic approach—but usually leaves the collection and dispensing of information to a resident or to a student member of the group.

In this type of teaching it is essential to centre the discussion on raw data—in this case it is the verbatim material of the interview. This material is obtained as accurately as possible—in our present set-up we are able to record the interview on tape and then listen to it directly or to a typed transcript of it. Occasionally the interview is observed through a one-way mirror and notes are added to the typed transcript in order to include more non-verbal material. In other words we try as much as we can to get at the precise events as they occurred in the therapeutic session. We do not want a paraphrase of the material, nor a summary of the material nor the doctor's impression of the material. It is the exact interchanges as they occurred that we wish to use for teaching purposes. I may add that an interesting chapter might be written on the resident's resistances which block the collection of this kind of information. Many complain that they cannot write and listen to a patient at the same time. Others can write down what the patient says—but always forget to write down what they say. Some forget to bring along a pen—and in the hands of other residents the pen is always running out of ink at the crucial moment. An occasional resident complains that the patient will not allow him to write. In our present set-up where it is possible to record an interview through a microphone in the ceiling—the resident forgets to throw the switch or he talks too low or mislays the tape. Many are the ways of resistance. However, if the instructor persists and is tolerant about the ways of the flesh—and especially if we are able to show the resident that even though the collection of verbatim material is not necessary for therapy to occur it is crucial for teaching and for scientific study—the student usually succeeds in bringing material to the group which can be utilized. This is the material from which the problems evolve, and it is examined by the group repeatedly for purposes of sensitivity training and to develop skills in observation. Focusing the group's attention and interest in the same area is done in order to force intensive data collection. In other words the class performance becomes task-oriented behaviour.

We have used these teaching methods in teaching all kinds of psychotherapy. In our work with residents and more advanced physicians our major effort has been in teaching the type of insight therapy I have briefly outlined above. The basic formulation of the method is to allow the resident to have an experience in working with a patient, scrutinize the experience, draw inferences from it and then generalize about it. We have made considerable use of other teaching methods. The demonstration of interviews, lectures and abstract discussions of therapy have their place. I personally believe that these are secondary methods, and are to be used only when the type of teaching described above cannot be undertaken. Many teachers have reported that they have found the series of sound films that Dr. Powdermaker and I have made useful to them. We use them after our residents have had the kind of training described above. Students tend to copy their teachers and to try to adopt the techniques used by them. It is very difficult to avoid this in one's students. We would much prefer to

have the student grasp the principles of the method of therapy, try it on his own—and adapt the principles to his own personal techniques of communicating with people. I also go along with John Dewey's idea that *demonstration* generally emphasizes the possession of knowledge and blocks the penetrating inquiry necessary for the discovery of new facts.

We have found it useful to define psychotherapy as a treatment in which the therapeutic agent is psychological (4). It is a treatment in which psychological means are used to remove symptoms, to resolve conflicts, to improve the patient's internal and external adjustment, to allow the patient to have the maximum use of his resources—and to prevent further illness. These are the ultimate goals. We believe that in psychotherapy the efficacy of the psychological agent depends in part on the meaning it has to the patient. Adolf Meyer once said that psychotherapy begins as soon as we see the patient. There is no doubt that psychological processes are involved in every human interaction between people and between the doctor and the patient—no matter what the purpose is. We would however prefer to limit the use of the word psychotherapy to planned therapy—and not use it for beneficial changes which occur in the patient unbeknown to the doctor and often in spite of the doctor. In each type of therapy there are immediate objectives and procedures useful in achieving these objectives. We have described the immediate goals, the procedures, and some therapeutic results elsewhere. Our major effort in teaching psychotherapy is in teaching the type of insight therapy previously described.

I should now like to report on another experience in teaching psychotherapy. Since I came to the University of Maryland seven years ago our department has had the responsibility of teaching psychiatry to undergraduate medical students throughout all four years. We felt that we would like to teach the kind of psychiatry which would be useful to doctors in working with their patients—which would help students to acquire and develop a therapeutic attitude toward patients, which would help them get patients to communicate freely. We wanted to teach the skills necessary for the development and utilization of a therapeutic doctor-patient relationship and the skills necessary ultimately to do psychotherapy.

In contrast to the psychiatric resident the medical student presents different problems. The resident (5) is usually "sold on" psychiatry—often has an uncritical acceptance. He usually considers psychoanalysis as the model therapy and is impatient of other kinds of therapy, which are considered superficial. The psychiatric resident is usually uninterested in the physiological and behavioural areas, and at present most residents, I believe, are not research-oriented.

Most students come to medical school equipped with information in limited areas, but usually unaware of how many kinds of knowledge and what diverse skills in thinking and performance are essential to the intelligent practice of medicine. The student usually does not associate the psychological, the social, and the interpersonal experiences with illness, treatment, or prevention. Nor does he assume that these relationships are matters for objective study. The same student who accepts his need to learn physical diagnosis, surgery, epidemiology, does not readily grasp that his professional competence hinges on his learning the subtle skills required in interpersonal malfunctioning. His interest and understanding may be actively blocked in these areas by prejudices ranging from vestiges of magical thinking and outmoded concepts of what makes people behave to a complacent and conservative so-called commonsense approach. Even the sophisticated student usually has need for an ongoing orientation as

well as for training in applying these ideas to the problems of patients.

One of our goals in teaching medical students—and we begin to work towards this goal as soon as we get sight of the students in the first year—is to get them to explore and to try to understand what are the building blocks they are to use in their work with patients. It seems essential to break down the barrier so that the student can move back and forth with facility from the physical and biochemical to the psychological and interpersonal levels. This flexibility in what we call horizontal locomotion is necessary for the student to be able to set up for a given patient at a given point in time a hierarchy of factors, and an awareness of their relationship. In considering any one area of subject matter another one of our goals is flexibility in vertical locomotion—so that the student can move up and down from fact to theory, to pre-supposition, to guess critically but with understanding and humility. We should like the student not only to recognize the role of the many factors in the aetiology and maintenance of disease and maladjustment but to be aware of the limitations imposed upon the doctors' actions by the present state of knowledge. All this is to occur in an atmosphere of critical acceptance.

To achieve the above is indeed a tall order, and yet these are by no means the only goals. Many other parameters which have not yet received adequate recognition in medical education enter the picture. These deal with value and status. Our concepts of adequate medical care, the economics of medicine, our attitudes toward patients and colleagues are deeply imbedded in our value systems. These concern personal as well as social values. Without such considerations it is, I believe, impossible to be intelligent about the moral factors in illness, and treatment, and about the role of the physician as an agent of society. One other area I shall merely mention—that is the attitude toward information and the process of obtaining and validating facts. This does not imply a formal course in epistemology—but it does imply the recognition of what we mean by a scientific frame of reference. The student must understand not only what we know but how knowledge in medicine and psychiatry comes about, and what are the ground rules of man's attempts at fitting the contours of nature. He must avoid the inept attempts at measuring words and feelings in a test tube and at the same time check his imagination by paying attention to methods of inference testing (4). He needs to understand that when we cannot measure we can still use definitions (6) and still can describe. It is the appropriate use of the best available methods for the study of all problems—not the slavish acceptance of a specific method or the complete surrender to doctrinaire theory—which is the essence of scientific inquiry.

One might well ask what has all this to do with the teaching of psychotherapy. The orientation and attitudes described above are necessary in the teaching of all subjects in medical school and elsewhere. Yet, few departments in the medical school are at present concerned with teaching attitudes and orientations. To be sure, students are identifying all the time with their teachers, some of whom through example are living models of the compleat physician. This is necessary, yet not sufficient. We want the use of selective identification to occur. We want the student to identify with the good in us and permit the evil in us to be interred with our bones. To achieve this requires more than exposing the student to the ideal teacher—he must be aware of the learning process, discriminating what he learns from the person who does the teaching.

In attempting to answer these questions within the confines of the competitive pressures of the medical school during the past ten years we have groped for a methodology. My own personal experience in doing many kinds

of teaching has made me feel that the conventional didactic teaching, useful as it is, does not fit the bill. Whether our lectures deal with neuropathology, or psychodynamics, or psychoanalytic theory—or feedback systems—in my opinion they leave much to be desired as a means toward our goals in medicine. The presentation or demonstration of a patient even to the first year students, the use of an interdisciplinary team of teachers, or even the didactic teaching of correlations between pathology and personality development and emotional precipitants or interpersonal events, represent a broader approach, but still are inadequate.

I should like to describe the first year course in psychiatry. Our first year class consists of about 100 students who in 1956–57 met for 1¾ hours each week during both semesters, about 32 sessions. In addition to the instructor, an internist, Dr. E. T. Lisansky, and a philosopher, Dr. John Reid, are usually present. At every meeting of the class a patient was presented from the medical or surgical wards. There were three requirements for the selection of the patient —that he have a common medical or surgical illness, that he be a patient in treatment with one of our fourth year students in psychiatry, and that he be not seen in advance by the instructor.

The course in 1952 began with a statement by the instructor—"According to the catalogue, this is a course in psychiatry. I wonder what you mean by psychiatry?" One student attempted to define psychiatry as a study of abnormal mental processes. Another student stated that psychiatry deals with mind. Another student brought up the idea that it deals with psychic. After further discussion another student mentioned that psychiatry is a study of sick behaviour. I encouraged further discussion by pointing out that these ideas are not very clear—maybe we can work out a more precise formulation so that we can understand what we are talking about. The discussion shifted to the mind-body problem. The gist of the discussion was that you really can't observe the mind. All we can talk about is behaviour—the behaviour of sick and well people. But behaviour is used very broadly to include not only the activity we see in a patient, but also the verbal behaviour—which tells us about the patient's feelings, ideas, attitudes, and problems. This was elaborated by several students, who pointed out the advantages and disadvantages of such a concept of behaviour. One student came back to the distinction between sick behaviour and normal behaviour. Another brought up what do you mean by normal behaviour? I referred to a chapter in Maurice Levine's book, in which he summarizes several definitions of normality (7). They discussed normal distribution curves—the use of normal as ideal and the problems inherent in this concept.

I asked the class if they would like to see a patient. There was an immediate flare-up of interest—I then asked what they would want to know about the patient. One student mentioned he would like to know about his dreams; another, about his problems; and a third, about his history. I asked, what would you want to know about his history? One student mentioned that he would like to know how he got sick; another, what kind of treatment he was getting. I asked if they would want to see the patient without hearing his history first—many students said no. I told them that I did not know the patient's history either. Would they want to see how I go about working with a patient whom I had never seen before? They hesitated—and agreed they would do so this time. I promised that we would hear the history after we had seen the patient. At this point, through a misunderstanding, the patient, a young male negro, was brought in before the class. I turned to the patient and said, "Would

you please mind waiting in the anteroom for a few minutes?" The patient said, "Alright", and walked out with the nurse. I then turned to the class and asked why I had asked the patient to leave the classroom. The discussion centred about what to say in front of patients. These first-year students discussed ward rounds—what they had heard about patients' reactions to disturbing statements coming from the visiting doctor, the resident, and the nurse. The discussion led to the problems of the confidential nature of the patient's communication. I added these were all problems of importance in medicine and were factors in the doctor-patient relationship.

I then asked if they would like to see the patient and asked them what they would want me to do. One student suggested hearing about his feelings, another about the history of his sickness. Another student suggested we find out about his dreams—why, I asked—because, he said, this is a course in psychiatry. Still another suggested finding out his problem and how he came to the hospital. Several students thought this was a good idea—and I agreed to do so. We discussed the problem of setting up goals in the interviewing situation, and I merely mentioned the ultimate goal for our work with patients in contrast to the immediate goal for the present interview. I asked the students how I should go about finding the patient's problems. They suggested I ask questions—what kind of questions?—or should I prefer to avoid asking questions? This gave us a chance to discuss leading questions, double questions—long, involved questions—specific or general questions. I then had the patient come in—introduced myself and the class—sat down before the class and had a ten-minute interview, focusing on the patient's description of his symptoms and the situation in which they occurred. After a few minutes I asked the patient if he would mind questions from the students. The patient said he would not—and the students asked a few questions—I would modify the students' questions, making them simpler—avoiding leading questions—and double questions. After the patient had left the lecture hall, I asked, what did they think? The first request was for the patient's history—I replied, yes—but first tell me what you noticed during the interview. One student said that I didn't do much talking—or didn't ask many questions; another student noticed that I did not achieve my goal even though I plugged at it. Another student noticed how the patient hesitated and looked down at the floor when I picked up the word "upset" that he had used. I asked, I wonder why he did that?—the students could not explain why he hesitated. Another student pointed out that he had noticed the patient also hesitated when he talked about his problems with his boss. Why? No one knew. We decided we could watch this phenomenon in other patients interviewed in the same setting. A student remarked that he noticed I called this negro patient Mr. Smith—and not John—why didn't I call a negro patient from North Carolina by his first name?—it was common practice down there. Several students brought up the problem of a negro patient in Baltimore. Should we call adult patients by their first names—even though they are negro and are treated on the wards? I told the story of a well-known Boston physician who could not understand why he always called ward patients by their first names—but for some strange reason, never did this with private patients. Several members had definite opinions why some doctors behave in this strange way. The discussion was brought back to a description of what happened during the interview—eventually the students began to add up what they had learned into building up a tentative diagnosis. They agreed this patient probably had arthritis. The diagnosis should also include boss trouble, hesitation in talking about "upset". He probably was avoiding talking

about his difficulties, he probably did not get a balanced diet in North Carolina, and maybe felt insecure among the white doctors in a large hospital.

The students then asked again to hear the history—and we asked the fourth year student who had been present throughout to tell the class what he had learned in working with the patient. The student—much to my surprise—turned to the class and said, "What do you want to know about the history?" A class member asked for past history. The fourth year student asked, "Why do you want to know that?" Many questions about the history were asked, and the fourth year student answered as best he could, only after the first year students had told him why they wanted to know a detail. After about fifteen minutes of this, the fourth year student presented the history, findings, diagnosis, and treatment. The fourth year student was asked to tell us next week what had happened to the patient. The class was insistent that the fourth year student try to get answers to their questions.

One of the many comments made by the first year students seems especially pertinent. One student said, "I can't understand why you have us see a patient with arthritis—this is supposed to be a course in psychiatry." I turned this question to the class. Several pointed out that maybe the patient with arthritis had some personal or social problem that was important in his illness. I merely added—"that's one of the theme songs of the course".

Discussion with maximum student participation formed the backbone of the method of teaching. Each session was begun by asking the students what they would like to talk about. The students were encouraged to bring up any topic they had in mind. This usually turned out to be a topic related to the interview. When a topic of interest was brought up, we attempted to have the class amplify the discussion and elaborate on the topic as much as possible. By "interest" is meant current interest on the part of the class, as gauged from frequent scanning of the group and through awareness of the behaviour of the students. At the same time we tend not to lose sight of the goals for the course, and to be aware of the extent to which the discussion was pertinent to these goals in topic or in approach. Through variations in behaviour, conveying or withholding interest in a topic, a technique derived from the doctor's role in psychotherapy, the discussion was steered so as to keep it as close as possible to the motivating interest of the students and yet pertinent to the goals for the course. If the discussion took the form of a question, the question was usually not answered but turned back to the student or to the class—"What do you think about this? Perhaps someone would care to answer." At times the same point was brought up during a session by different students. This was encouraged. When the opportunity to focus the discussion presented itself, we preferred to focus it on the problems of the patient, or the problems of the physician. In order to force intensive data collection and for purposes of sensitivity training, the attention and interest of the group was focused again and again in the same area. On many occasions the discussion was prolonged and the clarification of a point was delayed in order to stimulate the students to clarify the point themselves by more active intergroup discussion. Whenever possible, the observations were formulated as problems to be solved by the class. In other words, the class performance became a task-oriented behaviour.

The choice of this method was due to the special orientation of the instructor. It is our belief that the most meaningful teaching occurs when the student is involved in an experience of interest to him. We have felt that in teaching attitudes or a point of view, it is much more effective to have the student have an experience, scrutinize the experience, draw inferences from the

experience, and then, if possible, generalize about it. It would have been simple enough to describe the scientific attitude of the doctor, and we should have expected to have the students verbalize these attitudes. This was precisely what we wished to avoid. For this reason the emphasis was on observation and on participation in the brief interview of a patient. The students were encouraged to describe what they saw and heard. This occasion was used every week to stimulate their capacity for observation of such subtle matters as the patient's verbal and non-verbal behaviour, the gross and subtle interactions between the patient and the doctor, the vocal inflection of the patient and the sudden shifts of the topic in reaction to a remark of the doctor. After the class had described the observations, the instructor focused the discussion so as to force the students to make sense out of what they had observed. Often the students were able to see the appropriate inferences and even arrive at a theory. Topics were generally left open and alive. We avoided tying up or clinching a subject in order to keep it alive for subsequent discussion. Relatively rarely and for short periods of time was a more didactic approach used. Required reading and authoritative formulation were minimized, especially in the early weeks of the course. This was done to emphasize the importance of direct observation of the patients seen by the class. Later in the course a list of suggested reading was made available, with emphasis on reading from scientific literature—not from textbooks.

The major topics throughout the course were the doctor-patient relationship, methods of interviewing, and information on the psychological, interpersonal, and social factors in disease. Considerable time was spent on the attitudes, ethics, and values of the doctor, and on scientific methodology. The discussion was focused on the factors that promote or block effective therapy, on psychological mechanisms and defences. Again when the students attempted to push the discussion towards a formal presentation of psychodynamics, or of psychoanalytic theory, the discussion was directed into a description of the behaviour itself for which the theory attempted to account, or upon the psychological mechanisms as the basic theoretical constructs. Other content areas included personality development and psychoanalytic theory.

During the current course twenty patients were seen by the class essentially in the same way as described above. An effort was made to relate one case with another and to let the class point out the similarities and differences. Since the patients were seen in the same situation and since the behaviour of the instructor during these brief interviews was essentially the same, the student could get an impression of the range of activity seen in 20-25 patients. The students were encouraged to compare their observations based on their common classroom experience, and to draw appropriate inferences, differentiating between observation, inference, and theory. The function of the instructor was merely that of a catalyst—always making sure that the topic was covered as extensively as possible.

I fear that I have not done justice to my topic—I have left much unsaid and many questions with you. I do hope that they may come up in the discussion. I hope that I have conveyed the methods we have used in our teaching efforts and some of our thinking. We hope that the use of these methods may be of some help to physicians and to us psychiatrists in making us better therapists, sounder scientists, and more sensitive human beings.

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DISCUSSION

By Dr. Denis Leigh

In 1948 I spent twelve months at the Massachusetts General Hospital working in the department of psychiatry under Dr. Stanley Cobb. Dr. Jacob Finesinger was second-in-command and had been devoting himself to the technical aspects of psychotherapy, analysing the verbal, motor and expressional interplay of patient and doctor. One of the results of this was his well-known paper on "Some Principles and Procedures in Insight Therapy" which describes a method of psychotherapy since known as the Finesinger technique. It is therefore a particular pleasure today to be able to take part in this discussion of the excellent account he has given us of his method.

My own experiences are based on my work in charge of a Psychotherapeutic Unit at the Maudsley Hospital which I set up when I returned to England in 1949. In many respects this is modelled on the Harvard Unit, though there are, of course, differences. In the eight years since then, about sixty registrars have passed through this unit, each having a minimum of six months' psychotherapeutic training and a variety of foreign visitors have come to work with us. Undoubtedly the Finesinger method is the keystone in teaching and I regard it as the most practical method of teaching psychotherapy to beginners.

For the postgraduate there are several methods whereby he can obtain a knowledge of psychotherapeutic techniques. First he can pick it up, by practice, by trial and error, by reading, and by possessing a strong natural bent for psychotherapy. This method requires enormous determination and persistence and from my experience with such of my registrars who have been self-taught before coming to the Maudsley, it is only the exceptional person who can learn psychotherapeutic techniques in this way.

Secondly there is the personal or training analysis. Around London and one or two larger cities this may be a practical proposition, but over the great area of this country the facilities just do not exist. The difficulties are undoubtedly serious—the cost, the time, and the personal upsets which may occur have to be carefully considered in the light of the future plans of the analysand. But several mental hospitals around London have had numbers of their staff so trained, and the analytically orientated, to say the least, are now much more frequently encountered, and play a most helpful part in the work of the mental hospital.

Thirdly there is the type of training which is carried out at the Maudsley, and at one or two other psychiatric centres. The central thesis of this training is that psychotherapeutic techniques, both individual and group, are repro-

ducible, teachable and subject to intellectual analysis. It is with this third type of training, carried out, as I believe, within the framework of a busy and active psychiatric unit that I am concerned. All my subsequent remarks will refer only to individual psychotherapy—other physicians, notably Dr. Foulkes and Dr. Kraupl Taylor, are responsible for the teaching of group psychotherapeutic techniques: all their groups are formed from our out-patients.

It is surprising how, in spite of all the wealth of literature on psychotherapy, it has only been comparatively recently that attention has been devoted to the technique. An early book by Edward Glover *The Technique of Psycho-Analysis* was most revealing, if only in showing the wide diversity of techniques used in the psychoanalytic situation. The equivalent of an "Operative Surgery" simply does not exist—the nearest I know is the book by Wolberg on Psychotherapy. The dead hand of Freud perhaps still rests heavily on the subject—only by personal experiences can we master the techniques of psychotherapy. However attempts were begun in 1947 by Finesinger to describe some of the technical aspects of psychotherapy, and in a series of films, and a solitary paper he described a method of psychotherapy which experience has shown is particularly fruitful for teaching. This is his so-called Insight Therapy.

The method forms an admirable introduction to technique, and a basic skeleton on which to hang the flesh and blood of experience, but it has its drawbacks. Firstly, it is not a method which often produces insight; in fact a gain of insight, either intellectual or emotional, I have found very rarely occurs. Secondly, it is difficult to carry on for more than 20 interviews using a strict Finesinger technique, both for the doctor and the patient. Symptoms as a goal are most often very unrewarding, as the patient, by the time she comes to a psychiatrist, is stuck in a groove so stereotyped that each day's recital of symptoms is almost identical to the previous day's. Thirdly, the attempt to make interviews non-personal, as it were, is doomed to failure from the start, and transference material, as we all well know, can be seen from the first interview. To keep a young psychiatrist pinned down to one goal for week after week, as Finesinger did to me, is sheer cruelty and unrewarding in proportion to the efforts involved. But my first patient—the wife of a drunken Bostonian Irish slaughterman, with phobic symptoms—still sticks vividly in my memory, perhaps owing to the quite unsuccessful nature of the therapy and our mutual inability to proceed beyond "tell me about your symptoms".

Its great virtues are twofold. First in the setting of goals, so that from interview to interview the procedure can be planned, and therapy does not aimlessly drift along in an atmosphere of pious hope that something will come out. And second, in the use of recording. The insistence on some form of verbatim recording was comparatively new in 1948, and met with much opposition. Nowadays it is so accepted that a recording machine is almost the trade mark of a psychiatrist—at least in some circles. I have insisted on verbatim recording and tried most types of method, but for practical purposes I still regard the handwritten record as the most useful method. Of its drawbacks I am well aware, but for teaching purposes the written verbatim interview is ideal. This is not the place to go into the interesting technical details, nor my experiences with this and different methods—but I can only say that I do not think psychotherapy is teachable without some form of verbatim interview record.

The Finesinger method may be very suitable for training with in-patients, but it is not so useful with out-patients, at least when weekly or at most bi-weekly therapy is all that is indicated. On my own unit there is a marked

cleavage between the techniques used for out- and in-patients. The out-patient attends once a week by appointment for a 50-minute interview, and we aim at an average of 8–10 attendances. To carry out a useful psychotherapy under such conditions involves far more skill than is necessary with the relative inactivity of the Finesinger technique. A great deal more active intervention by the teacher is necessary in order to help the trainee. First he must make a psychodynamic formulation after the original diagnostic interview, and be able to present this in terms which are comprehensible to the trainee at the particular time—this is one of the tests of teaching and is always of interest. And secondly he must teach a different technique, depending primarily on the recognition of defence and patient-doctor feelings. I have always found the book by Alexander and French on Psycho-analytic Therapy excellent, and a paper by Coleman, published in the *Bulletin of the Menninger Clinic* is a very useful précis of the methods best fitted for this type of out-patient psychotherapy. Interviews are, of course, recorded, for without this teaching would be impossible, but recording in these circumstances is much more difficult than in the relatively peaceful Finesinger technique, for the doctor may be much more active. One of the most difficult things in writing down an interview verbatim is to record one's own sayings exactly.

Clearly the recognition of the patient's main defences is not easy for the tyro, nor is it easy for him to assess the patient's feelings towards him. But the main technical problem is that of when the doctor should intervene, and what form his interpretation should take. It is here that a knowledge of psychopathological theory is most useful—and lacking this to a large extent, the trainee must obtain more help from the teacher. Here is the place and the opportunity for a theoretical discussion of mechanisms. The trainee is given the problem of presenting to the group, let us say, the mechanisms of conversion, or of symbolization, he is given the references to look up, and all the group participate in a wide discussion of the particular point. Incidentally, this is a matter of some importance to our discussion today, for such a kind of training depends on easily obtainable sources. There must be a good library on the spot. At the Maudsley we are spoilt for choice—but it is not difficult to build up a selection of key papers or of books. I have used reprints considerably in teaching, when unobtainable I have had original papers Roneoed —a great help.

The selection of patients for this type of out-patient psychotherapy is another important point. Patients with sexual perversions I have found to be excellent subjects for teaching. The kind of sexual pervert I see in hospital practice has come largely to unburden himself and to be tided over some particular crisis. Eight to ten interviews along the lines I have mentioned, whilst of course producing no fundamental change, often help these unfortunate people, and at the same time, provide a classical illustration of some points of psychopathological theory. Again certain psychosomatic problems are very suitable, migraine, asthma, and some skin disorders, although again I have found the latter group to be notably unresponsive to treatment as regards the skin condition. Phobics and obsessionals are to be avoided, as are conversion hysterics—any patient where there is the likelihood of intense dependency reactions occurring should also be avoided. Frigidity and male equivalents such as impotence and premature ejaculation have also been most unrewarding problems. I am mentioning these because I feel these experiences are very germane to the larger considerations before this meeting. One of the most important things I have learnt is that no more than a comparatively small

proportion of psychiatric patients can be treated psychotherapeutically, certainly within the framework of my own unit. I am not going to subscribe to the view that this is only because not enough time is available, or that some particular school of psychopathological theory provides results which the non-initiated cannot hope to produce. Whilst admitting that there is a great need for more psychotherapy over the country as a whole, I think it is important to stress this fact. The trainee must not be left with the impression, so anxiety-producing, that he is only doing something which is second best, he must be taught what psychotherapy cannot do—and, whilst in no way decrying the specialist psychotherapist, I do believe that the general psychiatrist is the person to do the vast mass of the psychotherapeutic work in our hospitals and out-patient departments.

These are the two basic types of psychotherapeutic training—in the techniques of brief out-patient therapy, and in the Finesinger technique. But during the six months the registrar must be given the opportunity of learning something of other methods. If possible, he carries one patient using hypnosis, and also uses intravenous methedrine for abreaction, and L.S.D. for somewhat special purposes—for instances we have treated severely phobic patients, or girls with anorexia nervosa who are comparatively inaccessible to ordinary interviews. Flexibility is the aim—to produce a psychiatrist who will have a broad, flexible and tolerant approach to psychotherapy, ready to adopt new methods if necessary, but not to be overwhelmed by them, and above all, to preserve his critical faculties.