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The Grammar of Psychotherapy

Interactograms: Three Self-Monitoring Instruments for Audiotape Feedback

STUART LIEBERMAN and JOHN P. COBB

This paper describes the development of three self-monitoring forms to enable students to make constructive use of audiotapes of their interviews with patients. Each interactogram is described in detail, with examples where necessary.

The Grammar of Psychotherapy course is a method of teaching communication skills and elements of psychotherapy, as described in the accompanying paper (Cobb & Lieberman, 1987). An essential element of the course is supervised training supplemented by self-monitoring tasks. During development of the course, audiotapes were used in supervision. Listening to audiotapes without a structured method of attending to the material was found to be unproductive. Forms were designed that students completed in the privacy of their homes or offices while listening to the interviews which they audiotaped with patients. These forms focused the attention of the students on their interactional skills and psychological understanding. We decided that we would call the three self-assessment forms 'interactograms' because they are meant to examine the interaction between the doctor and the patient. Three interactograms were constructed.

Interactogram I

The first interactogram (Fig. 1) was inspired by various authors who have developed structured methods of teaching communication skills and interviewing skills (Beckvar, 1974; Maguire *et al*, 1978). We were particularly influenced by Ivey (1971), who trained students in the use of attending behaviour, minimal activity responses, verbal following behaviour, open enquiry, and reflection of feelings. He used the term 'microskill' to describe the discrete verbal and non-verbal components of an interaction.

The first interactogram was designed to examine in minute detail each actual intervention which the therapist uses when interviewing a patient. The interactogram is divided into three major sections: questions, facilitations, and statements.

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Glossary of terms

Leading questions. These often sound more like statements than questions. They imply that the questioner expects a certain answer and make it difficult for the respondent to disagree. The tone of the voice can be as important in this respect as the form of words. Leading questions are widely used in the media and in court. They tend to have a somewhat bullying quality; for example, "You *do* agree with me, don't you?"

Non-leading closed questions. In contrast to leading questions, non-leading questions do not expect any particular answer. Closed questions usually begin with the words "Is", "Are", "Do" or "Did". They can usually be answered briefly or with a "Yes" or a "No". They help to focus a discussion but they are a deterrent to wider exploration of any particular issue. Examples are, "Do you usually get angry at your boss?"; "Is there a particular type of woman that causes you problems?"

INTERACTOGRAM I
[Microskills analysis of therapist behaviour]

Questions
Non-leading open
Non-leading closed
Leading (open or closed)

Facilitation
Silence (3 seconds)
Noises

Statements
Orientation/introduction
Reassuring
Encouraging/empathic
Summarising
Checking/seeking clarification
Focusing/scanning/prompting
Self-revelation
Other (specify)

Play through a tape of your own and classify each of your interventions according to the above list. Think for yourself what impact your particular style of interviewing is likely to have on this patient.

FIG. 1.

Non-leading open questions. These usually begin with "What", "How", "Why" or "Could". They cannot be answered simply by a yes or a no, and invite wider discussion. They can make the person questioned feel more at ease and make the discussion less like a cross-examination. Examples are, "How have you been over the past week?"; "Could you tell me more about how you feel now?"

Silence. Though long silences are anxiety-provoking and can lead to a sort of battle, short silences give people time to think. The most useful length of silence in an average interview is 4–10 seconds, which strikes a reasonable balance between the two extremes. Students were encouraged to see that this was a general guideline and not an absolute rule. They were asked to think about what function they wanted the silence to serve. Under certain circumstances the general guideline might be ignored. So, in controlling a garrulous subject it might be best to reduce silence to a minimum. In contrast, if the therapist wanted to raise the patient's level of emotion, or allow time for deep thought at a sensitive moment in the interview, then a long period of silence could be appropriate.

Noises. These can be used either to encourage or discourage the other person from continuing to speak. They include noises like "Ahha" and "Umm" as well as short phrases like "OK", "I see", or simply "Yes". All of these are useful if, like salt, they are used sparingly. The danger is that with overuse they become either irritating or just plain ridiculous. Trainees soon become aware of this when listening to themselves on audiotape. In all communications the tone of voice may be as important as the semantic content. This is powerfully illustrated by discussion of the tone in which 'noises' in this group were produced.

Orientation/introduction. This refers to the initial part of the interview, which helps to set the scene. Trainees were taught to introduce themselves; to spell out the purpose of the interview right at the beginning and describe the amount of time available for the session. An example: "My name is Dr Smith and I am a psychiatrist. We have an hour and during this time I would particularly like to talk to you today about important relationships. I also want to make sure that we have time for you to tell me about things that are on your mind right now. Before the end of the session I hope we will be able to make some plans about future treatment."

Reassuring. Reassurance (Wilcox & Salkovskis, 1985) is much used by doctors, although frequently it is ineffective either because it is over-used or alternatively because it is patently untrue. Having said this, most people like to be rewarded and also to be admired and respected. Confirmation that they are doing a worthwhile job is usually welcome. The danger with reassurance, and this was often picked up by students during feedback sessions, is that the patient, eager to please and receive approval, will start to behave like a circus animal. Only those things which

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are likely to produce a reward are described. Thoughts, attitudes, behaviour, and emotions which the patient fears will provoke disapproval are then kept hidden.

Encouraging. This refers to any statement which is aimed at getting the other person to talk more. Examples would be, "Please tell me more"; "Please expand on that"; "I really want you to tell me more about those aspects of yourself that cause you guilt, anxiety and pain"; "Please go on from here . . . anywhere you wish". Simpler encouragement statements include "Go on" and "That's good". As has been pointed out already, statement categories overlap. Thus a statement such as, "I can see this is very tough for you but I'd like you to try to explore this further if you can", is both empathic and encouraging. For the purposes of the interactogram the student was asked to classify the statement according to the predominant intent. Lively discussion around this point might fail to produce agreement concerning the 'correct' category, but would serve to increase awareness of the impact of a particular statement on a particular patient.

Summarising. These are statements which give a précis of what the speaker has said. Provided they are brief and to the point, they show that the listener has been concentrating on what has been said. They are also useful in allowing the doctor to collect his thoughts, and highlight what appear to be key themes in the patient's description. An example is, "So in the past few minutes you've talked about this terrible fear and you feel that it is to do with the feeling that you could lose control completely and end up in a mental hospital."

Seeking clarification. Only a genius can understand everything the first time it is heard and unfortunately there are few geniuses around. For the rest of us it is important to be prepared to ask for clarification when something in the other person's communication is unclear. For example, "I think that you view things like this . . .". Beginners often assume that to admit "I didn't understand that" is to show weakness which will lower the doctor's image in the patient's eyes. Usually the reverse is the case, as illustrated by the awkward interview in which an intelligent patient got more and more entangled in obtuse and mutually contradictory self-philosophising. The therapist, bored and exasperated, eventually blurted out, "I'm sorry, I don't understand what you are saying." Whereupon the patient laughed and admitted, "Neither do I, this is the way I always carry on when I am anxious." This proved to be the beginning of more useful communication.

Checking. The main purpose of a checking statement is to ensure that the gist of the other person's discussion has been understood. For example, "From what you told me I can see that you are pretty happy at the moment but there seems to be great difficulty when it comes to finding a suitable long term goal", or "As I understand it, the key issue for you is not so much the depression itself, but that as a result of it your family will reject you." At one level a checking statement simply aims to ensure that the therapist has understood correctly. During supervision discussion, however, students realised that such statements convey other intents, such as confrontation. For example, "So you are saying to me that there is absolutely nothing you do from the moment you awake until you go to sleep which gives you even the tiniest bit of pleasure or satisfaction!"

Focusing/scanning. People often talk in paragraphs. During the course of a paragraph several different subjects may be mentioned. The listener *scans* the paragraphs and then has the opportunity to select one of the points to *focus* on for further discussion. For example, a patient may have mentioned that he is tired, it has been a long day, work has been particularly difficult and that he was called out of bed in the middle of the previous night to look after his daughter. The listener may think it is a good idea to encourage the patient to talk a little more about his tiredness, and respond by comment along the lines, "I don't know how you keep going when you must be feeling very tired." Alternatively, if interpersonal issues are a major problem, then the therapist may decide to focus on the daughter: "How did you feel about disturbing your sleep for her?"

Prompting. This refers to any device which may encourage the speaker to continue talking along the same lines. A well used technique is to repeat the last word or phrase of the speaker's sentence. An alternative is 'the unfinished sentence'. Here the therapist starts a sentence but dries up part way through. The natural response is for the listener to complete the sentence and continue talking: "So the death of your father . . ." or "The pills you are having . . .".

Empathic. An empathic statement indicates that the speaker has some idea of what the other person is feeling. To be effective, empathic statements need to be accurate and may need considerable skill in interpreting both verbal and non-verbal cues. For example, "Yes, you feel you've just about had enough today", "You are on the verge of tears right now", or "I think for two pins you would like to bash someone on the nose at this moment." Empathic

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statements have a powerful effect in enabling a patient to express emotions, especially if used in the here and now. Inappropriate use can cause difficulties. Expressed empathy near the end of a session may lead to a flood of emotion which has to be cut off when time runs out. Too much empathy, especially over past events – "You have been through it"; "It must have been awful" – can come over as patronising, a caricature of a caring professional.

Self-revelation. Used with care, self-disclosure can be a powerful way of encouraging people to talk more about themselves. Such self-revelation must be honest, and in ordinary circumstances ought to be limited so as not to overwhelm the patient. Self-revelation can involve feelings that the therapist is experiencing at the time of the interview; for example, "You know I'm feeling a bit apprehensive because I realise you are angry about being brought into hospital against your wishes". Alternatively they can involve experiences in the therapist's own life which seem relevant to the patient's difficulties; for example, "When my mother died I thought I knew all about mourning and could work it through myself. It was only six months later when I was in a real state that I was finally able to listen to a close friend and accept that I needed help."

Use of interactogram I

Interactogram I was used by trainees to monitor – at a microskill level – interviews with patients which had been tape-recorded either on the ward or in outpatients. Trainees were asked to classify each intervention they made and to record it on the interactogram form. Five-minute samples were analysed in this way. Often in different interviews, with different patients (or role-played patients) in different settings, characteristic patterns emerged in their interactograms time and again. Such patterns could be described as 'interactive fingerprints'. A good example (Fig. 2) is the typical medical model pattern which is probably the product of traditional medical student training (Maguire *et al*, 1978). Once completed, the interactogram provided the basis for feedback. Each trainee was asked to comment on his or her own form and to note the range and frequency of microskills employed, before showing the interactograms to other members of the seminar for their observations. Feedback was pragmatic. Trainees were discouraged from saying that any particular style was "right" or "wrong". Rather, they were asked to consider the questions, "What is the likely effect on the patient of this combination of microskills?" and "Is this style appropriate for the task in hand?"

INTERACTOGRAM I
[Microskills analysis of therapist behaviour]

Questions	
Non-leading open	✓
Non-leading closed	✓✓✓✓✓✓✓✓✓✓✓✓✓✓✓✓✓✓
Leading (open or closed)	✓✓
Facilitation	
Silence (3 seconds)	
Noises	✓✓
Statements	
Orientation/introduction	✓
Reassuring	✓✓
Encouraging/empathic	
Summarising	
Checking/seeking clarification	✓
Focusing/scanning/prompting	
Self-revelation	
Other (specify)	

FIG. 2. Typical 'medical model' interactogram, characterised by predominant use of non-leading closed questions.

Interactogram II

Interactogram II (Fig. 3) builds upon the work done in the previous stage of training. During categorisation of the different types of microskill, trainees became involved with the question, "Why is this particular skill, or this particular group of skills, being used in this interview at this particular time?" Teaching thus focused on the topic of therapist intent. The second interactogram is a device to aid this and is based on the Six Category Intervention Analysis (Heron, 1975). Heron claims that the six categories provide a comprehensive framework for all intentions manifest during the course of an interaction with a patient. As such they constitute a powerful analytic training tool for anyone who wishes to build up skills, and particularly aid the development of self-assessment and self-monitoring in the helping professions.

The six categories are prescriptive; informative; confronting; cathartic; catalytic; and supportive.

Authoritative categories

Prescriptive, informative, and confronting intents are authoritative, that is to say it is the therapist who is taking the overtly dominant or assertive role.

Prescriptive. The intent here is to give advice or to evaluate, be critical or judgemental; a prescriptive intent is one that seeks to direct the behaviour of the patient, especially behaviour that is outside the therapeutic relationship; for example, "This evening I would like you to try and persuade your husband

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INTERACTOGRAM II
[Microskills analysis of impact of therapist behaviour on patient]

Therapist intent	Microskill	Focus	Effect on patient
(Prescriptive, informative, confronting, cathartic, catalytic, supportive)	Question, statement etc.	Patient/therapist	Mild/moderate/strong positive or negative
(e.g. Catalytic)	(e.g. Self-revelation)	(e.g. Therapist)	(e.g. Mildly inhibiting)

FIG. 3.

to join us next week. Make a note of how the discussion goes so that even if he can't or won't come, we can talk about the way you set about approaching him over difficult matters."

Informative. The informative intent is to teach, to instruct, to inform, to interpret, to impart new knowledge and information to the patient. Although trainees recognise that 'lecturettes' are poor ways of putting across information, many fall into the trap of 'talking at' their patients and hoping for the best. Diagrams, booklets, charts may be used, and above all the therapist is encouraged to check that the patient has understood key information; for example, "Just tell me what your tablets are called, how many you are going to take and at what times?"

Confronting. This is to give direct feedback, to challenge, to try to alter the attitudes of belief or behaviour of the patient, in a sense to hold up a mirror to show the patient what he or she is like, either directly in regard to the relationship between the patient and the therapist or in the way in which the patient has behaved in the past or in the present outside the therapy situation. Confrontation can easily degenerate into a battle. The therapist becomes exasperated and angry, and the patient alienated and even more stuck with unproductive attitudes and patterns of behaviour. Effective confrontations help the patient to take a good look at himself, without feeling 'got at' by the therapist. Careful balance of microskills may be crucial in making the difference; for example, "Well, we have talked for about an hour. I can see you are very keen to get help. Symptoms have almost overwhelmed you in the past but you've shown a lot of courage in your struggle to keep going. Yet, despite your need and your efforts, two previous attempts at therapy have failed. Something in you seems to drive away therapists in the same way you have driven away other people in your life. History has a habit of repeating itself unless we learn from the past. So, to avoid this happening again with us, I want you to ask yourself the question – what is this destructive thing in me, which pushes people away and leaves me isolated and miserable?"

Facilitative categories

The next three categories are considered facilitative because the therapist is less obtrusive, more discreet, and seeks to elicit some kind of state of being in the client.

Cathartic. The intent here is to get the patient to feel, to show his or her feelings, to react with or abreact painful emotion, encouraging for example laughter, anger, fear, crying. The use of silence, in combination with empathic statements and non-leading open questions, is helpful in achieving this intent. Sensitivity to non-verbal cues is important. Sudden alteration in the tone of voice or faltering over a certain word alert the therapist that the patient is approaching a possible point of catharsis.

Catalytic. Here the intent is to enable the patient to learn and develop through his or her own self-direction. The therapist acts as a catalyst and allows a patient to explore his own problems and to then discover his own solutions. Rogerian counsellors (Rogers, 1961) make great use of certain microskills to achieve 'catalysis'. Repetition of the last word of the patient's sentence is so well known as to be parodied (Rhinehart, 1971). Noises, silence, summarising and checking statements are all typical of this mode of interviewing (Ivey, 1971).

Supportive. The intent here is to give approval, confirming or validating the worth, the value of the patient, as a human being. The therapist is not trying to promote change, although practical advice and information may be one of the ways of providing support. It usually helps a great deal if the therapist likes and respects the patient. Well-meaning attempts to provide support can founder if these qualities are lacking. Discussion of this, using audiotapes in combination with the interactogram, can lead to awareness of the ways that therapists give themselves away as far as their true feelings are concerned. This leads without difficulty into a discussion of counter-transference in subsequent seminars.

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Use of interactogram II

Interactogram II records not only the therapist's intent but also links in the microskills being used to achieve this. Blow-by-blow analysis of material from a patient–doctor session, with intent in mind, shows that some of the therapist's expressed purpose in the interview is based on an evident plan in the therapist's mind. At other times the therapist appears to be reacting to material produced by the patient during the course of the session. Trainees were asked to think about this and record their observations on the form. Finally, they were asked to consider the effect on the patient in contentious cases; role-play was often helpful here. Again the criteria were pragmatic: "How well did the therapist achieve his aim?"; "How much did the patient benefit from this stage in the interview?".

During a short segment of an interview it is quite possible to have two or three different intents. For example, a general practitioner often includes several intents: to be informative, to support the patient, and to prescribe within a six-minute consultation. The major intent in a psychotherapeutic interview may be catalytic, with an underlying intent of support. The primary intent in a behaviour therapy interview could be prescriptive, with a preliminary confrontation.

Interactogram II is used in conjunction with interactogram I so that the students are able to discover what particular interventions they use to further their intents.

Interactogram III

Interactogram III (Fig. 4) is an analysis of the relationship process. This interactogram is designed to make the therapist aware that it is not only his or her microskills and intent which govern what happens in the relationship with the patient. There are other factors which play a part in any human interaction. We use the term 'macroskill' to mean those skills which are used throughout the entire interview and relate to the broader process of the interview. The third interactogram is divided into two major sections, the first of which is related to the hypothesis. This is considered a working assumption about the interview which the therapist uses to understand the basis for the interview or part of the interview. Junior doctors were encouraged to establish working hypotheses to help them understand the difficulties that they were tackling. Developing a hypothesis can be highly therapeutic to the patient; alternatively, it can provide the basis for a plan of action to be agreed between the patient and the therapist. A skilled therapist would be one who avoids making 'divine revelations', and instead provides a series of hypotheses: educated guesses or ideas which would be the basis for further discussion. For example:

(a) "From what you've told me in this first interview I can see that you have already found out that if you stick with your anxiety in a difficult situation, it starts to decrease after a short while. Now, I wonder if we could make this the basis for our plans to help overcome the phobias." (*Basis for behavioural work*)

(b) "I know your father died over two years ago but I wonder if in a sense you are still haunted by him." (*Invitation to look at possible psychological basis for symptoms*)

(c) "Over the past weeks we've been through a lot together and I think that you're already starting to wonder how you are going to manage without these regular weekly visits." (*Invitation to look at meaning of psychotherapeutic relationship*)

Hypotheses can be very broad or very narrow. A broad hypothesis might be the idea that the patient has a psychological problem, rather than a medical illness. A narrow hypothesis might be that the patient's depression is being projected on to him by his wife, who is actually depressed and with whose depression he is identifying. A hypothesis is not meant to be a revelation of profound truth but a basis for communication between the patient and the therapist. Essentially, it is meant to be an approximation that can be open to negotiation from either side. If it is not acceptable to the patient it could be discarded. There is a process of learning to develop hypotheses. This process begins with the ability to observe and listen to the patient. When feeling stuck in an interview, or wondering what to do next, attention to the patient can help the therapist to develop useful working patient-focused hypotheses. For example, "From the way you describe your previous treatment I guess you have really got little faith left in doctors", or "Your manner of talking makes me wonder if part of your problem lies in feeling that no-one can ever understand you."

The next stage in making a hypothesis lies in the ability to link what the patient is communicating with material from earlier in the sessions, or from previous sessions and past history; for example, "You know, we keep coming back to the worries that you have about what other people will be thinking of you, yet it is all guesswork because you never try to find out what they are really thinking."

From this the therapist may make suggestions of ways in which both he and the patient are behaving which is playing a central part in the interaction; for example, "You know, I think you find my manner irksome because you have never liked being told what

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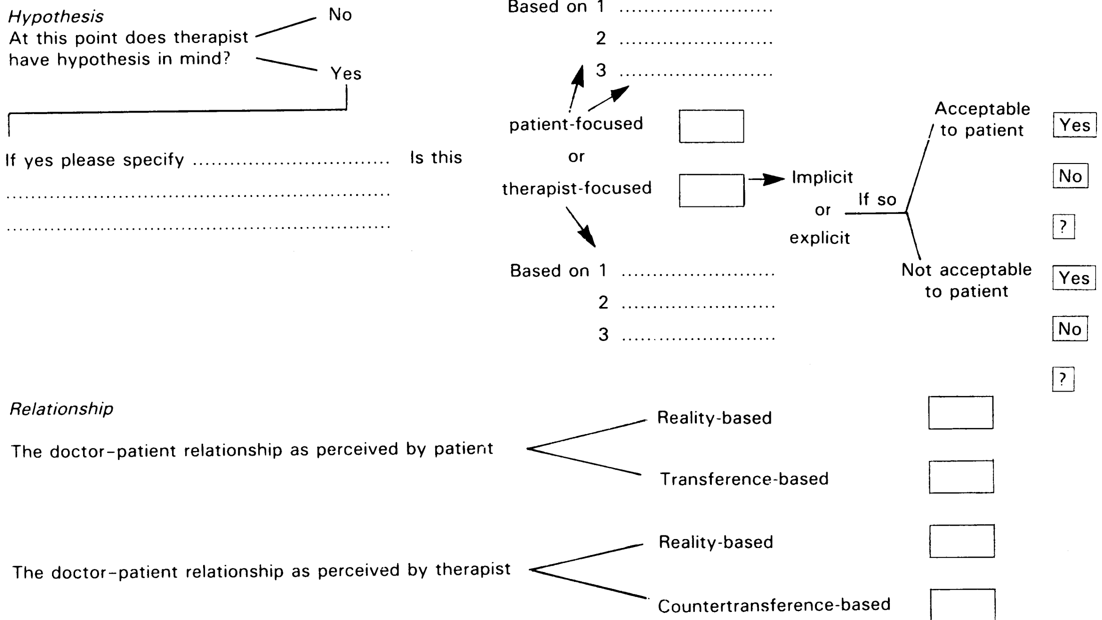

FIG. 4.

to do", or "We seem to be getting into difficulties and I think that may be because I have been encouraging you to think that I am going to take over responsibility for solving all your problems for you."

In the final stage the therapist starts to link what has been observed in the patient with his own theoretical ideas. These ideas come from watching other people working and from reading.

The number of different theories and the even greater number of individual variations of any one particular theory reflect the inventiveness of therapists in constructing hypotheses about the way in which their patients think, feel, and behave. If the therapist is more attentive to what is going on inside his own head than to what is going on inside the patient, the focus of the hypothesis will be therapist-based: "From my experience with other patients with anxiety like yours, I think . . .".

It is the ability and willingness to construct and use hypotheses which distinguish a psychotherapeutic style of interaction from plain interviewing. The skills can be most usefully acquired and developed by working with patients under supervision.

The second part of interactogram III focuses on the relationship between the doctor and the patient and introduces the concepts of transference and countertransference (Sandler *et al*, 1974). A number of factors influence the therapeutic relationship, both conscious and unconscious. The personality of the patient, the nature of the patient's difficulties, the personality of the therapist, the therapist's skill and experience, and the interaction between the patient and the therapist all play a part in defining the relationship. The doctor's ability to avoid imposing his own conflicts on the patient and distorting the material produced by the patient because of his own personality structure is an essential skill in the therapeutic encounter. Countertransference is both an essential part of therapy and an important phenomenon calling for self-awareness on the part of the doctor. We found that audiotapes of interviews, when specifically examined for evidence of countertransference, are a useful method of developing self-awareness.

Some aspects of patient and therapist are emphasised and other aspects minimised as the relationship develops. This process is unconscious and may be a re-enactment of previous patterns of relationship. The emphasis in the interactogram is that the relationship is a product of both participants, the

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doctor and the patient. What the doctor says and does and stands for are reacted to by the patient and vice versa, and an interpersonal feedback system quickly develops. This system must neither be ignored nor accepted blindly. The concept of transference is a special example of the way in which the feedback system operates when a patient reacts to the therapist as if he were representing some other person in that patient's past life, and the therapist is faced with what seem inexplicable responses to his words and actions. For example, one patient looked to a doctor as an authority on all subjects and depended on him to give advice on many areas of his life. This dependence and need for authority was a duplication of the nature of his relationship with his deceased father. He transferred his reactions from the relationship with his father to his relationship with the doctor.

By seeking information about past relationships, the therapist can identify the source of the transference. Without such knowledge the therapist can still be aware of the fact that the patient's reactions to the therapist are an unconscious re-establishment of some earlier relationship. The feedback system which develops between patient and doctor is a very important clue for the understanding of a patient's unconscious meaning. The reality-based perception of the doctor–patient relationship by both participants refers to the reason which brings together two participants in the interview: "We are here, you the doctor, I the patient, because I need help from you to deal with a particular problem or illness."

Conclusion

We believe that the use of these three interactograms is a helpful adjunct to psychotherapy supervision and provides a method for junior doctors to examine their audiotaped interviews with patients. This systematic approach, we believe, helps bridge the gap between traditional medical training and the psychotherapeutic approach which is an integral part of modern psychiatric practice.

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