

The Clarification and Assessment of a Method of Psychotherapy

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Summary: The 'conversational model' of psychotherapy was investigated with a view to discovering which behaviours distinguish psychotherapists trained in this method from others, of equal clinical experience. A rating scheme designed to capture the theoretical aspects of the model, and 30 predictions were made concerning behaviours which were expected to distinguish the psychotherapists. Five psychotherapists were matched to five psychiatrists who had not been trained in this method; each doctor took on four patients for therapy, and each patient was seen on five occasions. All interviews were recorded, and excerpts from the recordings rated. Only ten of the 30 predictions were upheld. In ten further predictions, the psychotherapists displayed the appropriate behaviours, but the behaviours were not peculiar to the model, since eclectic psychiatrists also displayed them. Six model behaviours were not practised frequently by the psychotherapists, and four 'non-model' behaviours were equally common in either group. The research formed the basis for the preparation of materials to teach psychotherapeutic skills in a more efficient way.

It takes a long time for a young psychiatrist to acquire skills in psychotherapy, and requires many hours in supervision time from a psychotherapist. The purpose of the present research is to investigate a way of speeding this process up by producing a self-teaching package, which can be made available to trainees before they take on their first patient for psychotherapy. The research is in two parts. In the first, we identify the behaviours which distinguish psychiatrists trained in a particular model of psychotherapy from eclectic psychiatrists of equivalent experience, while in the second (Maguire *et al*, 1984) we devise a self-teaching package, and study the effects on a group of trainees. A method of teaching psychotherapy should enable trainees to learn techniques which are specific to a particular theoretical model. Such techniques need to be distinguished on the one hand from non-specific ones, which are common to a wide range of psychological therapies, and on the other from components which, despite being part of the theoretical model, are not actually practised. Research of this kind requires direct observation of the psychotherapeutic process, but most psychotherapists have been reluctant to have their methods undergo detached scrutiny by independent researchers. We were therefore fortunate that one of us (R.F.H.) has been

concerned to develop and describe a method called a 'conversational model' of psychotherapy, and to have this method intensively studied.

The purpose of this research is not to compare the effectiveness of the conversational model of psychotherapy with alternate models, but to determine the essential component parts of the model, so that a more efficient teaching method can be devised.

The conversational model

The conversational model is described in more detail elsewhere (Hobson, 1977, 1984), but in essence, it consists of a process of interpersonal learning by means of focussed 'conversation'. The emphasis is on the patient's feelings and interpersonal problems, which are expressed in the 'here and now' of the therapeutic conversation, and not merely 'talked about' in a detached way. Problems may be explored, and solutions sought, in the relationship between the therapist and patient, and learned solutions generalised to relationships outside therapy.

To carry out this method, it is desirable for the therapist to display a number of specifiable behaviours. The patient must be given a clear framework, so that he knows what is expected of him, and what to expect of the therapist. These 'framework-

giving remarks' should occur in the form of certain introductory behaviours and at appropriate points in subsequent interviews, and should result in a clear 'therapeutic contract' at the end of the first session. The therapist should make statements rather than ask questions; and he should express his understanding of the patient's feelings in a way which makes it easy for the patient to correct him: this is called 'negotiation', and is a central feature of the model.

The therapist should express his involvement in a therapeutic dialogue by the use of the first person ('I' and 'we'). His suggestions should be clearly derived from what the patient has said or done, rather than from general theory; hence the recognition of verbal and non-verbal cues is vital. The therapist must listen and notice. His ideas regarding the meaning of messages conveyed by cues will usually be phrased as 'understanding hypotheses' about the patient's feelings. Sometimes the therapist will point out similarities between what the patient has said and behaviours which have occurred at other times: these are referred to as 'linking hypotheses'. Both kinds of hypotheses are directed at the accurate expression of states of personal feeling.

The aim of the present study was to clarify the conversational model, by stating its component parts in operational terms, and to devise procedures for making reliable ratings of these components.

The rating procedure

A lengthy preliminary study was concerned with the production of a set of operational definitions of model behaviours, so that ratings could be made with high reliability. In order to rate the interviews, each typed transcript was divided into statements, each of which roughly corresponds to a grammatical sentence. Each statement by the therapist was then rated in six ways:

1. Cue recognition—whether the therapist's statement was in response to a verbal or non-verbal cue from the patient.
2. Therapist involvement—whether the therapist used 'I' or 'we'.
3. Negotiation—whether the therapist expressed an openness to correction.
4. Function—question, information, advice, framework-giving comment, understanding, or linking hypothesis.
5. Content—psychiatric symptoms, feelings (general), relationships with others, doctor-patient relationship.
6. Time Focus—past, current time, here-and-now (in session), future.

This rather cumbersome rating procedure attempts to capture as many aspects of the model as possible, as well as to rate any 'non-model' medical utterances.

Within each code, there were 'model' behaviours which it was predicted would be displayed frequently by the index group, and 'non-model' behaviours which were predicted to be more frequent among the control group. We present the 20 'model' predictions as Table I, and the ten 'non-model' predictions as Table II.

The assessment of the model consisted in discovering the extent to which these predictions were confirmed in practice. The behaviours of psychiatrists trained in the model (the index group) were compared with those of psychiatrists of equal seniority who have not had this training (the control group). Those components which have been successfully taught would be practised by index therapists to a significantly greater extent than controls. The comparison between the groups would allow us to see which components of the 'conversational model' were not in fact practised by trained psychotherapists, and which behaviours were practised with equal, high frequency by the control psychiatrists, so that they are not peculiar to the conversational model. The reliability of these ratings was established with two raters, who each rated three interviews independently. Cohen's Kappa was computed as a measure of agreement between raters for each rating: the mean value was +.87 with a standard deviation of only 0.11. This was considered acceptable, and we also devised rating procedures for the opening of an initial interview and the formation of a therapeutic contract.

Method

Five psychiatrists judged by one of the authors (R.F.H.) to have learned and to be proficient in the conversational model were individually matched for seniority and number of years in the specialty, with five psychiatrists who had had no contact with R.F.H. Each group contained one consultant and four lecturers or senior registrars; and two members of each group held University appointments. The index group had a mean of 6.8 years experience (SD = 1.64 years) while the control group had a mean of 6.6 years (SD = 1.67 years).

Each psychiatrist was randomly allocated four patients to take on for therapy. They met each patient for a series of interviews, of which the first five were recorded on videotape. The patients were selected from the University out-patient clinics during the period of the study, according to the following criteria: they were presenting with minor affective illnesses in which problems in interpersonal relationships were thought to play an important part; they were not thought to require admission; they did not display schizophrenia, organic brain disease, drug addiction, or psychopathic personality, nor were they disabled by severe phobic or obsessional symptoms. Patients had to be of at least average intelligence, and to be between 18 and 50 years old.

Eligibility for the study was assessed by a consultant psychiatrist (D.G. or P.M.) using the Clinical Interview Schedule (Goldberg *et al*, 1970). The consultant completed a 'standard mandate' about each patient, which included a diagnostic formulation, a record of any drug treatment

TABLE I

Twenty behaviours which model therapists were predicted to practise significantly more frequently than control therapists

Name of Rating	Index group <i>n</i> =	Control group <i>n</i> =	Prediction confirmed	Prediction <i>not</i> confirmed	
				High, equal frequency	Low, equal frequency
<i>Initial behaviours</i>					
1. time available	18	7	P = .0004†		
2. purpose of interview	18	9	P = .0029†		
3. recording situation	19	7	P = .0001†		
4. feelings about recordings	18	2	P = .0000†		
<i>Whether based on cue from patient</i>					
	Mean %	Mean %			
5. verbal cue	47.2	39.5		F = 3.4 NS	
6. non-verbal cue	0.6	0.6			F = 0.03 NS
<i>Style</i>					
7. use of "I" and "we"	33.0	20.7	F = 5.3 P = 0.05		
8. use of statements	88.9	72.6	F = 6.5 P < 0.05		
9. use of "negotiation"	29.1	10.9	F = 11.0 P = 0.01		
<i>Function</i>					
10. restatement—verbal material (ReV)	14.2	14.7		F = 0.04 NS	
11. restatement—non-verbal material (ReNV)	0.7	0.8			F = 0.02 NS
12. comments about topic area (C-TA)	3.6	2.1			F = 5.0 NS
13. comments about procedure (C-Pr)	1.2	0.5			F = 0.8 NS
14. comments about progress of therapy (C-PT)	1.6	1.1			F = 0.6 NS
15. "understanding hypotheses" (UH)	44.0	19.8	F = 9.3 P < 0.05		
16. "linking hypotheses" (LH)	1.2	0.2			F = 4.8 NS
<i>Time focus</i>					
17. "here and now" in session	15.4	11.4		F = 0.5 NS	
18. current time, outside session	51.6	55.5		F = 1.2 NS	
<i>Contents of Dr's utterance</i>					
19. patient/therapist relationship	5.3	1.1	F = 5.4 P < 0.05		
20. patient's relations with others	33.5	25.5		F = 1.6 NS	

1–4 † Figures are number of times behaviour occurred in 20 introductory interviews, tests are Fisher's Exact Test.

5–20 Figures mean percentage for each code in subsequent interviews tested by analysis of variance. *df* 1, 8 for all F ratios.

prescribed, and a brief statement of the patient's need for psychotherapy, with an indication of the areas which might be explored during the ensuing interviews.

Eligible patients were asked if they were willing to participate, and told that the study would involve them being interviewed by their doctor on at least five occasions, in a small television studio. The standard mandates of all patients who agreed were randomly assigned to index and control groups by a medical secretary, who herself made the arrangements for the first interview. The psychiatrists were asked to study the standard mandate and to carry out an introductory 20 minute interview the first time they saw the patient. Thereafter, their follow-up interviews were to last between 30 and 45 minutes. They were permitted to see the patient after this time, to discharge them, or to refer them back to the original consultant.

All five interviews (a total of 200: 10 doctors × 4 patients × 5 interviews) were televised in their entirety, but the study was confined to the initial interviews (in order to allow us to rate initial behaviours and contract formation) and to two 15-minute sections, randomly chosen from the second and fourth interviews. The sections of the interviews selected for intensive study were transcribed, and the resultant typescript divided into scoring units prior to carrying out the rating procedure.

Results

No patient refused to collaborate with the study, although some failed to complete all five interviews; when this occurred, the patient was replaced by the next eligible one. Results from the Clinical Interview Schedule were used to test for possible significant differences between the patients

TABLE II

Ten behaviours which model therapists were predicted to practise significantly less frequently than control therapists (effect of index vs control group tested by analysis of variance: *df* 1,8 for all *F* ratios).

Name of Rating	Index group mean %	Control group mean %	Prediction confirmed	Prediction not confirmed	
				Low, equal frequency	High, equal frequency
<i>Whether based on cue</i>					
21. not based on patient cue	52.2	59.8			F = 3.4 NS
<i>Function</i>					
22. open questions (OQ)	2.3	7.1	F = 5.5 P < 0.05		
23. closed questions (CQ)	5.0	12.1		F = 4.8 NS	
24. understanding questions (UQ)	3.9	8.1		F = 3.4 NS	
25. information and explanation (I/E)	11.6	22.2			F = 3.7 NS
26. advice (Ad)	1.2	0.8		F = .08 NS	
<i>Time focus</i>					
27. the recent past	4.0	4.9		F = 0.4 NS	
28. the past	21.5	21.1			F = .04 NS
<i>Contents of doctor's utterances</i>					
29. psychiatric and medical symptoms	4.7	9.2		F = 1.4 NS	
30. feelings in general	32.2	25.3			F = 2.2 NS

observed with the model and control therapists respectively, in terms of the severity of symptoms. Each patient was assigned a score, calculated from twice the summed score for observed abnormalities plus the summed score for reported symptoms in the past week. The mean value of the total score was 21.0 for the model therapists and 22.3 for the controls. A *t*-test showed the difference between the groups to be non-significant. It was also possible to compare the two groups of patients for each of the 22 symptoms separately, and once more, there were no significant differences.

Transcripts of the initial interviews were examined to see whether the doctors displayed certain 'model' behaviours on first meeting their patients. Each of the four behaviours was scored as present or absent, and the results are shown as Codes 1-4 in Table I. It can be seen that all four behaviours were significantly more frequent among the index group.

The remaining codes were derived from transcripts of the second and fourth interviews, and analyses are based on percentages of the total number of recorded statements, rather than on absolute frequencies. This procedure has usually been adopted in psychotherapy research to allow for differences between individual doctors in the amount they talk (Marsden, 1974).

The effect of therapist group (model versus control) on the occurrence of each rating code was assessed in a series of univariate analyses of variance. A four-factor design was employed: therapy group by therapist by patient by interview number. Patients were nested within therapists, which were nested within therapy group. Therapy group and interview number were taken to be fixed factors, while therapists and patients were assumed to be random. Expected mean squares were calculated using the derivation rules of Cornfield and Tukey (1956). Under this model, the correct error for testing

the group effect is therapist within group, and has eight degrees of freedom. *F* ratios and significance levels for the 30 predictions are shown in Tables I and II.

When performing a number of simultaneous tests on data which may be correlated, there is a danger of falsely rejecting some of the null hypotheses (i.e. that some of the apparently significant results are actually due to chance). To check this possibility, the 'P-plot' technique of Schweder and Spjøtvoll (1982) was employed, which gives an estimate of the number of true null hypotheses. For the present data, this gave a figure of 15. In other words, we would expect to conclude that there was no effect of therapy group in half the codes. The fact that our analyses show no significant effect in 20 cases indicates that we are erring on the conservative side.

It can be seen from Table I that nine of the 20 predictions about behaviours which would be more frequent are confirmed in practice. All three of the measures of style (Codes 7, 8 and 9) are confirmed, and there is a particularly striking difference for 'understanding hypotheses'. These are guesses about the patient's experience which go beyond what he has already said, and are phrased as a statement: e.g. 'I think you are annoyed with me for being late today'. If the doctor is merely re-phrasing what the patient has already said, this is a 'verbal restatement' (Code 10), and can be seen to be no more common among the index subjects than the controls. Codes which are practised with high, equal frequency by the two groups (5, 10, 17, 18 and 20) are components of the model which are practised by the psychotherapists, but which are also practised equally frequently by eclectic psychiatrists of similar experience. In contrast, Codes 6, 11, 12, 13, 14 and 16 are aspects of the model which do not appear to be practised frequently (<5 per cent).

The ten predictions of behaviours which should be

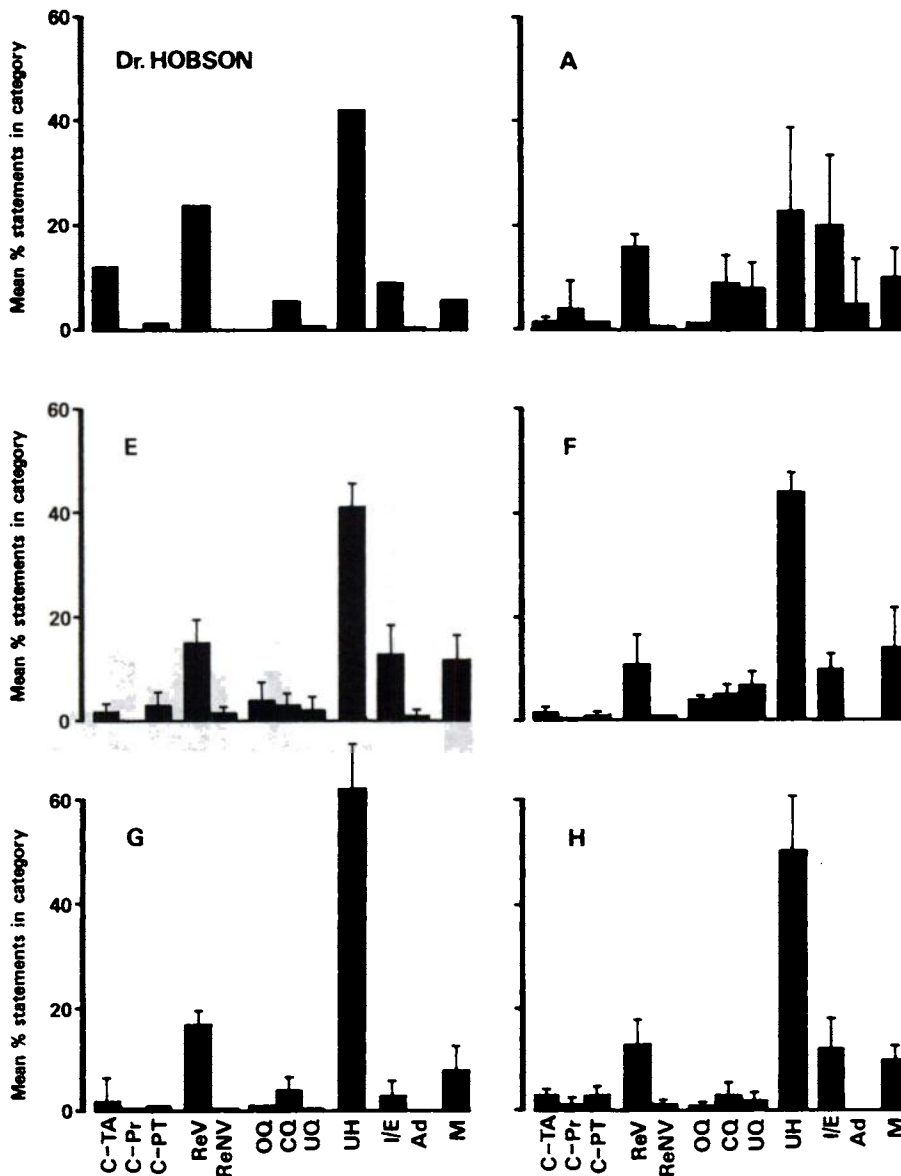


FIG 1.—Profiles of the psychotherapy teacher (R.H.F.) and the index group of psychotherapists for the function code. Each histogram shows mean and standard deviation calculated for 8 interviews (4 patients \times 2 occasions). For key to abbreviations, see Tables I and II.

infrequent among the index group are shown as Table II. The only significant result is for Code 22, which reflects the tendency to make statements, already recorded in Code 8. Ratings 23, 24, 26, 27 and 29 are practised (as predicted) infrequently (<5 per cent by the index group, but they are also infrequent in the control group. It is of especial interest that the eclectic psychiatrists did not spend more time than the psy-

chotherapists in discussion of medical and psychiatric symptoms (Code 29). Four 'non-model' behaviours (Codes 21, 25, 28 and 30) were frequent in both groups. It was disappointing to find that more than half of the statements made by the psychotherapists were, as judged by our ratings, not based on a cue from the patient (Code 21), and could thus hardly be said to constitute a 'conversation' in the sense intended.

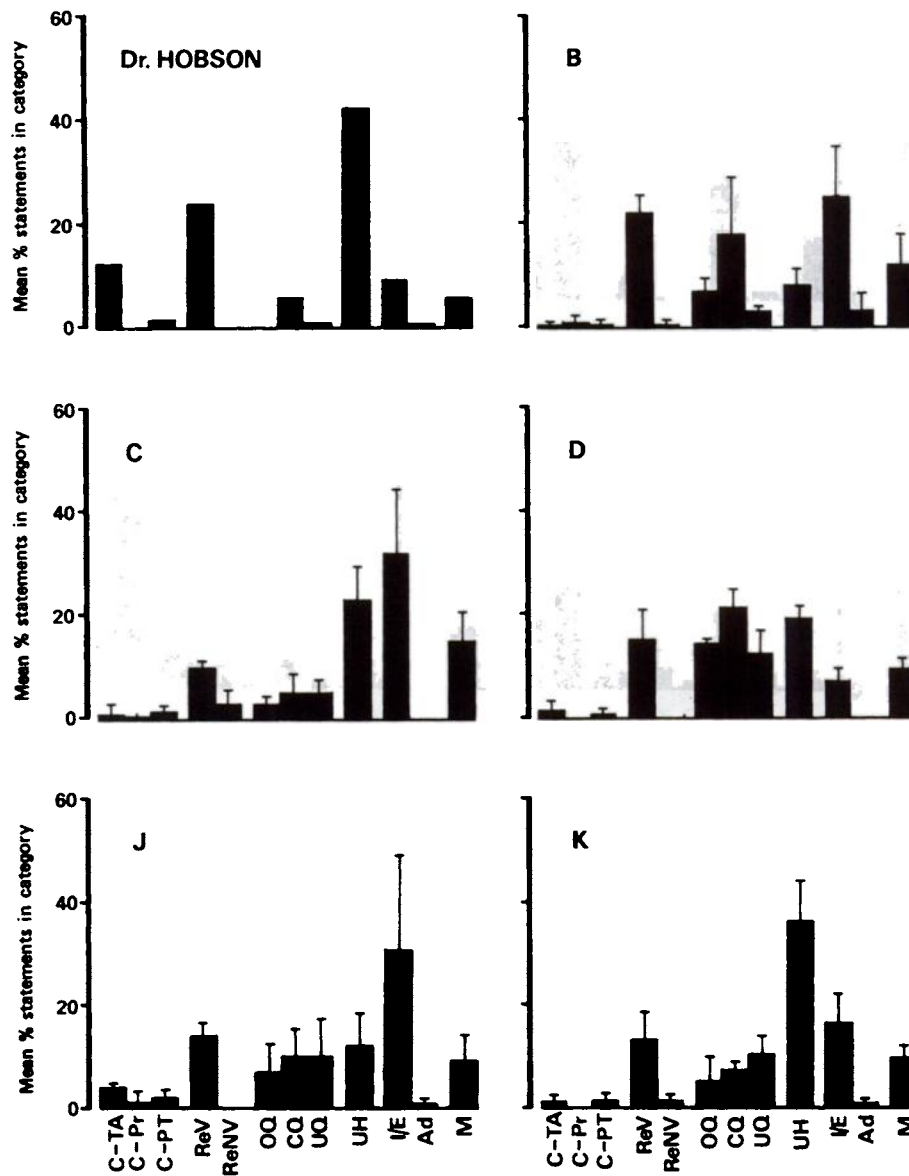


FIG 2.—Profiles of the control group of psychiatrists on the function code. Dr Hobson is shown for comparison. Each histogram shows mean and S.D. for 8 interviews: key to abbreviations, see Tables I and II.

The tendency for the psychotherapists to give less information and explanation (Code 25) fell just short of statistical significance, and both groups of doctors discussed the past with equal frequency. We were interested to observe that 32 per cent of the psychotherapist's utterances concerned 'feelings in general', and we return to this point in the discussion.

Therapist profiles

At this stage, it was thought of interest to compare the index with their teacher (R.F.H.), since several transcripts were available of interviews between him and patients with similar problems. In the interests of simplicity, we will show results for the 'function' code only (10-16; 22-26; and 'miscellaneous'). (See Figure 1).

R.F.H. has a highly characteristic profile, with three codes accounting for almost 80 per cent of his utterances. These are understanding hypotheses (Code 15), restatements of verbal material (Code 10), and comments about the topic area (Code 12). With the possible exception of therapist A, all the psychotherapists have learned to make understanding hypotheses, although none of them make as many comments about the topic area which should be discussed as R.F.H. Therapists E, F, G and H are strikingly similar to one another and to R.F.H. Therapists E, G and H had had most exposure to the model, while therapist A had had the least training, and shows a much less characteristic profile. The control group were more heterogeneous, and none had a profile resembling R.F.H. (see Figure 2).

Discussion

The present research has been concerned with the extent to which psychotherapists practise a particular theoretical model. We have devised a rating scheme which attempts to capture as many aspects of the model as possible, and have shown that there are considerably more differences between the behaviour of trained psychotherapists and that of eclectic psychiatrists of equivalent experience than would be expected by chance. It is useful to consider our findings in three groups.

First, and least interesting, are those aspects of the model that are practised both by the psychotherapists and by psychiatrists untrained in the model. These behaviours are clearly not peculiar to the model, and appear to be acquired by clinical experience. Both groups of doctors were equally likely to respond to what the patient had just said (Codes 5 and 10), to deal with problems in the present (Codes 17 and 18), and to discuss the patient's interpersonal problems. From our standpoint as postgraduate teachers, there is little point in designing special teaching procedures to enable trainees to acquire such behaviours.

Second, are the ten behaviours which differentiate between the two groups, and which therefore represent those aspects of the model that have been successfully taught to the psychotherapists. It is interesting to observe that eight of these behaviours relate to what might be called the doctor's style: four behaviours seen in the initial interview (Codes 1 to 4), the tendency to make statements rather than ask questions (Codes 8 and 22), to use the pronouns 'I' and 'we' (Code 7), and to show a willingness to be corrected (Code 9). It has been known that doctors trained by the apprenticeship method may acquire the mannerisms of their consultant teacher by modelling themselves upon him, and it would appear that these aspects of professional style are relatively easy to communicate, providing the teacher is respected by his students. It is legitimate to ask whether such behaviours are likely to be important, in the sense of

contributing to the therapeutic efficacy of the model. Such a question cannot be answered by our data, but it is our opinion that such behaviours are likely to contribute to the impression which a patient has of the doctor, and they are certainly intended to avoid some of the problems which arise when they are not practised, so they may be of some indirect therapeutic benefit. The remaining behaviours in this group—'understanding hypotheses' (Code 15) and 'patient/therapist relationship' (Code 19)—have greater potential as therapeutic components of the model.

Indeed, the principal investigators who were not trained in the model (D.G. and P.M.) would regard understanding hypotheses as its most characteristic component: they are, in effect, an attempt by the therapist to understand the nature of the patient's experience by expressing it in words which go beyond what the patient has just said. The therapist expresses this understanding in the form of a statement which is open to correction (Codes 8 and 9), and the hypothesis is developed when the patient amplifies, adds to, or corrects what has been said. The hypothesis should thus lead to a dialogue, aimed at understanding between doctor and patient, and it is this therapeutic 'conversation' which lies at the heart of the model.

The third group are 'bad' behaviours, which are equally frequent, and 'good' behaviours which are equally infrequent, in both sets of doctors. It was predicted that conversational therapists would spend less time talking about the past, since they would be engaged with attempts to understand experiences in the present: in practice, both groups of doctors discussed the past with equal frequency (21 per cent of all utterances in either group). Perhaps more seriously, well over half the utterances of each group were not based on a cue from the patient which was clear to our raters, so that a conversation—of either a simple or a subtle variety—could hardly be said to be taking place during substantial parts of the session. The two groups of doctors were also equally likely to discuss feelings in a general way. The original prediction that these would be less frequent in the index group was because the psychotherapists had been taught to encourage patients to experience and express feelings in the session, rather than to talk about them in a detached way. It was anticipated that such feelings would be rated under 'patient-therapist relationship' (Code 19, positive prediction), leaving Code 30 as a residual code for rating feelings which did not appear relevant to the process of therapy. These admirable intentions became lost in the rating procedure. Unless the feelings being discussed had a clear and unequivocal reference to the therapist, our raters consigned them to Code 30. As a result, sections of transcripts which seemed

reasonable examples of conversational therapy to the principal investigators were rated as 'feelings in general'. We have reported the prediction as we originally made it, but came to change our views about this behaviour as a result of experience in this part of the research. When we came to design teaching materials for the second part (Maguire, *et al.*, 1984) this code was therefore used as a desirable aspect of the model.

The model behaviours which were infrequently practised consisted of making various kinds of comment about the progress of therapy (Codes 12, 13 and 14), responding to non-verbal cues (Codes 6 and 11), and 'linking hypotheses' (Code 16). The finding that the various types of comment were infrequent was disappointing, since one would have supposed that this was a simple behaviour to teach, and it is possible that a doctor who provides some guidance about therapy might be more effective than one who does not. It is worth noting that responding to non-verbal cues and linking hypotheses are both rare behaviours with R.F.H. himself (Figure 1), so the fact that linking hypotheses only accounted for 1.2 per cent of the index therapists' utterances is not necessarily discreditable; we should also note that a statistically infrequent behaviour may nonetheless be therapeutically important. In view of the possible therapeutic importance of comments about the topics which should be covered and linking hypotheses, it was therefore decided that they should be included in any teaching package that was designed for our future trainees despite the fact that each of them just missed significance at the 5 per cent level (Maguire *et al.*, 1984).

Although none of the control group had been exposed to teaching from R.F.H., it is worth emphasising that they had all had training in some aspects of psychotherapy. The inclusion of such doctors in the control group constitutes a more stringent test for the conversational model than if the control group had consisted solely of psychiatrists without any training in psychotherapy.

Some of our negative results are undoubtedly related to shortcomings in the rating system developed for the project. Psychotherapy is a complex process, and any attempts to reduce it to a set of ratings are bound to be comparatively crude. It would hardly be surprising if some of the subtlety eluded the rating system. For example, the central concept of the model is a 'conversation'. This sounds simple, but it is not. In order for a conversation to occur, the therapist must 'hear' what the patient is 'saying'. Inevitably, nuances are lost in the rating scheme, which sometimes includes banal, everyday exchanges with more subtle responses.

Cue recognition is a case in point:

Example

Patient: "I'm sorry that I did not keep my appointment last Tuesday. It was raining very hard and I could not get my car to start."

Let us consider three therapist responses to this:

A. "Well, you seem to be looking really well today. Tell me what has been going on."

B. "I noticed that you smiled slightly when you said that you didn't keep your appointment."

B. "Was it Tuesday that it rained? I thought it was Wednesday."

Response A will be rated as 'non-verbal cue recognition', yet it is not the sort of non-verbal cue which R.F.H. has in mind, since there is no response to anything that the patient has just said. Response B is, of course, included as the sort of non-verbal cue recognition which R.F.H. does have in mind, as this cue (the smile) relates to feelings which the patient has about the therapy, and thus—probably—the therapist. It would be very easy to discuss such feelings after Response B. Response C causes great problems, since it will undoubtedly be rated as 'verbal cue recognition'. It was indeed a response to what the patient actually said, but there was no response to what the patient is 'saying', in the more subtle sense intended by R.F.H. Provided that the therapist makes some response—however banal—to something which the patient has just said, we have to rate it as 'verbal cue recognition'. This was not what R.F.H. had intended, but it was the best we could do. When we attempted to rate more subtle verbal cues in the preliminary phase of the research, we were unable to achieve satisfactory inter-rater agreement. So reliability has been achieved at the expense of validity.

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Evaluating the Teaching of a Method of Psychotherapy

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Summary: A teaching package was produced to help trainees in psychiatry learn the techniques specific to a 'conversational model' of psychotherapy, prior to group supervision. This consisted of a booklet and three videotapes. The third tape used a micro-counselling approach to illustrate each key skill and was viewed together with a teacher. After this, trainees met in groups of three with a psychotherapist for eight weekly sessions. To evaluate this teaching, 12 trainees were asked to interview simulated patients before and after they used the package and after supervision. These interviews were recorded on videotape and rated. There were significant improvements on most of the key skills as a result of this training, and nine of the 12 trainees improved considerably. There was a strong negative correlation between improvement scores and a biological orientation to psychiatry. It is concluded that the teaching package is an economic but effective way of helping trainees learn the basics of a method of psychotherapy before they are given supervision.

The aims of this second study were to develop and evaluate methods of teaching the 'conversational model' of psychotherapy (Goldberg *et al*, 1984) to trainee psychiatrists,

Teaching methods

The objective was to produce a teaching package which would enable inexperienced psychiatrists to learn the key concepts and skills contained within the conversational model, before they were given psychotherapy supervision. The package included those behaviours which were found to be much commoner in the therapists trained in the 'conversational model' (Goldberg *et al*, 1984) (Table I).

Three behaviours which did not distinguish therapists trained in the model from other psychiatrists (picking up verbal cues, code 5; recognising non-verbal cues, code 6; and use of linking hypotheses, code 16) were retained because of their potential therapeutic

relevance. Guidance was given about how to form a therapeutic contract (new Codes 31–33) and the importance of solving problems in the 'here and now' was emphasised (code 17). These skills were presented in a booklet and three videotapes.

The booklet described the 'conversational model' and told trainees how to use the videotapes, the videotapes used a micro-counselling approach (Ivey, 1971). Each skill was explained and demonstrated separately. The examples were taken from interviews conducted by 'model' therapists and from videotapes of Dr Hobson (R.F.H.) using his 'conversational model'. The first self-teaching tape explained the basic concepts, in ascending order of complexity, and provided illustrations of each one. The second self-teaching tape showed the key skills being used during a psychotherapy session, while the third tape was seen with a teacher. Each skill was demonstrated in turn on videotape, and the student asked to use that skill in