British Journal of Psychiatry (1987), **151**, 589–594

The Grammar of Psychotherapy

A Descriptive Account

JOHN P. COBB and STUART LIEBERMAN

The Grammar of Psychotherapy is a method of teaching both communication skills and the elements of psychotherapy. Supervised training is supplemented by self-monitored tasks. The course is economical in terms of tutors' time, and is particularly suitable for trainees in general psychiatry.

Psychiatrists spend much of their time talking with their patients. Even when not engaged in formal psychotherapy, the abilities to converse effectively and to understand their patients in psychological terms are essential psychiatric 'tools of the trade'.

Whether or not basic psychotherapeutic skills can be learned through technical training is keenly debated. The traditional view is that effective psychotherapy owes as much to non-specific factors as to technical expertise acquired through specific training (Frank, 1978). Research over the past 30 years has increasingly challenged this negative view. Rogers (1951) was the first to use audiotaped recordings of therapist–patient sessions as a means of both studying what went on in the sessions and training students. His colleagues (Truax & Carkhuff, 1967) identified specific effective therapist behaviours that could be acquired through relatively short training programmes. This approach was further refined and developed by a team of workers in Massachusetts, whose approach was labelled 'micro-counselling' (Ivey & Simek-Downing, 1980). A micro-counselling programme is structured to focus on teaching 'key' components of therapist behaviour. Control studies showed that specific skills such as attentiveness, accurate reflection, and summarisation of feelings occurring in the session can be taught by a five-hour structured training programme (Ivey & Simek-Downing, 1980). For example, after training, therapists interrupted less, spoke less and increased their response delay.

Similar work has also shown that specific interactional skills can be taught in both behavioural psychotherapy (Loeber & Weisman, 1975) and cognitive therapy (Beck *et al*, 1979). Several components are found in most training programmes. The training is introduced by a descriptive lecture, which is illustrated by a live or videotaped demonstration. Skills are then practised through role-play followed by feedback and discussion. Finally, supervision of patient interviews recorded on audio or video tapes provides a basis for discussion involving both supervisor and peer group.

This type of research has been criticised. Much of the early work done by the Rogerian school focused on therapist behaviour out of context of the interaction with the patient. More recent work has stressed the importance of looking at therapist behaviour from the patients' perspective, as well as from the view of independent judges. Much of the research has been done on neophyte therapist professionals or non-professional mental health trainees, such as undergraduates, parents, or teachers.

Several authors in the USA (Goin & Kline, 1974; Reiss, 1975; Friedmann *et al*, 1978) have discussed psychotherapy training for junior psychiatrists. Some favour traditional supervision; others found new techniques, such as videotape feedback, to be effective alternatives. In the UK, Cox *et al* (1981*a*,*b*) showed that psychiatric interviewing style could be studied effectively and conclusions drawn about the effects of various styles. Recently Goldberg *et al* (1984) and Maguire *et al* (1984) evaluated a teaching package which aimed to teach 'The Conversational Model' (Hobson, 1977) of psychotherapy to junior psychiatrists. This package included a booklet, two self-teaching videotapes, eight weekly seminars led by a trainer who supervised role-play, and videotape feedback of trainees' interviews. Basic psychotherapy skills can be taught to junior doctors using such a training package. Similar results have been found in teaching interviewing skills to medical students (Maguire *et al*, 1978).

Postgraduate psychotherapy training for psychiatrists may be viewed as a 'soft' area as far as data is concerned and thereby does not lend itself easily to scientific studies. Above all is the difficulty of determining the meaning of 'success' as far as training is concerned. Therapists' behaviour which is approved of by trainers may not necessarily be that which is effective in producing change with patients.

In any case, such change is difficult to measure. Because of the time-consuming nature of measurement, the number of trainee studies is likely to be small (Matarazzo, 1978). The population of patients varies from centre to centre, as does the general attitude towards psychotherapy as a method of treatment. Psychotherapeutic methods themselves vary widely, and the personality of teachers may be highly influential with trainees, but is difficult to quantify. The time available for training is variable, as is the commitment given by each junior doctor. Despite these objections, surveys of general consultant psychiatrists indicate that they recognise the importance of training in psychotherapeutic skills (Lieberman *et al*, 1978; Hafner *et al*, 1977; Scorer, 1985).

Course

Aims and structure

Faced with the task of teaching psychotherapeutic skills to over 100 psychiatric trainees scattered throughout the South West Thames Region, we have independently developed a systematic course whose content is derived from work done by Maguire *et al* (1978), Heron (1975), and Ivey & Simek-Downing (1980), and whose philosophy follows that of Sullivan, Freud and Rogers. The aims are to teach

(a) simple interview skills such as the collection of objective information, the communication of clear instructions and ways of structuring the interview
(b) complex psychological and interactional skills such as the ability to be sensitive to important psychological and emotional issues, the capacity to construct possible alternative hypotheses to understand the patient's problems in psychological terms; the ability to circumvent or modify rigid attitudes; and an awareness of the importance of the therapeutic relationship and the various factors which can modify this.

'Grammar' may be defined as the art and science concerned with a language's inflections or other means of showing relations between words as used in speech or writing, its phonetic system, and the established rules for using these. We use the word 'grammar' as a metaphor because it sums up our belief that we are teaching the study of components of that process of communication which is the basis of a working relationship between therapist and patient.

For teaching purposes we looked at three different levels of interaction. The most superficial of these focuses on the basic skills used by the therapist. Deficiencies in these basic skills may for example be demonstrated by the trainee who finds difficulty in getting patients to talk at the beginning of the interview and equal difficulty in stopping them talking at the end. The second level looks at a wider issue stressed in the writings of Ivey & Simek-Downing (1980) and Heron (1975). This is concerned with the therapist's intent in the interview and is one of the key factors which distinguishes a professional interview from an ordinary conversation. A common example of the way that this can go wrong is when a trainee who intends to take a history starts the interview with a series of confronting statements, and is then surprised that the patient clams up.

The final level of interaction looks at the interview as a whole and asks the questions "What was the therapist's understanding of the patient's problem?" and "What were the factors affecting the therapeutic relationship?".

General description

The Grammar of Psychotherapy course was planned to include 13½ hours of teaching time, starting with six consecutive weekly seminars. Three 1½ hour seminars were devoted to theoretical teaching using both lecture and role-play. Three written handouts were distributed and a multiple choice question (MCQ) test on the content was administered following the last theoretical seminar.

The theoretical seminars were followed by three 1½ hour audiotape supervision sessions in which small groups of students (3–6) presented their audiotapes for scrutiny by peers and one of the trainers.

Three follow-up supervision sessions took place six months later. These were consolidation sessions of a similar nature to the last three feedback sessions.

Specific components

The specific components included the interactograms, the role-play and the audiotape supervision sessions.

Reading material was prepared from various sources and presented as handouts. The first handout provided some theoretical information about the developmental aspects of verbal and non-verbal communication and interpersonal relationships. The second handout was about verbal and vocal communication skills. The third handout went into a number of factors which determine the way in which therapeutic relationships develop. Students were given an MCQ test which was based on this material.

Interactograms

The interactograms served to engage the students by involving them in a series of self-monitoring tasks. Attention was focused by those tasks on the students' current range of interactional skills, and psychological understanding. Trainees were encouraged to discuss their own interactograms and to pick out the aspects of their interviewing styles with which they were satisfied and also those things they would like to change. They were invited to show their interactograms to the rest of the group to ask for comment. Interactogram 1 deals with the simple basic skills of interview technique. Interactogram 2 deals with the intention of the doctor while doing his or her interview with the patient. Interactogram 3 deals with the doctor's mental set and the issues of transference and countertransference. These instruments are described in greater detail in the accompanying paper (Lieberman & Cobb, 1987).

Role-play

Role-play was used extensively in the teaching seminars, and during the feedback sessions if students had difficulty in recording live patient interviews. Role-play requires the student to attempt to see the world from the patient's viewpoint, as well as giving an opportunity to rehearse new skills. Earlier in the first training session one trainer took the role of a patient and the other the role of the doctor. The patient chosen was determined through discussion with the students about their own patients. The demonstration introduced the trainees to role-play as a technique and generated audiotaped material, which was then analysed with the group using the first interactogram.

Later the students were asked to role-play patient and doctor in exercises designated to restrict the doctor's repertoire. These 'restriction exercises' were based on previous knowledge of students' patterns of interaction. For example, if the use of silence was rare, students were asked to practise pausing for at least three seconds between the patient's response and the next therapist intervention. If students used a 'cross-examination' style consisting of an endless series of questions, the rules of the restriction exercise would confine the therapist to statements only.

Later in the course, restriction exercises gave the opportunity to examine problems associated with those intents that students found difficult. In particular, students wanted help with confrontation and catharsis. For example, as an exercise on confrontation, students are divided into groups of three with a protagonist, agonist, and observer. A 'doctor' is asked to confront the 'patient' in a clinical situation. The 'observer' marks the interactogram, including which particular microskills were used. The object of the exercise is to encourage the patient to look at his behaviour without damaging the doctor–patient relationship. After five minutes the 'doctor' discusses what he did, noting both good points and those points he would like to change. The 'observer' gives an account of what he sees. The 'patient' describes his feelings and his reaction to the therapist. He discusses whether he could see what the doctor was driving at and whether change was likely. This exercise is then repeated, with everyone swapping roles until all participants have had a chance to be 'doctor', 'patient', and 'observer'.

Seminar 1

The first seminar started with a role-played interview done by the seminar leaders, which was then analysed using the first interactogram. Invariably this promoted a lively discussion concerning the nature of a particular question or statement. Questions were easy to classify, although experience showed that the traditional split into leading/non-leading, open/closed questions is inadequate. Doctors often used the 'multiple choice question'; for example, "Do you think you're having problems because your work has been too difficult, or because your marriage is under strain, or because you are worried about your children at school?" where the patient has to respond to a forced choice. A different type of question is the 'multiple question' where the doctor asks a number of questions at the same time, leaving the patient to choose which will be answered. For example, "How have you been this week, have things worked out the way you expected, and have you had any side-effects from your medication?". The point was made during this discussion that there were no such things as 'good' or 'bad' interventions, but that some were effective and others counterproductive. Any strategy could have a use with certain patients at certain points in the interview. For example, direct leading questions, which are considered to be inadmissible by many, turned out to be used in practice by experienced therapists. They are inappropriate at the beginning of an interview where the interviewer is attempting to open up discussion, but they may be a perfectly acceptable way either of focusing on specific points of information or of establishing control in an interview which is getting out of hand. Statements fit less easily into neat categories, and during the evolution of our course we changed the labels on our statement 'pigeonholes' several times. Discussion about classification made the trainees aware of statements that they used

well and those that they used awkwardly or not at all. For example, some trainees never used empathic statements, while others employed so much polite social reinforcement that it became meaningless. Quite commonly trainees used nothing but questions in their interviews. When asked to role-play a patient being subjected to such an interrogative style of interviewing, many of them admitted that it felt like uncomfortable persecution.

An explicit aim was to encourage trainees to widen their range of basic skills. Time and time again trainees noted that they did not use 'silence'. They recognised that following even the slightest pause they intervened so quickly as to cut off any chance the patient might have had to think. Many admitted that they considered silence in an interview to be some kind of failure, although they could see there was no rational basis for this.

As well as building up a range of basic skills, trainees (and indeed the seminar leaders) became more aware of irritating idiosyncratic habits. A common example was the frequent use of a non-verbal utterance such as "ah-ah". Less common, although more damaging to the interaction, was the tendency for some therapists to answer their own questions!

Seminar 2

Very often, discussion of the first interactogram led the trainees to point out that the same intervention expressed with different emphasis or intonation might convey a very different meaning. This led on naturally to an examination of what the doctor was trying to achieve in this part of an interview. Therapist intent can be conveniently divided into information gathering, information seeking, catalysis, prescription, confrontation, catharsis, and support (Heron, 1975). Different basic skills were needed to achieve different intents at different points during the interview. An obvious example would be the use of a combination of open questions, silence, empathic statements, and reflections, in encouraging a patient to open up and explore a particular problem. Alternatively, a combination of feedback together with supportive statements might be an effective way of achieving a confrontation. When an interview was going wrong, trainees were asked to look first of all at what they were trying to achieve and secondly at what particular microskills they were using at the time. Garrulous or hypomanic patients often overwhelm the interviewer. A closer look at the microskills sometimes showed that skills appropriate for catalysis were being used, with the inevitable result! Another common difficulty was the trainee who grumbled that the patient seemed to run out of things to say. This was hardly surprising in the light of a microskills analysis which showed almost exclusive use of closed questions.

Seminar 3

By the time the trainees came to the third level they usually had become familiar with the task of looking at what they were doing in the interview rather than what their patients were doing. They were now asked to look not only at the question "What am I trying to do?" but "Why am I trying to do this?" Another way of approaching the same issue would be to ask the question "Why am I choosing to focus on this aspect of the patient's life rather than any of the other possibilities?" As a first step towards answering these questions we asked the trainees to 'brainstorm'. The object of this was to generate a number of alternative hypotheses to account for the patient's problems and symptoms. Such hypotheses could fairly easily be classified into the following categories: medical model; intrapersonal; interpersonal; and social. Alternative hypotheses were then discussed to see how much they were supported by information from the history or from observations in the sessions. If such evidence existed the hypothesis was termed a 'patient-focused hypothesis'. Very often we found little evidence to support an idea and we then had to conclude that the hypothesis came from the doctor's own head rather than being generated by the information available to him ('therapist-focused hypothesis'). A good example is the situation we termed the 'amateur psychoanalyst', in which appropriate and possibly damaging interpretations were made, often based on the latest book read by the trainee rather than on material presented by the patient. Examination of both the focus chosen by the doctor and the hypothesis used led easily to discussion of the way in which the doctor's own personality and experience was influencing interaction with the patient. Trainees were often intellectually aware of the meaning of countertransference but had not previously had experience of the way that it affected their own practice. Further evidence of this came from close analysis of sudden changes of style during an interview which at first instance appeared to be inexplicable. For example, a doctor by skilful and sensitive use of a range of microskills might encourage a patient to become emotional and to start to explore difficult and uncomfortable issues. Suddenly the tape-recording of the interview would document a dramatic change of style in that the doctor would revert to a traditional medical use of history-taking questions. Trainers were then able to

ask the question, "Why at this particular point in the interview do you think you suddenly changed direction?" The other side of the coin, transference, could also be explored by following up similar openings.

Conclusion

We have run the Grammar of Psychotherapy courses for about 25 different groups of students. Most of the courses have been for trainee psychiatrists, but we have also taught other groups of paramedical personnel in both psychiatry and general medicine. Some of these courses were part of a study which compared students with matched control subjects. This allowed systematic evaluation of this teaching package, the results of which are now complete and will be reported in a subsequent paper.

Considering first the package as a whole, this was for many of our students the first time that they had ever listened to themselves talking to a patient. Laying aside for the moment the question of whether or not the specific items in our package were themselves of value, it did seem that the Grammar of Psychotherapy, with its individual 'interactograms', provides a framework which encourages trainees to tape-record sessions and then look critically at the way they interact with their patients. Merely listening to a tape of themselves can be for many trainees an intimidating and pointless procedure. However, by having to fill in an interactogram they are able to focus on certain issues which makes the process appear more worthwhile to them.

Informal feedback indicates that the course was well received by both students and clinical tutors. To quote:

> We normally do not write to individual lecturers thanking them for their contributions to our programme [statement] but in your case I feel I must write to thank you and say how impressed we all were with your series of lectures at Beechmont, St Francis Hospital. The trainees have found them extremely useful.
>
> [Silence]
>
> Our programme for next term is already arranged [another statement]. Do you feel you would like to come again to talk to the trainees during the autumn term [question]?

Courses were well attended. The structure enabled trainees to accept feedback and to involve themselves in lively discussion without feeling threatened. Surprisingly, some students gained insights into aspects of themselves through focusing attention on their own interactions with patients.

Many of the trainees attending our course are likely to go on to be general psychiatrists, and some will no doubt specialise in psychotherapy. Knowledge learnt through attending this course should be useful both to general psychiatrists and specialist psychotherapists.

In this course we avoided any particular theoretical stance and encouraged students to judge pragmatically whether a particular microskill or intervention was effective or not. The choice of course title was determined by the belief that the grammar of psychotherapy is the examination of the components that make up the relationship between therapist and patient, and that this is something that the plethora of schools of psychotherapy have in common.

Acknowledgements

This work was carried out under a Research Grant from South West Thames Regional Health Authority.

We are indebted to Coral Jackson for her help in monitoring this course.

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British Journal of Psychiatry (1987), **151**, 594–601

The Grammar of Psychotherapy

Interactograms: Three Self-Monitoring Instruments for Audiotape Feedback

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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.