3. They then form groups of four. Each of them is given a tape cassette recorder and records a short interview with a patient each week.
4. The student plays back his interview each week and rates it.
5. The group meets weekly, and one student's tape is played and discussed in the presence of a tutor.

The tutor ensures that each student has at least one chance to receive feedback.

When students fail to acquire certain skills or to experience difficulties, the tutor gives them feedback via video after they have had the chance to practise these skills.

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Teaching Psychotherapy Skills to Postgraduate Psychiatrists

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An assumption underlying this paper is that knowledge of psychotherapy should be available to all psychiatry trainees, not just to those with a special interest in psychotherapy. It does not, of course, follow that all trainees should practise psychotherapy throughout their careers, but they should know something about the therapeutic aspects of the doctor-patient relationship. These aspects are highlighted in psychotherapy but are by no means exclusive to it. Given this assumption, we are faced with the problem of how to provide this training—in terms of content and logistics.

The title of this paper, 'Teaching Psychotherapy *Skills*' implies a certain view of psychotherapy training: *skills* can be taught which have an immediate bearing on psychotherapy practice; it does *not* follow that the skills *are* psychotherapy, or even that they have yet been identified. One important consequence is a decision to develop effective and efficient ways of teaching psychotherapy by identifying those skills which make constructive change in the patient more likely.

This approach borrows from the behavioural tradition in so far as an attempt is made to analyse a task systematically: in this case, both a particular model of psychotherapy treatment and the separate task of teaching the component skills incorporated in this model.

However, it seems likely that factors not yet specified in the relationship between patient and therapist, and between therapist and supervisor, are also likely to be important (Shapiro, 1980).

In view of this, do we *need* to specify any component skills in detail to teach psychotherapy? It can be argued that the effective agent in supervision is a relationship in which the trainee has the opportunity to discover and overcome his own difficulties in relating to his patients; the components that could be described as 'skills' would be viewed as secondary. Moreover, there is at present no definitive evidence which favours one model of psychotherapy supervision over any other at present. This matter is reviewed in Hess's recent book (Hess, 1980).

However, research in teaching medical interviewing skills to undergraduates has shown that certain skills are most efficiently taught with specific teaching methods—particularly giving the student feedback about interviewing behaviour within a conceptual framework (Maguire *et al*, 1978).

Research is in progress in the Manchester University Department of Psychiatry which attempts to examine similar areas in psychotherapy teaching. The project links three relevant questions:

1) Can we describe a plausible 'model' of psychotherapy which can be specified in terms of aims and therapist behaviour? This model should not, however, oversimplify the reality of clinical practice by overdetermining the responses a therapist might make.
2) After describing this model, do we know whether thera-

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pists who say they use it actually do? This component of psychotherapy research is often assumed to be true without evidence.

3) If the above are true, can this model be taught efficiently and effectively?

The first part of the research involved clarifying and specifying a pre-existing model described by R. F. Hobson which is concerned with interpersonal learning and uses the relationship between patient and therapist so as to lead to effective problem solving in other relationships. A main task of the therapist is to deal with the anxiety which blocks exploration of these interpersonal difficulties. The practical aspects of therapy largely centre on ways in which anxiety can be maintained at an optimal level.

The second research step followed from this and will be reported in detail elsewhere. There were some clear differences in behaviour between therapists using this model and a group of psychiatrists matched for experience. The differences corresponded to a considerable extent to predictions based on the theoretical model. These findings made it possible to develop a teaching format based on the model.

The teaching phase of the project, in progress at present, involves unselected trainees. Each receives a period of introductory teaching in a predetermined form lasting about three hours (see below). This is followed by a period of eight sessions of group supervision, with three trainees in each group. Supervision is flexible, but mainly involves videotape feedback of individual interviews. Trainees will be assessed at three points in their training, using measures derived from earlier research.

The project has led to the development of several different teaching materials, for use initially in the research, but potentially applicable elsewhere. The materials include a booklet introducing the model of psychotherapy; it describes basic techniques of starting interviews and forming a therapeutic contract which are widely applicable in psychiatry. There are also specified techniques such as the use of statements rather than questions; focusing on feelings experienced by the patient during the session; and making links between those immediate feelings and other material.

The written material is amplified in three videotapes.* The first videotape is a series of examples taken from a large number of therapy sessions, with added comments. These examples are closely linked to the written introduction.

The second videotape examines one interview in detail. The commentary puts the underlying themes in therapy in perspective. There are also captions identifying some of the points explained in the first tape.

The third videotape uses a technique called 'microteaching' (Ivey *et al*, 1968). The fundamental requirements of 'microteaching' are: 1) teaching one skill at a time; 2) presenting a model example of the skill on videotape (usually coupled with a written explanation); 3) practice with videotape until the skill is mastered, usually with self-observation. (See Forsyth and Ivey, 1980 for a more detailed account.)

We use a modification of the microteaching technique. The third videotape is divided into sections closely linked to the initial teaching booklet. Each section begins with a brief reminder about the topic, followed by an example. For each section there is, then, a series of practice examples.

For instance, in teaching the trainee to use statements rather than ask questions, the narrator on the tape gives a question and the trainee is asked to rephrase this question in the form of a statement. There follows immediately an example from an interview where a similar statement was used in context. A teacher is present throughout, firstly to encourage the trainee to express his version out loud, and, secondly, to give appropriate feedback.

Our research is still in progress and will be reported fully, but some of its implications can be considered. The present state of knowledge is not adequate to make a definitive statement about precise psychotherapy training requirements. It is unlikely anyway that all trainees would benefit from the same training package. Some trainees respond enthusiastically to microteaching, whereas others find the situation unrealiistic. Some trainees might benefit most from close individual supervision, possibly over a number of years. The number of psychotherapists available to give this long-term supervision makes the need difficult to satisfy, though the use of 'peripatetic' supervisors as in the South-West Thames Region can make the best use of available resources (Lieberman *et al*, 1978). The usual compromise is to offer supervision on an 'ad hoc' basis with emphasis on trainees who wish to specialize in psychotherapy.

The main aim of this paper is to present for discussion a number of potential developments for research in psychotherapy training. The simplest would be to develop teaching material to introduce trainees to basic concepts of psychotherapy so that available supervision time can be spent more profitably. The content of the teaching videotapes can be matched with each individual supervisor's approach.

A more far-reaching development is to integrate some of the newer teaching techniques, such as microteaching, into psychotherapy training. This entails looking at the practice of psychotherapy from a different perspective which could draw on techniques from behavioural therapy—such as task analysis, forming therapeutic contracts, and setting aims—whilst continuing to be concerned with those processes '... whereby meaning is accorded to experience' (Ryle, 1978). Neither of these theoretial stances excludes knowledge gained from a psychodynamic approach incorporating the concept of the unconscious. Indeed, there is a current trend in psychotherapy towards an integration of different models: behavioural, cognitive, interpersonal, dynamic etc. It is appropriate that psychotherapy supervision be included in this trend.

*For further information about the teaching booklet and videotapes contact the author.

Conclusion

Some training in psychotherapy is an essential part of postgraduate psychiatric education. In many areas, however, there are practical difficulties in arranging long-term individual supervision. Methods have been developed to teach interviewing skills to undergraduates. Research is in progress using similar techniques for psychotherapy training. This research has generated a variety of teaching materials which may allow a supervisor to use his time more effectively. It is important that psychotherapy supervision integrates different theoretical approaches, including dynamic, behavioural and cognitive. Teaching techniques drawing on these approaches are possible and seem to be acceptable to trainees.

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Making a Psychodynamic Formulation

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In psychiatry signs and symptoms are observed and arranged into diagnostic patterns or clusters. The diagnosis is the 'what' of what is wrong with the patient. In order to plan effectively, we also need to know the whys and wherefores of his state. The understanding that we have of this is expressed in the psychodynamic formulation. In preparing it we draw upon our human capacity for understanding and empathy, our capacity to read the story of the other person's reactions.

A psychodynamic formulation explains how and why the equilibrium of the patient has become disturbed, how the patient's problems have arisen and are maintained, and indicates the logic of the therapy. It is based upon information, should be expressed in simple words, and contains hypotheses that are testable and that may be modified.

In shaping the direction of therapy in psychiatric practice, the formulation is equal in importance to the diagnosis. Through it, aetiological links are made between personal disturbance and social influences, the origins of the disturbance elucidated, the probable consequences of change predicted and the likelihood of those changes occurring estimated. The formulation, therefore, serves both as a map of therapy and as a guide to which map to choose.

The ideal psychodynamic formulation contains answers to the following questions:

A. *Causes and effects*

1. To what current stress(es) is the patient reacting and why?
2. What, if any, is the meaning of the symptoms?
3. How is the stress being handled—what type(s) of defence is being used and how adequately? How is the stress related to the symptoms?
4. What biological and environmental influences have created the patient's vulnerability to this stress (1) and how? What is the history of this reaction?

B. *Maintenance factors*

5. What advantages (primary and secondary) do these symptoms confer?
6. What factors in this person's life maintain the problems?
7. How does the vulnerability of the patient engage with the vulnerabilities of the significant people in his world?

C. *Change factors*

8. What disadvantages does the patient incur? What limitations of personality or function through symp-