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Teaching psychotherapy differs specifically from every other type of medical teaching. One teaches attitudes rather than facts and that which is intuitive, abstract and personal becomes more significant than the factual or historical. Part of the confusion in the present day teaching of psychiatry arises from the effort to teach psychopathology and dynamics concurrently with teaching the process of a therapeutic doctor-patient relationship.

The supply of psychiatrists has never been adequate but with the tremendous increase in public interest and the interest on the part of doctors in psychosomatic medicine, the supply has become even more inadequate. In addition, it is obvious that we are unable to produce adequate satisfaction of the public's hunger for information about our field. This is largely a result of the inadequacy of words in portraying the field of psychiatry.

Most physicians start practice with a pretty

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good understanding of how much they can contribute towards the cure of physical illness. In contrast, very few realize the contribution they make to their patient's health and welfare by their bedside manner. Many of them become negatively conditioned by the patients they cannot help and have little conception of what factors in their contact with patients are therapeutic and what aspects of the doctor-patient relationship can be traumatic to the patient's effort to cure himself of his emotional disturbance. The co-therapist experience which we are describing is calculated to develop increased ability in this area.

Teaching the practicing physician to do psychotherapy is one way to help satisfy the community's need for psychotherapy and keep the psychiatrist's time from being obstructed by patients who might have obtained sufficient help from the general practitioner if he had had a little more professional experience in the methods of psychotherapy. This means of teaching also serves to better the professional relationship between the psychiatrist and the referring doctors. It makes the psychiatrist's job easier, since as a by-product the practitioner is able to develop his capacity for working through the referral of the seriously ill patients. Thus, the patient does not become antagonistic to the practitioner and is able to make an independent decision about her desire for extensive therapy. She is thereby much more apt to approach the psychiatrist with a decision to do something about herself and a readiness to go on through with her psychiatric treatment. Secondly, the joint-therapy experience is one answer to those colleagues who ask,

"Is there any way I can learn to use what the psychiatrist has to offer in my private practice though I am

not a psychiatrist and even though I am not going to handle psychiatric patients as such?"

It becomes easier to define this method which has been used for 6 years if the principle of a limited objective is invoked. The ability to develop a more therapeutic doctor-patient relationship is such an objective. Reading psychiatry and discussion of cases seems to be of little help to the practitioner who wants to develop an ability to help patients with emotional and functional disturbances. Practicing physicians can read about psychiatric diagnosis, pathology and etiology but therapy itself is only poorly described. Surprisingly enough it is easy to teach if the psychiatrist and practitioner have a joint experience. The simple principles of a good relationship can be formulated in terms of what the participants did and felt, what they could have done or would do next time, and the rationale of their experience can be discussed without the use of technical language. In fact, the method seems as effective with only limited discussions; the interview is the experience and the discussion is like an effort to describe a countryside they have just traversed together.

The war proved it possible to do psychotherapy under tremendous limitations. Psychiatrists were able to constrict the interview time from two hours down to 15 minutes and still have a successful relationship. If the situation was accepted by the patient and the doctor, one could hold a therapeutic interview in the middle of a crowded room. Yet few psychiatrists have encouraged practitioners to be participating co-therapists as a method of teaching. It is possible if the psychiatrist is willing to work out a method, to make a second person part of the therapeutic procedure. This necessitates certain limitations, however. (1) There must

be a warm friendship between the therapist and the practitioner to facilitate the give-and-take. The therapist might well invite first someone whom he regards highly as a physician and as a friend. (2) The practitioner should be present from the beginning of the therapeutic process and it should be understood that he will be present for every interview. (3) The selection of patients should be done without a preliminary interview by the psychiatrist since the initial relationship should be to the team. (4) The method should be utilized for treatment cases only and not in situations where the problem is basically diagnostic. (5) For simplicity's sake it is better that we include those cases treated by psychotherapy only and delete cases where treatment utilizes drugs, shock treatment, environmental manipulation or merely reassurance. (6) One may further restrict the method to those patients who are going to be seen for a series of interviews. A patient who is immature and has a degree of anxiety reveals the dynamics of the therapeutic process most adequately.

The patient shall have the right to reject the second therapist at the time of the initial interview, but if he accepts the second therapist it should be understood that this arrangement will continue throughout the course of his therapy. Each of the therapists must feel comfortable in being himself in the presence of the other and the practitioner should be accepted as part of the therapeutic team by the experienced psychiatrist. He will find the practitioner's contribution to their understanding of the dynamics most invigorating and stimulating to his own thinking. The two doctors may be more comfortable if they discuss with the patient the fact that this is a teaching procedure for the second therapist. They will find that their

ideas and feelings will not be the same but even the open expression of differences in the presence of the patient does not seem detrimental.

Therapy done in this way reverberates to the advantage of each of the therapists and the patient as well. The practitioner develops new insights into what takes place, acquires a new competence in his own intuitive functioning and frequently finds therapeutic repercussions in his own living. Such was the case with a dermatologist who said that his golf score went down 10 points after a period of time with this type of experience. He had resolved some of his resentment of functional patients and his guilt at not making an organic diagnosis on every patient. Furthermore, he found he was more the doctor and less the father to his patients and this seemed to be a benefit to his regular work.

The experienced psychiatrist finds a new challenge for his capacity to verbalize the abstractions of psychiatry, the concepts of personality structure and the therapeutic process. In contrast he will be humbled at times to be brought face to face with the capacity which these practitioners have developed over the years. Their realism, pragmatic learnings and practical wisdom frequently cut across his ideologic patterns and bring into sharp focus concepts which he has allowed to remain as hazy generalizations.

You may ask, "What of the patient?" Experience has shown that even the private patient who is offered this modified relationship and accepts it as his source of therapeutic help is able to use it to his benefit. Patients seem to get as much help from this method even though the psychopathology revealed is more limited than that of individual interviews. In fact, once a patient has related himself to dual therapists it

is almost impossible for an individual therapist to take over the treatment function.

Where facilities make it feasible a subsequent arrangement might be made in which the psychiatrist becomes a consultant in the practitioner's office, sitting in to help with every patient for several days. The proceeds of this can be rich indeed. In many patients the intruding consultant produces a closer team relationship between practitioner and patient though each may have mild resentment of him during the interview.

May I illustrate?

A young matron of 30 was referred for depression and confusion following a diagnostic study by her general practitioner. He had talked with her about her physical symptoms and her feelings of inadequacy in relation to her fatigue and palpitation. It was suggested that the therapist and the practitioner see her jointly. The first interview was largely a process of "active listening" to this country girl's story of brilliant success but increasing tension in the social whirl of an eastern city. The practitioner was wise in not bringing out any of the anamnesis previously obtained in his office. The therapist found it easy to be deeply interested but not curious and avoided any "Mr. Fixit" function with its implied magic tones.

The next several interviews enabled the therapist clearly to limit the area of discussion to their pondering her confused living, her ideas, and her philosophy. The need to be dependent and her wish to relax the appearance of competence burst into full flame with child-like crying but she was helped to a gradual realization that she must still handle her outside life. The practitioner had been the first to face such questions as, "Should I tell my children how I feel?" and he had decided that she must answer them for herself. Now he was able to see the patient gain the strength to decide, to act and to tell only in retrospect. During the therapy it became obvious that he was essential to her therapy and when he was on vacation she elected to fight through an attack of acute anxiety alone rather than see the psychiatrist only, so that she could "see you both together as I did before." This

came up again in the dream in which they were her father and mother. The final decision to "try it on my own" was expressed tentatively to the practitioner, and when he accepted it, restated to the psychiatrist. She asked if she could come back if she needed to, but she made an excellent adjustment after the first few weeks of turmoil at home.

SUMMARY

It is suggested that many practitioners who would like to learn psychotherapy can be helped by the simple expedient of making them co-therapists in a specific case or series of cases. This necessitates a warm relationship between the psychiatrist and the practitioner and the careful selection of patients. The method is aimed at teaching the process of psychotherapy as a doctor-patient relationship. As an exercise in psychotherapeutic method it develops a stereoscopic view of the doctor-patient relationship.

DISCUSSION (*Abstract*)

Dr. S. Katzenelbogen, Washington, D. C.—Both physician and psychiatrist should be mindful, above all, of what not to do. I am alluding to iatrogenic factors.

I think that every psychiatrist, every psychotherapist, particularly those who do private practice, must be impressed with the fact that in patients coming from the general practitioner, the internist to the psychotherapist, not infrequently, the psychotherapist must, first of all, handle the fear of the patient caused by unwise remarks or attitudes of the doctors.

I recently had a patient aged about fifty years who came to me because about fifteen years ago, during a physical examination, her hypertension was accidentally discovered, as it happens in many cases of essential hypertension. Thus, she had not come to complain about the high blood pressure, but her doctor had made the remark, "Well, it is all right now, but at about the age of fifty you may die," so she landed in the office of a psychiatrist at just about the age of fifty.

That was fifteen years ago, and you may think that

in the last decade, during which there has been so much talk about psychosomatic medicine, much has been learned about iatrogenic factors; and that nowadays physicians have changed their attitudes in this respect. That does not appear to be the case. As I learn from patients, doctors of deservedly high reputation and with wide experience in their fields commit similar errors. Only a few days ago in a class of students, we were told that the resident and the internist, in the presence of the patient, said, "She must be referred to the psychiatrist." That has upset the patient.

Physicians often ask this question: "What shall we do if we think the patient needs psychiatric help? Shall we keep quiet?" I think psychiatrists will agree that, more often than not, it is not too difficult to have the patient accept the advice to go to a psychiatrist, if it is explained to the patient what psychiatry means with regard to his or her difficulties and what kind of treatment he or she will get. One must be aware of the fact that if the patient's understanding is, as is often the case, that psychiatry is not even a branch of medicine, that it treats only crazy people, then the suggestion of psychiatric treatment will be felt as an insult. If, on the other hand, the physician makes it clear that psychiatry deals with personality difficulties in individuals who may be intellectually above the average, then the patient's reluctance will be easily overcome. The psychiatrist himself is to blame for iatrogenic factors. Only recently an intelligent young psychiatrist with a good background, including a didactic analysis, allowed himself to think aloud while he was taking the history. The patient, a woman thirty-five years old, related that she had started taking lessons in singing. While he was writing his notes he made this remark, just thinking aloud, "At that age?" That finished him in the eyes of the patient; she went to another psychiatrist. Maybe he was right that it was too late, at the age of thirty-five, to start lessons in singing. First of all, he did not investigate what her aim was, whether she wanted to become a concert singer or was simply taking up singing as a hobby to satisfy her own need. Yet, without his knowledge as to what her ambition was, he made this remark. Even if he were correct in assuming that her ambition was to become a concert singer and he thought it to be foolish, he certainly should not have conveyed it to her as he did. Unfortunately, we physicians have the tendency to express to the pa-

tient ideas that may be correct, but harmful to the patient. We should bear in mind that in the patient we are dealing with an individual who looks up to the doctor as an authority; that, therefore, whatever he says may have a great impact. This attitude of the patient toward his doctor is, of course, an essential and very positive factor in psychotherapy. By the same token, an iatrogenic attitude on the part of the doctor amounts to practicing negative psychotherapy.

Dr. Lawrence F. Woolley, Atlanta, Ga.—Dr. Whitaker is with us at Emory University. I have been very much impressed with the way the work is done of teaching undergraduates just this kind of relationship.

I think Dr. Katzenelbogen is too hard on the general practitioner. At least I have had a very refreshing experience in Atlanta with the doctors there. During the war, and for a long time, they were left stranded; they had very little help. Dr. Young, who was the only active psychiatrist there at the time, was ill most of the time during the war and he died in 1945, as you remember, and during a very trying period when we were very busy, the general practitioners in the city of Atlanta were left to their own devices and I think developed a remarkable insight and attitude toward psychiatric patients.

Psychotherapy remains about the hardest subject to teach. Maybe it would compare with the teaching of painting or art of any kind in an abstract way. We must keep in mind the fact that the person who is going to do the treating, the general practitioner, the medical student, or whomever we are teaching, is a different person from ourselves, that that person has a right to be himself, and honestly himself, in a therapeutic situation, so he cannot do just what we would do. When he is drawn into a dynamic situation of give and take with another doctor, as he is with the psychiatrist sitting in as Dr. Whitaker described, many things happen and he is a part of that happening. He experiences these things emotionally himself; he makes mistakes; he does all kinds of things, and we do, too. Sometimes he has a chance to call us down. I do not know of any better way to teach psychotherapy to anyone than this.

The general practitioner and men in other medical specialties should understand psychiatric things as one would understand enough to take care of a cold in a

patient. He would not call in a chest specialist for that. He does not need to call in the psychiatrist for many of the emotional problems of his patients. I do not see any reason why the whole thing should be on the psychiatrists' shoulders.

Dr. Whitaker (closing).—I am rather depressed about the possibility of teaching even the limitations of therapy verbally. We spend two years in weekly sessions, an hour a week in the first year and two hours a week in the second year. Essentially it is all free-floating group psychotherapy. The first year the students are the patients and the second year the student group treats a clinic patient. Basically, this is all to modify the attitudes that are part of our freshman medical students when they arrive.

The problem of trying to help the general practitioner find his areas of personality stress and any conflict in his relationship to his patients is a very difficult thing.

I fear that if one utilizes "noes" as one is inclined to when he works in conjunction with someone who is not a trained therapist, he will frequently alienate the student. He feels so inadequate when he comes into the situation that even a very quiet "no" makes him feel hopelessly inadequate and afraid to continue. This method amounts to teaching by emulation. He begins to see you; not the things you say, not the things you do, but he sees you and the patient reacting to each other. For two or three sessions he may not say anything, or perhaps only a few words. He will, however, reverberate in his thinking and feeling to this joint experience, since he brings not only his intellect but his whole personality. Our objective is to help him modify and purify his own clinical sense in the art of medicine by offering him added sensitivity to this aspect of the practice of medicine.

As to the referral problem, I hope all of you have read or will read Dr. Finesinger's article in the September *A.P.A. Journal*. The patient must come with as great a percentage of the motivation for treatment as is possible, and this is the one thing that the general practitioner learns most of all about referrals. He learns not to force the patient to become dependent upon him or upon the psychiatrist and lets the patient control the pattern of this dependency.

The doctor at least becomes interested in what can be done with such a patient. This very frequently helps

him overcome his resentment towards all these patients, based on that feeling of fatalism most people have about helping patients who are emotionally disturbed. He comes into the psychiatrist's office and sees patients get help and he begins to try again, as he tried when he first began to practice.

Once he envisions the possibility of his own effectiveness he will develop his own approach to areas he had previously neglected.