AN EXERCISE IN EXPOSING GENERAL PRACTITIONERS TO PSYCHOTHERAPEUTIC ORIENTATION*  
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SUMMARY  
General Practitioners undergoing short training courses in psychiatry invariably express a need to learn about psychotherapeutic approach. A batch of 10 general practitioners were offered an year's exposure to psychotherapeutic orientation. Both the staff and trainees felt the exercise rewarding. This paper describes the exercise.  

Introduction  
The need to train general practitioners in psychiatry is too well known. This is especially so in countries like India where the available specialist services as well as the psychiatric training of medical undergraduates are insufficient to meet the community's need.  
As a part of the programme of the community psychiatry unit of NIMHANS, the author conducted his first ever training course in psychiatry for general practitioners in 1977 with the help of a few colleagues. In that training course a recurrent theme expressed by the trainees during discussion was: "How to interview a patient with psychiatric problems to therapeutic advantage?"  
Balint (1964) was a pioneer in the field of psychotherapeutic training to general practitioners. With varying degrees of modifications, his method continues to be used in the West (e.g. deBoer et al. 1970, Smart & Berkow 1977). The method consists of a group of general practitioners examining each other's clinical material with the assistance and leadership of psychotherapists. These groups function either as continuous open groups called 'Balint groups' or as long duration groups of 2 to 3 years.  
But, in India, where larger numbers of general practitioners need training by fewer available specialists in shorter periods of time, the emphasis must necessarily be on shorter courses of training. The only way to make the psychotherapeutic orientation shorter, simpler and safer is by shifting the emphasis from psychotherapy per se to the process of interpersonal interaction, and by limiting its scope to application of the principles of counselling and supportive psychotherapy. The assumption is that with extremely wide range of clinical material at his disposal, a motivated practitioner would continue to improve his skills in interviewing, counselling and supportive therapy. Moreover, in the present Indian context of shortage of specialist manpower, who can be a better teacher to his peers than a practitioner who has acquired elementary therapeutic skills largely by his own effort in his own clinical practice with the introductory help from the specialist?  
This paper is a descriptive account of training programme conducted in Bangalore in 1979-80 aimed at: (i) familiarising a batch of general practitioners in the process of doctor-patient interaction (ii) encouraging the trainees to organise a similar programme themselves among their peers.  

Material and Methods  
A training course in psychiatry for general

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* Paper presented at the 'Workshop on Community Mental Health in India - An evaluation of Research of first decade (1975-85)' held at NIMHANS in October 1985.
practitioners was conducted in 1977-78 by organising one afternoon session a month for 2 years (Shamsundar et al. 1978 and 1980). Out of 90 doctors, about 20 (22%) attended nearly all the 24 sessions participating more in the discussions and discussing more about their own clinical material. After the training was over, these 20 doctors were offered one afternoon session a week training in psychotherapeutic process for an year. They were informed that about 10-12 of them will be selected for the exercise. 16 of these 20 doctors volunteered. Based on his observation over the preceding 2 years, the author selected 10 doctors (about 10% of the total 90 doctors) who had seemed more 'psychologically minded'. After these 10 doctors were briefed on the purpose and nature of the programme, a particular day and time was fixed for the weekly once afternoon sessions. A colleague of the author, a lady psychiatrist, who had known the 10 doctors during their preceding 2 years training joined the programme as a co-leader.

The training programme was conducted in three consecutive and contiguous phases of 4 months each. The first phase was devoted to sensitise the doctors to the undercurrents of communication and human behaviour through the medium of a 'self experience group'. The interpretations were limited to 'here-and-now' group behaviour, taking conscious care not to expose transference phenomena. After each session, the two psychiatrists reviewed the session among themselves, the author maintaining the notes.

The second phase was devoted to facilitate the doctor to learn to put his sensitivity to clinical use. This was done by each doctor, in rotation, presenting an interview material for discussion. He was required to select a patient with whom he felt comfortable, give him a separate appointment for detailed interview, and write up a detailed record of the interview soon after for subsequent presentation and discussion in the group. During the discussions, the foci of attention were:

a) Facilitation of the interview by emphasis on:
   (i) What the patient is trying to convey.
   (ii) Clues that the patient may be offering.
   (iii) Acknowledging how the patient may be feeling.

b) Some understanding of the patient's predicament by viewing his problems in terms of:
   (i) Psychodynamic concepts including family dynamics.
   (ii) Learning theory.

c) Management in a supportive manner by:
   (i) Prescription of suitable drugs where appropriate.
   (ii) Identification and re-inforcement of patient's achievements and positive potentials.
   (iv) Facilitation of the patient's examination of an experimentation with alternate strategies of coping.
   (v) Where necessary, involvement of other's co-operation like family members.

d) Identification of interpersonal difficulties in the doctor-patient interaction for consultation and referral.

At the end of each session, all the doctors including the two psychiatrists assessed and scored the presentation on a proforma (Appendix 'A'). This proforma called 'the assessment of presented interview material', contained four-point scales of 5 characteristics which, the doctors were taught, would be the natural outcome of an ideal interview. In addition, each doctor was required to submit a typed copy of his interview material for independent scoring by
another psychiatrist on a proforma (Appendix B). This proforma called the 'assessment of written interview material' contained 5 desirable attributes of a counsellor (positive attributes) and their opposites (negative attributes). These attributes were included as they were thought to be comparatively easy to identify in a transcribed interview material. However, these two proforma were not pre-tested for reliability and validity.

The third phase was devoted to direct observation of each doctor's interview skills by the group for subsequent discussion. This was done by means of pairs of doctors, in rotation, role-playing an interview. One of the pair played the role of a patient he knew about, and the other interviewed this 'patient' before others. The ensuing discussions were similar to discussions in the second phase. Like in the first phase, in both the second and third phases, reference to transference phenomena were deliberately avoided during the discussions. The third phase was not subjected to any formally recorded assessment.

After the completion of this one year programme, the doctors were given a set of questions (Appendix C) for their feedback about the training. They were encouraged to form a case discussion group among themselves and to meet regularly on their own, recruiting their interested peers, and discuss their psychiatric clinical material. This case-discussion group would strengthen their learning, and facilitate the doctors to continue their self-learning through the medium of peer-review. In addition, the practitioners newly recruited to the group would not only get exposed to psychiatric orientation but would also in turn evoke a teaching-response from the trained doctors. They were assured that the two psychiatrists would alternate in attending such a group regularly in the beginning and less frequently subsequently. The regular visits of the psychiatrists would enable them to: (i) re-inforce the practitioners' self-learning (ii) followup the effort initially invested and (iii) monitor and help in any possible interpersonal problems that might arise in the doctor patient relationship. The gradual phasing-out of the psychiatrists' visit was designed to strengthen the self-confidence of the group as well as of the doctors.

Results and Discussion

As this paper is a descriptive account, for the purpose of continuity and convenience, discussion follows each observation or sets of observations. The description of the 10 general practitioners is shown in Table 1. The doctors as can be seen, formed a rather heterogeneous assortment. The only common factors among them were: (i) they had attended the previous 2 years training regularly (ii) they had taken active part in the discussion about their own clinical case materials (iii) the author felt they had 'psychological mindedness', (iv) they volunteered for this exercise.

The first phase showed many of the typical group processes in their sequences, which overlapped a great deal. The initial few sessions saw irregular attendance, doubts and provocativeness sandwiched between silence or 'gossips'. In the next few sessions, the attendance was reduced to about 4 doctors per session. The doctors very seriously examined many issues like the utility of this exercise, whether the group would be able to deal with possible unpleasant consequences of interaction, the competence of the leader and how to keep the leader happy. In the subsequent sessions, the attendance was reduced to about 4 doctors per session. The doctors very seriously examined many issues like the utility of this exercise, whether the group would be able to deal with possible unpleasant consequences of interaction, the competence of the leader and how to keep the leader happy. In the subsequent sessions, there was a gradual improvement in attendance and punctuality, while the group began exploring anxieties related to the members' concepts of what will and should happen in a group, the theme of anger appearing for the first time in the 10th
## Table 1
Description of the participant general practitioners

| Doctor | Age in years | Number of years in practice | Average No. of patients seen daily ** | By his opinion, % of his patients with psychiatric problems | "Observable traits" ** |
|--------|--------------|-----------------------------|--------------------------------------|-------------------------------------------------------------|-----------------------|
| S.M.   | 38           | 12                          | 60                                   | 40                                                          | Assertive, intellectualising |
| A      | 38           | 10                          | 25                                   | 20                                                          | Hesitant, reserved, not comfortable with anger |
| J.P.   | 29           | 6                           | 20                                   | 10                                                          | Boisterous, voluble, denies feelings, avoids potential unpleasantness |
| S.J.   | 29           | 6                           | 45                                   | 10                                                          | Pessimistic, low self-esteem |
| M      | 31           | 8                           | 40                                   | 30                                                          | Idealistic, assertive, serious |
| K      | 44           | 7                           | 6                                    | 25                                                          | Reserved, timid, rigid and cautious |
| B      | 42           | 15                          | 30                                   | 50                                                          | Belligerant, assertive, denies feelings |
| V      | 32           | 3                           | 10                                   | 25                                                          | Assertive, denies feelings, rigid |
| S'     | 26           | 2                           | 10                                   | 30                                                          | Intellectualising, afraid of disagreements |

* Wife of Dr. V.  
** Based on author's impressions over the 1 year of psychotherapeutic orientation  
*** Doctor's own statement

## Table 2
Comparison of scores of assessment of interview material for those general practitioners who had presented twice

| Presenting general practitioner | 1st presentation | 2nd presentation |
|---------------------------------|------------------|------------------|
|                                 | Mean of scores by all doctors | Mean of scores by the two psychiatrists | Mean of scores by all doctors | Mean of scores by the two psychiatrists |
| A                               | 7.8              | 7.0              | 9.0              | 11.5              |
| S.M.                            | 10.3             | 6.5              | 12.5             | 12.0             |
| J.P.                            | 7.1              | 3.0              | 4.8              | 4.5              |
| V.                              | 11.6             | 11.5             | 11.7             | 13.0             |
| K.                              | 5.1              | 6.0              | 5.5              | 7.0              |
| M.                              | 10.1             | 8.5              | 11.5             | 9.0              |

'Before = After' or First = Second comparison:
(i) Scores by all doctors $t = 0.7048$ (df = 5) N.S.
(ii) Scores by psychiatrists $t = 2.8742$ (df = 5) $p < 0.05$

## Table 3
Assessment of typed interview material by an independent psychiatrist (Appendix B)

| General practitioner | Positive qualities | Negative qualities |
|----------------------|--------------------|--------------------|
|                      | 1st presentation   | 2nd presentation   | 1st presentation   | 2nd presentation   |
| S.M.                 | 10                 | 6                  | 1                  | 1                 |
| A                    | 3                  | 3                  | 2                  | 2                 |
| M                    | 5                  | 1                  | 1                  | 1                 |
| K                    | 2                  | 5                  | 0                  | 0                 |
session. In the last few sessions, the attendance used to be full, and the group’s recurrent theme was of assertiveness.

The two psychiatrists too had their difficult, awkward and tense moments. For example, when the doctors were covertly or overtly provocative, when the atmosphere was gloomy and silent in a thinned-out group, or when the group began its assertiveness at the ‘cost of the psychiatrists’. Retrospectively, the psychiatrists felt the experience rewarding not only in terms of the richness of personal experience with their first ever group of general practitioners, but also in view of the fact that the progressive group processes manifested over such a short period as 4 months. This has to be viewed in the context of both the psychiatrists and the doctors having already been familiar with each other during the preceding 2 years’ training in psychiatry.

In the second phase, the doctors presented their interview materials with enthusiasm, and the discussions generally lasted an hour, more at times. Though the doctors presenting the material continued to report of their initial anxiety at being the target of assessments and comments, they were enthusiastic and active participants in discussions. The participation of the psychiatrists was comparatively more than in the first phase. The doctors showed ability to empathise with the patient’s feeling and to elicit important psychosocial factors operative. Though they seemed hesitant to apply with confidence the different principles of counselling, they were adept at suggesting alternate strategies for the patient to try out. The scores of assessment of presented interview material as assessed by the two psychiatrists were compared by correlation co-efficient ‘r’. The value, ‘r’ was + 0.6115 (d.f. 11) (P < 0.05). For each presenting doctor, the scores by the two psychiatrists were averaged. Similarly, the scores by other doctors were averaged. When the averaged scores by the psychiatrists were compared with averaged score by other doctors, the ‘r’ value was + 0.7712 (d.f 14) (P < 0.001). Even though the small sample size restricts the weightage of the statistical operations, the proforma of assessment does seem to promise a high degree of inter-rater reliability. 6 of the 10 doctors had occasion to present the interview materials on two occasions, at an interval of about 8 weeks. Table 2 shows the comparison of scores of first and second presentations by paired ‘t’ test. The scores of the second presentations are marginally higher than of the first ones. It is probable that more refined tools of assessment would enable to clearly establish gain attributable to this phase of the exercise.

The typed interview material of only 4 doctors were available for coding and blind assessment by an independent psychiatrist on a proforma assessing the written interview material. The results are shown in Table 3. Only marginal to moderate improvements are noted for two doctors (A, and K) in respect of negative qualities. But, the positive qualities seem to show decline for all the 4 doctors. These findings, in the overall context, are not difficult to account for:

(i) the extremely small size of the sample
(ii) previously untested tool
(iii) only one assessor
(iv) the nature of the exercise may have influenced the doctors to concentrate more on the negative aspects of their attitude during this short phase.

During the role-play interviews of the third phase, the doctors were much more actively involved in the discussions than in the second phase. The quality of the role-played interviews were better than interview materials of second phase. The interviewing doctor tended to eagerly begin the discussion by talking about his retrospectively perceived deficiencies. The interviewee as well tended to comment on how he perceived the interview and the interviewer.
### Table 4
Doctors’ feedback
(Each single sentence on the right hand column represents the response of one general practitioner. Similar statements by other doctors are not repeated)

| Item (Appendix - C) | Feedback, responding doctor in parenthesis |
|---------------------|--------------------------------------------|
| Identification of Psychiatric problems. | Better than before (J. P). Now, can identify well and boldly (S. J). No difference, but more thorough now (S. M). Now, I make conscious effort (K). More accurate now (M). |
| Diagnosing the nature of patient’s problem. | Previously vague, now more accurate (S. J). Definitely improved, more confident, and have become aware that the clinical diagnosis alone is not sufficient (S. M). |
| Patient’s satisfaction with the interview. | Majority of them are satisfied (S. J). Definitely, yes (S. M). Not able to judge (K). |
| Doctor’s own satisfaction with the interview. | Feel better, and find it easier (J. P). Quite happy, and in command of the situation (S. J). Very satisfied because there is now a purpose and goal, getting more patients by word of mouth and feel more confident (S. M). Previously hesitant to ask questions, now not at all so (M). |
| Counselling the patient and family members. | We were doing it all the time without knowing it. Now I know it and do it better (J. P). I have become a good listener, still not confident with counselling (S. J). Now, there is a definite change, more and more patients seek me out even though I avoid prescribing drugs (S. M). Patients seem more co-operative now than before (M). |
| Any change in one self, personal life, and with others. | Less arrogant and short tempered (J. P). More tolerant of other’s upsetting behaviours (S. J). More confidence in handling the minor problems of life, more aware of own limitations, less hurtful and judging in communication, more contentment (S. M). Less upset by situations and better understanding of these situations (K). Emotionally more stable, and more positive in outlook (M). |
| Comments on the three phases of exercise. | Though all three were necessary, the role play impressed me (J. P). In the order of preference: interview exercises, role-play, and self experience group (S. M). During the self-experience group, most of the time I was uncomfortable, and benefits not apparent (K). Retrospectively, I now understand the importance of self experience group (M). |
| Any comments | (Unanimous). These exercises should be extended to all general practitioners. |

There was also a qualitative positive change in the way the doctors interviewed.

The table 4 shows that the feedback information from the doctors using the pro forma called ‘doctors feedback’ (Appendix C). Though generally indicative of the perceived effectiveness of the whole exercise, many of the contents show that the experience expressed were not entirely determined by a favourable bias.

The author observed two important changes. The first was in relation to the doctors’ almost unanimous belief at the beginning of the exercise that it is not possible
to adequately interview a patient because there was not sufficient time in the busy practice, and the patient would not like to be so interviewed for eliciting psychological problems. These beliefs had persisted even after the earlier orientation training which contained lectures and discussion on these prevalent attitudes of doctors on psychosocial aspects of management. Only with scepticism did they give separate appointments to their chosen patients for interviewing in the second phase. It turned out that both the doctors as well as their patients liked and benefited by separate appointments. The second change observed was in relation to the doctors' unanimous belief in the beginning that the patients in general demand quick cures by injections and they felt compelled to oblige by prescribing harmless injections. During the discussions in the third phase, the majority of the doctors reported that they had found themselves able to manage most of their neurotic patients without prescriptions and others reported that such a management was possible with some patients. These observations demonstrate that these attitudes commonly prevalent among doctors can and does change only with the help of exposure in practice to dynamics of interpersonal relationship.

Six of the doctors (S. M., A., J. P., S. J., M and B) called 'veterans' for the purpose of this article, agreed to meet on their own once a week on a definite day and time for an year in S. M.'s clinic to discuss their psychiatric cases among themselves. They did so, and were able to recruit seven other general practitioners who had earlier been trained in psychiatry through short courses. Each of the two psychiatrists attended on alternate fortnights and functioned mostly as observers. The attendance was regular. No objective and formal assessment of these meetings were attempted. However, a few observations were too obvious to be missed.

(i) The quality of discussions was high compared to the quality of discussions that usually take place in short training programmes for general practitioners.

(ii) The doctors were able to deal effectively with 'emoting' patients by use of empathic and consoling comments as though they had an innate ability to do so.

(iii) The perceived benefit among themselves was so much that after an year, they decided to and did continue these meetings for 3 more years, at fortnightly intervals, expecting the psychiatrist to attend once in 2-3 months, which the author obliged.

(iv) The kind of cases about which they tended to consult the psychiatrist during his attendances were mostly alcohol and other drug addictions.

Retrospectively, the author concludes that:

(i) Among the general practitioners who undergo short training courses in psychiatry, about 10% of them are likely to be suitable for and motivated to undergo training in psychotherapeutic orientation.

(ii) One psychotherapeutically oriented psychiatrist, or at the most two should be able to train 10-12 interested and suitable general practitioners in psychotherapeutic process over 50-60 afternoon sessions at a time.

(iii) The majority of the doctors so trained would be able and interested to perpetuate such a training effectively among their peers with minimal specialist support.

Acknowledgements

The author gratefully thanks the general practitioners who participated in this training programme, his ex-colleague Dr. (Mrs) Usha K. Sundaram for her enthusiastic and active
help throughout the programme, and his present colleague Dr. M. N. Shivaprakash for his help in assessing the typed interview materials.

References

BALINT, M (1964), "The doctor, his patient and the illness", 2nd edition, Pitman Medical, London.

DE BOER, R.A., JASPERS, J.M.F., VAN LEEUWEN, P., VAN DER MEER, F., RADDER, J.J. & VAN SCHAIK, C. TH (1970). An evaluation of long term seminars in psychiatry for family physicians, Psychiatry, 33, 468-481.

E.R. SMARR & BERKOW, R. (1977), Teaching psychological medicine to general practical residents. American Journal of Psychiatry, 134, 984-987.

SHAMASUNDAR, C., KAPUR, R.L., USHA, K. SUNDARAM., SHAILA PAL & NAGARATHNA, G.N. (1978). Involvement of general practitioners in urban mental health care, Journal of the Indian Medical Association, 71, 310-313.

SHAMASUNDAR, C., USHA, K. SUNDARAM., KALYANASUNDARAM, S., SHAILA PAL & KAPUR, R.L. (1980). Training of general practitioners in mental health, a two year experience, Indian Journal of Psychological Medicine, 3, 95-90.
Assessment of presented interview material

Assessor: Date:

1. a. Was the initial, brief background information sufficient?
   0 = insufficient
   1 = moderately sufficient
   2 = satisfactory
   3 = excellent
   If not 3, what was lacking? .................................................................

   b. Did the above information in (a) give you a clear idea about the patient's main problem?
   0 = not at all
   1 = only vaguely so
   2 = some idea
   3 = very clear idea
   If your answer is 3, what is the patient's main problem? ......................

   c. Did the above information in (a) give you a clear indication of the doctor's problem?
   0 = not at all
   1 = only vaguely so
   2 = some idea
   3 = very clear idea
   If your answer is 3, what is the doctor's problem ..................................

2. a. Did the interview material presented appear to flow smoothly from issue to related issue?
   0 = too discontinuous
   1 = frequent jumps
   2 = only an occasional discontinuity
   3 = flowed smoothly

   b. Did the above interview material reflect a transaction with literal meanings or with underlying implied/affective meanings?
   0 = exclusively with literal meanings
   1 = predominantly with literal meanings
   2 = predominantly with implied meanings
   3 = exclusively with implied meanings

3. In today's exercise, what were the most important things you learnt? ..............
   ...........................................................................................................

4. Any comments? ......................................................................................
   ...........................................................................................................
Appendix - B
Assessment of written interview material

Code No: .................. Assessor ............

(Note: Each time a positive or negative attribute is identified in the transcribed interview material, put '1' under the respective box)

| Positive aspect of the attribute | Mark '1' if present | Mark '1' if present | Negative aspect of the attribute |
|----------------------------------|---------------------|---------------------|---------------------------------|
| Non-judgemental and neutral      |                     |                     | Judgemental and biased           |
| Non-authoritarian                |                     |                     | Authoritarian                    |
| Ability to follow patient's      |                     |                     | Absence of such ability          |
| line of thought and feeling      |                     |                     | Blockage or hinderance to        |
| Facilitation of outflow of       |                     |                     | outflow of information           |
| information                      |                     |                     | Doctor's communicatory behaviour|
| Doctor's communicatory behaviour |                     |                     | seems inappropriate              |
| Total number of times the        | Total number of     |                     |                                |
| positive attributes are present  | times the negative  |                     |                                |
|                                  | attributes are      |                     |                                |
|                                  | present             |                     |                                |

Appendix - C
Doctor's feed back

Name of the doctor:
Signature: Date:

Under each heading below, kindly give a brief account of the influence this one year training programme had on you.

1. a) The extent to which you are able to identify psychiatric problems in your clients.
   b) The extent to which you are able to diagnose the nature of the patient's problem.

2. a) The extent to which you feel that your patient is satisfied with the interview.
   b) The extent to which you feel satisfied with your interview.

3. The extent to which you are able to counsel the
   a) Patients.
   b) The family members.

4. a) The way you feel in yourself.
   b) The way you conduct yourself with others.

5. Your opinion and assessment of 3 phases of the programme.

6. Any comments?