AN APPROACH TO PSYCHOTHERAPY

ANTHONY HORDERN, M.B., M.R.C.P.(EDIN.), M.R.C.P., D.P.M.

Consultant Psychiatrist, Mental Hygiene Authority, Victoria, Australia

PSYCHOTHERAPY is a technique of treating patients through verbal and non-verbal communication in contrast to methods utilizing drugs, mechanical appliances and surgical operations. It can be regarded as a specialized verbal process accompanied by an emotional attitude by means of which a therapist—a doctor or layman—helps or tries to help an individual or group of individuals to solve their emotional problems. Group psychotherapy, however, is too large a subject to be discussed in this article.

The basis of individual psychotherapy is generally held to be the relationship established between the therapist and the patient, a specialized relationship christened the 'transference' by the psycho-analytic school. The transference is formed during treatment and consists of feelings that the patient harbours towards his nearest and dearest, his rivals and adversaries, and the world at large, which he 'transfers' on to the therapist and gradually exposes. Added to these are more or less realistic evaluations of the therapist which, however, in Sullivan's (1955) apt phrase, may be 'parataxically distorted', i.e. influenced by fallacious interpretations formed as a result of early experiences. In the course of time, by exposing his attitudes to a helpful non-critical therapist and re-experiencing them in a concentrated model relationship, the patient can disinvest them of terror and guilt; he learns to trust people as he trusts the therapist, and alters his attitudes with resulting improvement in his condition. The psychology of the transference, therefore, is of great importance and merits detailed consideration; it is a specialized relationship which has points in common with many other relationships the individual makes in the normal course of development, and can be brought into alignment with them. In addition to the problems of transference, the problems of counter-transference—the therapist's attitude to the patient—must be considered.

Most basic, most primitive and deepest of relationships is that existing between baby and mother—totally dependent, defenceless and unprotected, the child gains everything from the mother—love, security, food, warmth and life

itself, a situation from which the mother normally derives infinite happiness and satisfaction. In a similar but much less intense way, the psychotherapist gains satisfaction from giving security and love to his patients, and helping them to mature. As in the mother's case, there is nothing unhealthy about this relationship, which is a necessary transitional stage in treatment, though at times difficult and trying to maintain. His satisfaction is analogous to the mother's. Samson Wright's quotation from Rabbi Akiba expresses it neatly: 'More than the calf wishes to suck does the cow yearn to suckle'.

The importance of a secure mother-child relationship in early years has of late been increasingly stressed; as the precursor and originator of all other relationships, the self-confidence and personality of the child in later life depend on it a great deal. Among many who have dealt with this concept in detail Bowlby (1952) and Suttie (1960) may be mentioned.

After this relationship to the mother, the individual relates to the father and to parent figures generally such as teachers, relatives and other significant adults. Riesman (1950) has pointed out that, in older 'inner-directed' societies, these early relationships are so important that they provide the individual from such a society with a psychological mechanism analogous to an inner gyroscope. Thus equipped, the individual, in the privacy of his inner life, pursues his course relatively impervious to unpopularity and criticism from his fellows. In the newer 'outer-directed' societies by contrast, early relationships to adults are surpassed in importance by relationships to the peer group; the individual conducts his life by means of a psychological 'radar', guided in his behaviour by self-appraisals reflected from the group, which, to maintain his emotional security, must be consistently favourable. He is thus forced to surrender his privacy and conform to groups more in order to receive the approval he cannot do without, and to avoid the group's disfavour, which, to him, is profoundly unsettling.

Later in life this orientation to the group is usually replaced in both types of society by emotional adjustments orientated towards the

marriage partner, the children and the grandchildren with a final return to the conventional aspects of contemporary religious observances. Thus the human being is in a constant state of emotional flux, his relationships evolving dynamically from the dependent egocentric immature material state to the independent altruistic mature spiritual state. It is the purpose of the psychotherapist to further the individual's progress between these two extremes; to do this he may have to occupy the roles of mother, father, teacher, child and altruistic friend. In facilitating this transition the psychotherapist is much more than a passive spectator; his reward, though obscure, is none the less real. 'Like a father who teaches his child to walk' Kennedy (1960) observes 'he is content to know that when he himself has been forgotten the child will walk unaided'.

An examination of the great religious figures of history reveals that they were supreme psychotherapists. Such individuals as Christ, Buddha and Confucius, through the love they brought, possessed the ability to absolve the individual of guilt, to free him of his self-reproach and to enable him to mobilize new energy for the task in hand. The essential feature of this type of love is that, though it does not necessarily approve of the person's actions, it approves of the person himself. The relationship between psychotherapy and religion has been studied by Jung (1958) and Weatherhead (1952) amongst many others. The psychotherapist, like the mother and the Saviour, takes away guilt and provides love, which helps the patient to change and progress.

Aims of Psychotherapeutic Treatment

Apart from these academic and theological aspects, it is apparent that the transference relationship—the kernel of psychotherapy—is an extremely important factor in the doctor-patient relationship, though it is often not recognized as such. It is a particularly valuable instrument in the treatment of neuroses and psychosomatic disorders, but its sphere of usefulness extends to the psychoses, and, indeed, embraces every ailment the doctor has to treat. The object of studying psychotherapy is to ensure that this powerful weapon is used economically and to the best advantage. It may, therefore, be as well to deal immediately with the objection that no treatment by 'merely talking' could help to affect illness; the most adequate refutation of this misconception has been provided by Freud (1952): 'The patient's unenlightened relatives—people of a kind to be impressed only by something visible and tangible, preferably by the sort of action that may be seen in the cinema, never fail to express their doubts as

to "How can one do anything to cure illness by mere talking?" This is, of course, both shortsighted and inconsequent. These are the very people who are so certain that the patient is "merely imagining" his symptoms. Words were originally magical and even today the word has retained much of its magic power. By words a man can make another man happy or drive him to despair; by words the teacher transfers his knowledge to his pupils; by words the speaker carries his audience with him and determines its judgment and decisions. Words evoke emotions and are the universal means of influencing our fellow creatures . . .'

Since Freud made these remarks, it has become more generally realized that people are influenced by the attitudes of others towards them, as well as by their actions, and that the words that accompany these attitudes and actions may or may not correspond. Taken in this sense, words are communicative to a greater or lesser degree, but in themselves are not always as significant as certain obsessional 'magical' operations would suggest.

Whatever the rights of the situation, the craving that patients experience for 'something visible and tangible' persists insofar as treatment is concerned. Thus patients pay more readily for a rapidly performed surgical manoeuvre, than for an equally skilful, but much more time-consuming, psychotherapeutic interview. Similarly, patients are usually willing to pay as much for a single electrically-induced convulsion as for a methodical and painstaking medical consultation, or psychotherapeutic session lasting an hour.

Whereas psychiatric treatment in general includes manipulation of the environment as well as treatment of the patient, psychotherapy properly aims at altering the patient so that he can tolerate his difficulties more easily or so that they no longer trouble him. He must be helped to develop as far as possible into a mature, self-reliant individual capable of withstanding stress and uncertainty. The treatment given may be superficial or deep, short or long term, and analytic or non-analytic; its actual nature will depend on such variables as the intelligence of the patient, his ability and willingness to submit to therapy, the time available and the skill and experience of the therapist. In this regard it may be helpful to consider some of the factors relating to the psychotherapist in order to show the would-be therapist the type of psychotherapy most likely to produce results in his hands, as also to mention some pointers as to how the treatment itself should be conducted.

A valuable insight into the aims of psychotherapy has been given by Jung (1954) in an essay under-

that title. He stresses his acceptance of Freud's concept of the disturbances evoked by deviations of the sexual instinct, and he believes that Adlerian views on the importance of the inferiority complex have validity. Nevertheless he thinks that each theory contains only a part of the truth, and goes on to describe how he has learnt more from his failures in treatment than in any other way. He feels that the neuroses of the young are characterized by a hesitance or a shrinking back from the concrete goals of life, a 'psychology of life's morning' involving a retention of an incest relationship inimical to development and happiness. The old, on the contrary, shrink back from death; the 'psychology of life's afternoon' is marked by a constriction of forces, an affirmation of what has been achieved and by the curtailment of further growth. Jung feels that the aims of therapy should be modified to meet these facts, and that the age of the patient is, therefore, of some importance; 40 is said to be about the normal dividing line between 'morning' and 'afternoon'.

Jung makes the cogent point that certain psychological systems suit some people better than others, e.g. people like Adler are likely to do well with Adler's formulation of the problems of life. Jung's own view is that the therapist should follow nature as a guide, and he feels that, as there is no ready-made philosophy of life to pass on, help can be gained from the study of dreams. He believes that dreams are symbolic guides acting through the medium of the unconscious though not always open to ready interpretation. For this reason his psychotherapeutic approach employs dreams extensively, a procedure that does not appeal to every therapist.

Learning Psychotherapy

It is best if the person learning to be a psychotherapist can find in it something to satisfy his ethics as well as his intellect, something to give him pleasure and pride within the limits of a sense of proportion. Psychotherapy can be very tedious at times and so a sense of humour is a great help. A colleague once remarked 'I treat my friends as I treat my patients'—at first sight a peculiar statement; but how applicable it is with inversion: 'I treat my patients as . . . my friends'. Thus it is very difficult, if not impossible, for an individual who fundamentally despises and dislikes his fellow man to be a good psychotherapist. Treatment must be carried out in the atmosphere of toleration, understanding, respect and friendliness. The qualities of the perfect psychotherapist are those of a saint; but as Gertrude Stein once remarked: 'It is not necessary to be the best plumber in the world; it is enough to be a good plumber'. The important thing is for the therapist to convey to the patient

that he realizes he is in difficulty and that he wants to help him; this feeling goes a long way with a patient, further, many think, than the 'impartial screen' attitude advocated by the early psychoanalysts. To the objection that such an attitude fosters dependency the reply can be given that dependency in some degree is always present in the doctor-patient relationship; the goal is to reduce this dependency steadily and gradually in order that the patient can learn to do without the therapist, rather than to attempt to practise a one-sided relationship in which the patient finds it difficult to get his bearings.

The patient must, however, be kept in sight of the fact that the therapist is human and, therefore, fallible; this will prevent his attachment becoming insecure and out of touch with reality, as well as acting as a counter to the therapist's narcissism. The therapist must have endless patience, and, like all healers, must resign himself to the likelihood that those he strives hardest to help are usually the least grateful; the most frustrating aspects of therapy are probably the excessive slowness with which people learn from therapeutic experience, and their surprising ability to forget the basic insights learnt laboriously in the course of many interviews. But, again, the satisfaction of helping a patient through such therapy is probably the greatest satisfaction the doctor knows.

In teaching psychotherapy, it is necessary to decide what should be taught and the best way of teaching it; both content and method must be adapted to the level of those under instruction. Two broadly divergent approaches are available with many variations within them. On the one hand there is the approach which urges that any sort of interference with the patient's adaptation is dangerous and futile, and that the best thing is to push his neurosis back below the surface with non-specific reassurance; on the other hand, the analysts are satisfied with nothing less than a minute interpretative chronological dissection of the thoughts and fantasies that the patient presents to them over an extremely long series of interviews. For practical purposes the best course lies somewhere between these extremes. Many patients can be helped by psychotherapeutic 'first aid'—four or five interviews of an hour; it is more practical to arrange this than to plan hourly interviews four times weekly for two or three years. Such 'brief contact' therapy is usually more effective than dismissing the patient with amylobarbitone and superficial reassurance.

As well as suiting the patient, the therapy should suit the therapist—the materialist will find satisfaction in the Freudian system, the mystic perhaps in Jungian dream analysis. In general, it is useful if the therapist is able to employ the appropriate

general principles of each school as and when the occasion arises. Many therapists now believe that therapy is compatible with physical or drug treatment, and feel that in some cases they can be used synergically with great benefit.

The various analytic schools have insisted on a period of apprenticeship under supervision with cases, and have usually preceded this with an analysis of the would-be therapist; this analysis may take several years and can be very costly. The object of such an analysis is theoretically to make the initiate aware of his own mental mechanisms, and deal effectively with them, so that they will not interfere when he is treating his patients—e.g. many therapists have a need to be liked which, if not kept in check, may affect treatment adversely. They may approach the patient in such a way that he is compelled to express gratitude and affection; thus a need for approval prevents them from administering necessary rebukes to the patient, which bring in their train a certain amount of hostility. Obviously the therapist must be sufficiently secure emotionally to be able to withstand hostility from the patient, if it is to be the latter's ultimate good to express it to him. A personal analysis may make it easier for the therapist to handle his emotional difficulties. Nevertheless it should be realized that it may also upset the psychic equilibrium of the therapist severely; bringing new areas of insight and increased conviction, it sometimes subtracts perspective and the ability to criticize. Psychoanalysis has been likened to Freemasonry; those who belong cannot criticize the structure, while the criticisms of those who do not belong are adjoined invalid since it is asserted they do not have the knowledge to express an accurate opinion. The psychoanalysts are the most rigorous of all in their demands for the preparation of the therapist; but many feel that other ways of attaining self-knowledge and emotional security exist beside a personal analysis. Intelligent self-scrutiny carried out in the context of changing roles and varied conditions, learning to accept philosophically life's vicissitudes, enduring and surmounting its deprivations, and restoring the self through phases of withdrawal and return are some of the approaches that come to mind.

Leaving the consideration of the psychoanalytic approach at this point it may be observed that it has made discoveries of great value which can, however, be utilized in therapy without slavish adherence to classical psychoanalytic techniques. As Balint (1954a) remarks: 'The only systematic training in psychotherapy, that is, psychoanalytic training, has turned into a therapy with exaggerated demands...' The immediate problem would seem to be to train general practi-

tioners to the point at which they are capable of handling the bulk of neuroses on psychotherapeutic lines and are able to deal with disease generally in a similar manner. This will probably not entail delving into the problems of deep transference, but, again quoting Balint: '... does not consist only in learning something new but inevitably entails a limited though considerable change in the doctor...'.

In medical students interest is readily aroused in psychiatry and a psychotherapeutic approach is well taught; in this connection most medical schools are beginning to realize the size of the problem of neurosis in general practice. At Aberdeen students questioned by Millar (1954) about their psychiatric teaching preferred the instructional methods used there in the following order: the one-way vision screen, lecture demonstrations, individual case-taking, and lastly formal lectures. Through the one-way vision screen, the psychiatric interview can be observed by a class of students; they are usually provided with a commentator on their side of the screen for explanatory purposes. In lecture demonstrations, films and tape recordings of interviews and abreactive sessions can be used with advantage.

Practical Psychotherapy

Although a great deal of help can be obtained from mechanical aids, psychotherapy remains an intensely personal art which can only be learnt over a long time by personal experience and, unfortunately for the patient, by making a number of mistakes. Nevertheless, if copious notes of the session are taken, or recordings made, a great deal of assistance can be gained by case discussion and the sifting through of material. It is also helpful to interview the patient in the presence of a senior colleague, who either conducts the therapy or observes the situation, afterwards discussing the way it was handled with the student. But the best way for a physician to learn psychotherapy is probably to start doing it, and whenever possible to seek an opportunity to discuss the progress made with an experienced psychotherapist. Ideas of speedy gain will have to be relinquished and the would-be therapist must begin to exercise tolerance, patience, compassion and humanity; his skin may need to become a little thicker or a little thinner, as the case may be.

There are many things that the therapist has to learn. He must find out the type of patient most likely to respond to treatment, and the type with which he is most often successful by reason of his own personal approach; thus some therapists are better in the role of father, while some are better in the role of friend. A common initial mistake is overidentification with the patient; the therapist

counter-haloes him, becomes too deeply involved in the affair, and only realizes after long and fruitless attempts that the patient just could not be helped beyond a certain point, because of environmental handicaps, intellectual limitations, or a basic inability to give up the illness since the therapist could offer nothing better. After this phase may come a period in which psychotherapy is discounted entirely and the psychiatrist, becoming cynical, believes it useless and deprives patients of a little time for discussion and interpretation which would help them greatly. It is best for the therapist to come to terms with reality and appraise carefully what can and cannot be done with patients.

Many feel that it is difficult if not impossible for a therapist to treat adequately someone he dislikes and disapproves of; in such cases his motive for treatment may not be the patient's betterment, but the satisfaction of his own ego. He has to learn a balanced, tolerant, optimistic, common-sense view of humanity, realizing its weaknesses and applauding its better qualities. For this reason it is of great value for the therapist to have a wide general experience, if not in travel at least through judicious reading and the study of human reactions. He must learn to speak the patient's language and yet preserve his own viewpoint. Oscar Wilde once remarked that for social success it was necessary 'to treat a prostitute like a duchess and a duchess like a prostitute'; this is not the way to succeed in psychotherapy, however; each must be approached in their own right as disparate individuals. Not infrequently in this context, social barriers raise a problem—though the middle-class therapist is usually comfortable dealing with the middle-class or working-class patient, the upper classes may constitute difficulties by making him feel inferior and leading to the release of over-unctuousness or reactive hostility. It is probably safest to treat all patients alike on a friendly basis, never losing sight of a certain amount of mutual respect. It is advisable to address one's patients as 'Mr.' and avoid the use of the bare surname; similarly it is as well to persuade them against calling the therapist 'Sir' unless they are more comfortable doing this; for general purposes 'Doctor' is more personal and more suitable. Many patients talk more freely if they are allowed to smoke; and there is no real reason why they should not be permitted to do this during their treatment sessions. The amount of explanation, suggestion and interpretation given will depend on the therapist's approach; but, in general, it is a good working rule to encourage the patient to work things out for himself so far as he is able.

Transference difficulties may cause some concern to the therapist, as may his counter-trans-

ference. The simplest way to deal with this situation is probably to have it out in the open so that neither therapist nor patient surreptitiously feels that there is something embarrassing and potentially dangerous between them. In treatment, a couch may or may not be used: many patients talk better lying on a couch, and the physical attitude of relaxation in a situation where they cannot see their therapist directly is often symbolic of their trust in the doctor. Again, many find it easier to discuss painful and embarrassing topics with less hesitation than they show when constrained to watch the therapist's face, which may too readily register aversion or boredom, or alternatively be mask-like, kept abnormally composed. None the less, nowadays many feel that a couch introduces an added unnecessary artificial hurdle, and prefer to conduct the treatment 'face-to-face' which they claim gives them better results. Perhaps the best solution is for the would-be therapist to try both methods and discover which, for him, is the most effective.

Another useful aid to treatment is the keeping of journals in which the patient records his thoughts and sometimes his dreams, with preferably some attempt at analysis of the dominant motives therein before he sees the therapist. It may help considerably if he can look back on the recorded impressions of his daily life and gain some insight into his behaviour; he may be able to interpret his dreams by becoming familiar with his own particular dream imagery. When treatment is finally terminated—and in almost all cases this is best done by the patient himself, who is then unable to blame the therapist for discharging him prematurely—it is usually wise to tell the patient that he can return at any time if he feels the need. This provides a degree of security and confidence which is of great value; a surprisingly small number of patients subsequently return.

Classical Freudian analysis consisted of the consecutive phases of establishing the transference, working through the transference neurosis and finally weaning the patient from it, i.e. a progression from the 'positive' to the 'negative' transference. Many have criticized this scheme as indicative of the therapist's own tabu on tenderness and his fear of becoming emotionally involved with patients. Accordingly, they believe that the therapy is best conducted on a warm, supportive, positive basis, which actually fosters a degree of dependence on the therapist that gradually diminishes as treatment proceeds. The negative transference appeared to be of little value except when used in a prearranged plan by one therapist to provoke a closer relationship between the patient and another therapist, who is unable, without it, to get sufficient transference from the patient. In-

cidentally, the patient's actual feelings towards his therapist may differ markedly from what the latter imagines, and it is well to work through them from time to time to encourage more complete understanding.

Therapists need to acquire practical understanding of psychological mechanisms and the basic patterns of society. Such knowledge can be obtained from lectures and directed reading but, it should again be stressed, acquiring an informed intellectual background is only the lesser part of the technique that is needed. Reading about psychotherapy and learning about it in this way is as unrewarding as learning anatomy without a cadaver or surgery outside the operating theatre. Most training schedules for pre- and post-graduate students have realized this, and seen the inherent possibilities of putting them in charge of patients very early on in their psychotherapeutic training. Thus the course in teaching psychotherapy to general practitioners given by Balint (1954a) consisted of groups of six to eight doctors meeting weekly for three terms of 10 to 12 weeks in the space of a year. The aim was to enable the doctors to treat patients from the start under supervision, and to give them insight into their approach to patients so that they could discard the bad aspects and retain the good. Balint tried to make his pupils sensitive to what was going on—to teach them the art of careful listening so that they noted the subjective views of the patients as well as the objective facts and were able to check up on their responses to the patients—a way of learning their own automatic reactions. Each weekly conference consisted in the detailed presentation of a case by a physician with a description of what had been said, how he had formulated the problem, what he had sought to do and what had actually happened. Members of the group were encouraged to comment and criticize. Balint's (1954b) justification for this method of instruction is interesting.

'Intellectual teaching, however good and erudite, has hardly any effect in the process of liberation and general easing up. What is needed is an emotionally free and friendly atmosphere in which one can face the experience that quite often one's actual behaviour is quite different from what has been intended and from what one has always believed it to be. The realization of this discrepancy between one's actual behaviour and one's intentions and beliefs is not an easy task. But if there is good cohesion between doctors in the group, the mistakes, blind spots and limitations of any individual can be brought into the open and at least partly accepted by him. The group steadily develops a better understanding of its own problems, both collectively and individually. The

individual can more easily face the realization of his own mistakes when he feels the group understands them and can identify with him in them, and when he can see that he is not the only one to make mistakes of this kind. Moreover, it takes only a short time for the group to discover that the technique of each member, including the psychiatrist group leader, is an expression of his personality and so, of course, of his habitual mistakes . . .'

One very beneficial aspect of this training of general practitioners is the way in which it is brought home to them that their lightest and most casual utterances can be interpreted by their patients in the direst ways, so that severe and unnecessary iatrogenic overtones are added to the picture. Often the doctor's very concern and conscientiousness is at fault. The mere mention of blood pressure or heart disease can upset the patient's equilibrium, rousing severe anxieties which, incidentally, can be difficult to allay if the therapist is not medically qualified. The essence of the psychotherapist's approach is the preservation and maintenance of the patient's peace of mind, so that the good doctor will not lightly sacrifice this most precious of possessions in the pursuit of vague therapies which have never been proved effective. Thus, for instance, it is probably better for the elderly mild hypertensive—who has a fairly good prognosis anyway—to be told nothing about his blood pressure. A recent patient in this situation was plunged into a severe hypochondriacal depressive state, which culminated in a determined suicidal attempt, by the general practitioner informing him that his blood pressure was 'bubbling over', and that if he didn't take it carefully he would be 'dead in a few months' as he was 'on the verge of a stroke'. Such flagrant examples of iatrogenic illness are rare but lesser degrees are not uncommon.

In the sphere of psychotherapy in general it is probably true to say that in many instances too much guidance is given. Even conferences on psychotherapy in many centres are dominated too much by senior members of the staff. Diffident in strange surroundings, the student tends to remain silent, not wishing to reveal his uncertainty and need for guidance. One solution is for everyone who wishes to learn psychotherapy to select one or two suitable patients and resolve to see them weekly or fortnightly for an hour, for a year or more. Detailed histories can be taken; in every case an attempt should be made to construct a dynamic concept of the adaption of the individual at different ages to different problems. On Adlerian lines, a 'life-style' can then be formulated, which will be of great assistance in deciding the length of therapy and the likely goals to be

achieved. A plan of treatment can be evolved, and mistakes and interruptions in the execution of the plan can be discussed with a colleague from time to time. In this way, above all, the would-be therapist can personally learn the advantage and limitations of psychotherapeutic treatment.

I particularly wish to express my thanks to Dr. Otto Will, Jr., of Chestnut Lodge, Rockville, Maryland, for his helpful comments and suggestions, several of which have been incorporated. Dr. Cyril Burt also provided valuable criticism. Finally, I should like to thank the Mental Hygiene Authority of Victoria for permission to publish this paper.

REFERENCES

- BALINT, M. (1954a): Training General Practitioners in Psychotherapy, *Brit. med. J.*, **i**, 115.
 — (1954b): Method and Technique in the Teaching of Medical Psychology. II—Training General Practitioners in Psychotherapy, *Brit. J. med. Psychol.*, **27**, 37.
 BOWLBY, M. (1952): Maternal Care and Mental Health. Geneva: World Health Organization.
 FREUD, S. (1952): Introductory Lectures in Psychoanalysis, p. 13. London: George Allen and Unwin.
 JUNG, C. G. (1954): The Aims of Psychotherapy, p. 36, in *The Practice of Psychotherapy*. London: Routledge and Kegan Paul.
 — (1958): Psychology and Religion: West and East (translated by R. F. C. Hull). London: Routledge and Kegan Paul.
 KENNEDY, A. (1960): Chance and Design in Psychotherapy, *J. ment. Sci.*, **106**, 1.
 MILLAR, W. M. (1954): Method and Technique in the Teaching of Medical Psychology. I—Teaching Methods in Psychiatry, *Brit. J. med. Psychol.*, **27**, 30.
 RIESMAN, D. (1950): *The Lonely Crowd*. New Haven, U.S.A.: Yale University Press.
 SULLIVAN, H. S. (1955): *The Interpersonal Theory of Psychiatry*. London: Tavistock Publications.
 SUTTIE, I. D. (1960): *The Origins of Love and Hate*. Middlesex: Penguin.
 WEATHERHEAD, L. D. (1952): *Psychology, Religion and Healing*. London: Holder and Stoughton.