Small Group Videotape Training for Psychotherapy Skills Development

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Abstract

Psychotherapy teachers have used video-technology to train residents for over 40 years. Though it has met with some controversy, many will argue videotape review is essential for self-directed learning and accurate psychotherapy supervision. The author describes a technique of small group videotape training (SGVT) as provided in a psychiatry residency training program. He reviews the merits and limitations of this format and suggests simple and inexpensive technical approaches to augment this training. The author concludes that SGVT is an efficient psychotherapy training format that encourages self-monitoring and the exchange of supportive peer feedback.

Introduction

Videotape supervision has been an adjunct to psychotherapy training since the early 1960's. 1 Since then it has become central to some psychotherapy training and research programs. 2 Despite this acceptance, the use of videotape supervision has historically been limited in some residency training programs. 3 Although the problems, 4-6 merits, and unique features 7-10 of this form of teaching have been described in the literature, little has been written about providing videotape training in a small group format. Experience with this method suggests small group videotape training (SGVT) is a specific and efficient training method. Moreover, this training sets a stage for lifelong self and peer-directed learning. In this review I will describe the potential problems, merits and a technical approach to SGVT as is being provided in a psychiatry residency training program.

Program Structure

The training process begins with recording the psychotherapy session. Trainees record their psychotherapy sessions on a weekly basis in rooms that are dedicated for video-recording and tape review. These suites are arranged so that the recording captures the patient and the trainee face-on in a mirror placed beside the patient, allowing a view of both the patient and therapist. Other recording approaches include use of a split screen or picture-in-picture device with 2 cameras or use of a wide-angle lens to capture both participants side on. Recording through a one-way mirror is an approach that removes the camera equipment from the interview room. Optimal sound volume and clarity generally requires an amplified speaker versus relying on built in microphones.

Training groups typically consist of a supervisor and 2-6 trainees who meet for a 1½ -3 hour supervisory block. Meetings are held weekly in a room equipped with a videocassette recorder, a

moderately large (> 20 inch) television and a board to write on. The supervisor verifies how many cases are being reviewed that session to apportion the time accordingly.

Process of SGVT Sessions

Supervisee Preparation

The trainees are expected to adequately prepare for the group training session. They should preview the session videotape, note important areas and attempt to self-supervise. Trainees are encouraged to specifically note the state of therapeutic alliance, selection of focus, adherence to focus, nature of interventions, timing of interventions, and the emotional signals in the patient. Trainees should then arrive prepared to present their material and, in some ways, to function as a co-supervisor of the tape.

Tape review

Supervision starts with the viewing of the very first moment of contact. As trainees and supervisors have often noted, the first few minutes often dictate how the whole session is likely to progress. The patient has presented “where they are” at that time and the therapist's job is to respond to this in accordance with the therapy model being used. One may continue playing the tape or fast-forward to a later segment of the session. In general, 25- 30 minutes into the session will be a peak of focus and emotional mobilization, thus a good place to observe and comment on the process. The trainee may suggest a specific segment to review. Two longer segments are usually adequate to form a reasonable impression of the session. Optimally, each trainee has at least 30 minutes to show videotape and discuss his or her case.

Role of Supervisee While Showing Tape

At the end of each segment, the supervisor may elicit comments from the trainee regarding the trainee's view of relevant theoretical and technical issues. This is an opportunity for the trainee to supervise himself or herself in a supportive setting.

Overall, the supervisor's task is to monitor both the therapy process and patient / therapist capacities to work within that model. Feedback should first address the therapist's functioning within that treatment model. Thereafter, feedback may include a brief review of a theoretical point, such as a first principle of the specific psychotherapy model in use.

Role of Other Trainees

Co-trainees are expected to observe both the presented videotape and the supervisory process. They may offer comments or questions in a supportive manner and at times in a constructively challenging way. Co-trainees are often seen encouraging their colleague to stay focused on the therapeutic task. They will often share one of their own parallel learning experiences to the supervisee on the “hot seat”.

Adjunctive Procedures

Concurrent Seminars

This weekly training session may be complemented by a seminar on the psychotherapy model being used. This is an opportunity for trainees to see supervisor's videotapes and to learn relevant theoretical aspects in an interactive fashion. The supervisor should provide a broad range of videotapes that illustrate various technical aspects of the therapy being studied. The supervisor should be comfortable showing and describing incidents in which therapist-related problems interrupted the treatment relationship. 7 This seminar may be the most appropriate setting to examine technical and theoretical problems experienced by the training group.

Large Group Observation of SGVT

Trainees who are who are not yet in the program, may observe the supervision group. Thus, observers may also benefit from this open supervisory model. Trainees who are not yet comfortable joining the SGVT can use this process as an intermediate step to becoming an active participant within SGVT.

Special Issues and Drawbacks With SGVT

Video equipment and technical support are *costs* to the training program. Video equipment and playback equipment were a significant deterrent in the 1960's when basic equipment could cost in excess of $20,000 in 1960's dollars. With recent price reductions the same technology, including a reasonable quality VCR, 20 inch monitor, and a camcorder, could be purchased for as little as $1000.00 (Canadian).

There is potential for *patients to refuse* treatment that involves video-recording. This would be more likely with highly anxious patients, those with paranoid ideation, and public figures. In practice, the rate of refusal is very low, especially when one explains the purpose is to directly and indirectly improve treatments provided.

While anxiety is normal in the process of recording and showing one's work, *some trainees may experience extreme anxiety* . Introductory teaching including showing of the supervisor's videotapes may desensitize and prepare these trainees for recording and showing their own tapes. Experience shows that persistence with recording and self-review generally results in improved tolerance of the process over the course of 6-12 months. For the more anxious trainee, the ability to self-review, coupled with the support of a small group may make SGVT a learning model of choice.

Extremely *anxious patients* may be unable to tolerate being video-recorded. These same patients usually have such low anxiety tolerance that treatment techniques may need to be modified significantly to accommodate. Recording a session may be considered a relative contraindication in patients with active psychosis regardless of the treatment provided.

Video-recording, as with any other form of any medical intervention, should be done in consideration of *patient-physician confidentiality* . The therapist should become aware of local, or regional policy informing the patient's rights. A clear consent form in layman's terms should be developed incorporating how confidentiality will be protected, where and how long tapes will be kept, who will see the tapes, whether or not the patient has access to the tapes, and who owns the tapes. It should be clear that treatment would not be withheld because a patient is currently or later becomes unwilling to be recorded.

Benefits of SGVT

The benefits of SGVT substantially outweigh its costs. These benefits include the positive effects of video recording and the benefits of the small group as a learning vehicle. Following is a breakdown of some of these benefits.

Benefits of Video-recording

Video-recording *eliminates the need to record notes* during the session and permits a full focus on the patient. This focus may facilitate the initial rapport and ongoing working alliance. Complete notes may be written during post session tape review.

Therapist self-observation and self-awareness are enabled by having one's own videotape to review. Seeing oneself on tape allows a more “objective“ period of self-observation, free of any in session pressure and distraction. This allows trainees to “self supervise” while anticipating the supervisor and group's feedback. Thus, tape review allows self-monitoring and self-supervision skills acquisition that may facilitate ongoing professional growth and development.

Direct observation of the patient's appearance and behavior is possible with videotape of the session. As a specific example, the tape may indicate the degree and manifestations of emotional states in the patient. The trainee and supervisor may then focus on these specific patient cues to inform the therapist's response.

Specific, observable therapist behaviors may likewise be directly viewed. This allows a supervisory focus on therapist activities including for example, selection of focus, maintenance of focus, efforts to engage the patient, efforts to maintain the therapeutic alliance and adherence to specific therapeutic technique. Many ps ychotherapy schools have specific treatment manuals with adherence guidelines. In session videotape may reveal the degree to which the therapist uses these specific interventions.

Videotapes are an excellent means to assess *treatment outcome.* Specific changes may be observed when comparing pre therapy to post therapy videotape segments. Often these changes are not reflected in one's notes or patient self reports. This review is the process by which therapeutic techniques may be developed, researched and fine-tuned by both therapists and researchers. 2

As an extension of this, one may use tapes to evaluate *trainee acquisition of skills.* With the use of standardized adherence criteria, tapes could be reviewed blindly to demonstrate change in

therapist behaviors over the course of training. Hence, videotaping is a vehicle for research in psychotherapy education.

Benefits Related to Using a Group Format

Having several trainees in the same session effectively *multiplies the amount of teaching* that may be provided to each participant. This becomes critical in our current climate of decreased resources to provide supervision. 11 For example, instead of a supervisor meeting 4 residents for 1 hour each, he or she may meet four residents for 2 hours total thereby halving the amount of time taken and doubling the amount of teaching for the residents.

In the group format, trainees are able to see and *follow the cases of other participants.* This allows exposure to a broader range of patients than they otherwise could see. This is especially important in residency training programs where there is limited time allotted for psychotherapy cases and supervision.

Although the focus of the training group is not group therapy, many of the *benefits of a group process* may make this an excellent learning and growth opportunity. 12 Included among these "therapeutic elements" are cohesion, support, universality, reality testing, modeling and group learning.

Training programs are often criticized for not providing *training in how to teach and supervise.* This group format allows a unique opportunity for trainees to directly observe a supervisory process. In conjunction with their own supervisory component, they may learn first hand some of the basic elements of psychotherapy supervision.

The group format allows for *group members to provide feedback* to one another. As noted, this tends to occur later in the supervision process. Experience shows this feedback is supportive and increasingly insightful as time goes on. It eventually becomes supportively challenging. Non-supportive intervention by a trainee has rarely been observed in this format.

SGVT helps trainees become accustomed to *openly discussing their work.* They become comfortable with giving and receiving feedback in a respectful and supportive way. Hence, they become comfortable with peer-based learning as a vehicle for lifelong personal and professional growth.

Program Evaluation

Trainee evaluations, results of pre/ post tests and other indirect measures suggest this format is both valued and effective.

Trainees provide written feedback to the supervisor every 3 months. This training has been rated highly, averaging 4.9 out of a possible rating of 5 over the past 5 years. Written comments frequently describe the training as challenging but highly beneficial to learning. Three quarters of the residents in the program seek this elective training experience in their senior years.

In the short-term dynamic psychotherapy training group, trainees complete a 20 question multiple choice questionnaire prior to and after 6 month training blocks to assess knowledge acquisition: thus far (N=19) there is over 1 standard deviation (5.5 point out of 20) improvement from pre to post 6 months of training. The past 16 courses have been highly evaluated by trainees with average global rating of 4.6 out of 5.

Patient self reported outcomes offer an indirect measure of the program's effectiveness. In the short-term dynamic psychotherapy training group, before and after therapy measures are currently used routinely. With an N of 21 completed therapy courses, the mean global symptom score improved from the abnormal to normal range with a 2 tailed *t* test, $p < 0.05$. The global interpersonal problem rating improved almost to the normal range with a non significant *p* value of 0.31.

Another indirect measure of its success is awards won by this program. Three of the past 4 Residents Association “Teachers of the Year” were teachers using this format. The program resulted in the 2001 Canadian Psychiatric Association Chairs of Psychiatry Award for excellence in education.

Conclusion

I have described an approach to psychotherapy supervision in which a group of trainees record and show their actual interview materials on a weekly basis. The model poses potential drawbacks that are far outweighed by the benefits of this approach. Recording allows the supervisor and group members to provide input based on a direct view of the process and content of the session. The supervisee is more easily able to learn self-monitoring skills. The supervisor's time is used more efficiently, providing each resident with more training time. The trainees are able to follow more cases than they could otherwise. Group members may learn an approach to supervision, again, through direct observation. The supervisor provides a model of self-reflection and openness to peer input. Trainees are able to have a supervised experience of giving and receiving peer input and support. Finally, they are facilitated to efficiently learn general and specific psychotherapy skills.

A multi-modal evaluative component allows monitoring and remediation of the training program. Patient self-report outcomes allow quality assurance evaluation as well as indirect measurement of learning. The fact that the program is sought out and highly rated suggested it is not only palatable but also the resident's training approach of choice.

In conclusion, costs and anxieties should not dissuade program directors from ensuring that this training approach be available in post-graduate psychiatry training programs or other formal psychotherapy training programs. To my colleagues, I would strongly encourage the provision of this supportive and challenging opportunity for your trainees.

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