Small-Group Videotape Training for Psychotherapy Skills Development

Allan Abbass, M.D., F.R.C.P.C.

Objective: *Psychotherapy instructors have used video technology to train residents for over 40 years. Though it has met with some controversy, many will argue that videotape review is essential for self-directed learning and accurate psychotherapy supervision.* **Methods**: *The author describes a technique of small-group videotape training as provided in a psychiatry residency training program.* **Results**: *He reviews the merits and limitations of this format and suggests simple and inexpensive technical approaches to augment this training.* **Conclusion**: *The author concludes that small-group videotape training is an efficient psychotherapy training format that encourages self-monitoring and the exchange of supportive peer feedback. (Academic Psychiatry 2004; 28:151–155)*

Videotape supervision has been an adjunct to psychotherapy training since the early 1960s (1). Subsequently, videotape supervision has become central to some psychotherapy training and research programs (2). Despite this acceptance, the use of videotape supervision has historically been limited in a number of 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 is a specific and efficient training method. Moreover, this training sets a stage for lifelong self- and peer-directed learning. In this review, the author describes the merits and potential problems of small-group videotape training as well as a technical approach to this method as it is used 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 reserved for video-recording and tape review. These suites are arranged so that the recording captures the patient and the therapist face-on in a mirror that is placed beside the patient. This allows a frontal view of both the patient and the therapist. Other recording approaches include the use of a split screen or picture-in-picture device, with two cameras or the 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 require an amplified microphone.

Training groups typically consist of a supervisor and two to six trainees who meet for a 1 1/2 hour to 3-hour supervisory block. Meetings are held weekly in a room equipped with a videocassette recorder (VCR), a moderately large (> 20-inch) television, and a board to write on. The supervisor verifies how many cases will be reviewed during the session in order to apportion the time accordingly.

Dr. Abbass is Director of Education at the Dalhousie University Department of Psychiatry, Halifax, Novia Scotia, Canada. Address correspondence to Dr. Abbass, Dalhousie University Department of Psychiatry, 5909 Veteran's Memorial Lane, Halifax, NS, Canada, B3H 2E2; allan.abbass@dal.ca (E-mail).

Process of Small-Group Videotape Training Sessions

Supervisee Preparation

The trainees are expected to adequately prepare for the group training session. They should preview the session videotape, note important segments of the tape, 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 frequently 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 to 30 minutes into the session will mark 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 a 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 trainees to supervise themselves in a supportive setting.

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

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 colleagues to stay focused on the therapeutic task. They will often share one of their own parallel learning experiences with 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 the 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. Additionally, 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 for examining technical and theoretical problems experienced by the training group.

Large-Group Observation of Small-Group Videotape Training

Trainees who are not yet treating patients may observe the supervision group, and thus may also benefit from this open supervisory model. Trainees who are not yet comfortable recording their sessions can use this process as an intermediate step to becoming an active participant.

Special Issues and Drawbacks Using Small-Group Videotape Training

Video equipment and technical support are expenses the training program must assume. In the 1960s when

basic equipment could cost in excess of $20,000, video equipment and playback equipment were significant restrictives. With recent price reductions, the same technology, including a reasonable quality video cassette recorder (VCR), 20-inch monitor, and camcorder, could be purchased for as little as $1,000 (Canadian dollars) today.

There is potential for patients to refuse treatment that involves video-recording. This would more likely be the case for highly anxious patients (patients with paranoid ideation or patients who are public figures). In practice, the rate of refusal is very low, especially when one explains that 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, which includes showing the supervisor's videotapes, may desensitize and prepare 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 to 12 months. For the more anxious trainee, the ability to self-review coupled with the support of a small group may make small-group videotape training a learning model of choice.

Extremely anxious patients may be unable to tolerate being video-recorded. These patients usually have such low anxiety tolerance that treatment techniques may need to be modified significantly in order to accommodate them. 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 medical intervention, should be done in consideration of patient-physician confidentiality. Therapists should become knowledgeable of local or regional policy regarding patients' rights. A precise consent form written in layman's terms should be developed. This form should incorporate how confidentiality will be protected, where and how long tapes will be stored, who will see the tapes, whether or not the patient has access to the tapes, and who owns the tapes. In the form it should be clear that treatment will not be withheld if a patient is unwilling to be recorded at any time.

Benefits of Small-Group Videotape Training

Benefits of Video Recording

The benefits of small-group videotape training substantially outweigh the costs. These benefits include the positive effects of video recording and the advantages of a small group as a learning vehicle.

Video-recording eliminates the need to take notes during the session, and it permits a full focus on the patient. This focus may facilitate the initial rapport and ongoing working alliance. Complete notes may be written during postsession 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 feedback from the supervisor and the group. 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 that, for example, include selection of focus, maintenance of focus, efforts to engage the patient, efforts to maintain the therapeutic alliance, and adherence to a specific therapeutic technique. Many psychotherapy 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 excellent means to assess treatment outcome. Specific changes may be observed when comparing pretherapy to posttherapy 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).

Videotapes may also be used to evaluate trainees' 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 supervisors meeting four residents for 1 hour each, they may meet four residents for 2 hours total, thereby decreasing the amount of time taken by one-half 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 provide 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 education in how to teach and supervise. The group format allows a unique opportunity for trainees to directly observe a supervisory process. In conjunction with their own supervisory component, they may learn firsthand some of the basic elements of psychotherapy supervision.

The group format also allows group members to provide feedback to one another. As noted, this tends to occur later in the supervision process. Experience shows that this feedback is increasingly insightful as time goes on. Eventually, it also becomes supportively challenging. Nonsupportive intervention by a trainee has rarely been observed in this format.

Small-group videotape training helps trainees become accustomed to openly discussing their work, as they become comfortable giving and receiving feedback in a respectful and supportive way. Hence, they become at ease with peer-based learning as a vehicle for lifelong personal and professional growth.

Program Evaluation

Trainee evaluations, results of pre- posttests, and other indirect measures suggest that the group 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, ($N = 26$) there is over 2 standard deviation (7.5 points out of 20) improvement before and after 6 months of training. The past 16 courses have been highly evaluated by trainees, with an average global rating of 4.6 out of 5.

Patient self-reported outcomes offer indirect measures 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 56 completed therapy courses, the mean global symptom score (13) improved from the abnormal to normal range, with a two-tailed t test, $p < .001$. The global interpersonal problem rating (14) improved nearly to the normal range with a nonsignificant p value of 0.10.

Another indirect measure of the success of this training method is the honorable recognition it has received. Three of the past four Residents Association "Teachers of the Year" were teachers using this format, and the 2001 Canadian Psychiatric Association Chairs of Psychiatry Award for excellence in education was established as a result of the program.

CONCLUSION

The author has described an approach to psychotherapy supervision in which a group of trainees record and show their actual interview materials on a weekly basis. Although the model poses some poten-

tial drawbacks, they are far outweighed by the benefits. Recording allows the supervisor and group members to provide input based on a direct view of the process and content of the session. Thus, the supervisee is more easily able to learn self-monitoring skills, and 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 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, trainees are facilitated to efficiently learn general and specific psychotherapy skills.

A multimodal evaluative component allows monitoring and remediation of small-group videotape training. Patient self-report outcomes allow quality assurance evaluation as well as indirect measurement of learning. The fact that small-group videotape programs are sought after and highly rated suggests that they are not only palatable, but a training approach of choice.

In conclusion, costs and anxieties should not dissuade program directors from ensuring that the small-group videotape training approach is available in postgraduate psychiatry training programs or other formal psychotherapy education. The author strongly encourages the provision of this supportive and challenging opportunity for trainees.

The author thanks Jeff Hancock and Jennifer Haynes for reviewing this manuscript, the Department of Psychiatry, Dalhousie University, the Nova Scotia Department of Health, and Dr. K Roy MacKenzie for his mentorship with this and many other projects.

References

1. Alger I: Therapeutic use of videotape feedback. J Nerv Ment Dis 1969; 148:430–436
2. Davanloo H: Short-Term Dynamic Psychotherapy. New York, Jason Aronson, 1980
3. Rodenhauser P: Trends in psychotherapy supervision. Am J Psychother 1992; 44:240–249
4. Friedmann C, Yamamoto J, Wolkon G, Davis L: Videotaped recordings of dynamic psychotherapy: supervisory tool or hindrance. Am J Psychiatry 1978; 135:1388–1391
5. Hunt D, Dagadakis C, Ward N, Ries R: Live versus videotaped interviews. J Med Educ 1981; 56:916–918
6. Brown E: Problems of the use of videorecordings in training for psychotherapy. Psychother Psychosom 1990: 53:139–141
7. Gruenberg P, Liston E, Wayne G: Intensive supervision of psychotherapy with videotape recording. Am J Psychotherapy 1969; 23:98–105
8. Corradi R, Wasman M, Gold F: Teaching about transference: a videotape introduction. Am J Psychother 1980; 34:564–571
9. Goldberg D: Resistance to the use of video in individual psychotherapy training. Am J Psychiatry 1983; 140:1172–1176
10. Aveline M: The use of audio and videotape recordings of therapy sessions in supervision and practice of dynamic psychotherapy. Br J Psychotherapy 1992; 8:347–358
11. Winer J, Klamen D: Psychotherapy supervision: a current method. Acad Psychiatry 1997; 21:141–147
12. Blackman J: Teaching psychodynamic technique during an observed analytic psychotherapy session. Acad Psychiatry 1997; 21:148–154
13. Derogatis L, Melisaratos N: The Brief Symptom Inventory: an introductory report. Psychol Med 1983; 13:595–605
14. Horowitz L, Rosenberg S, Baer BA, Ureno G, Villasenor VS: Inventory of Interpersonal Problems: psychometric properties and clinical applications. J Consult Clin Psychol 1988; 56:885–892