ADDENDUM

# Videotaping and Rating Your Own Sessions: Two Valuable Ways to Improve the Quality of Therapy

We know of no better way to increase your mastery of this therapy than by taping therapy sessions and then watching and analyzing them, either alone or—preferably—with colleagues. We have developed a scale to evaluate how well therapy sessions achieve the objectives of this therapy, the Achievement of Therapeutic Objectives Scale (ATOS). Rating sessions on this scale can help therapists get even more benefit out of reviewing videotapes.

**Why videotape?**

This therapy was born out of thousands of hours of analysis of and research on videotaped therapeutic encounters between patients and therapists. As many other professions have discovered over the years (e.g, sports, teaching, surgery, etc.), there is no better way to improve effectiveness than by reviewing and analyzing videotape. With patient consent, videotape can be used in individual, group, family, and couples therapy. Videotaping therapy sessions has many benefits (Alpert, 1996):

- Patients benefit directly when therapists give them a copies of the videotapes, which they can review between sessions. Many patients have told us that this is the single most powerful intervention in their recovery, because they can see their defenses and relive the affective exposure by watching videotapes of their own sessions. This review provides another opportunity for desensitization of Affect Phobia. Under appropriate circumstances, patients can watch tapes with significant others, which can help others understand the patients' struggles. Patients also benefit indirectly when therapists use the tapes to improve the therapy.
- Therapists benefit from watching tapes of sessions they have done; it allows them to note material to return to, missed opportunities, errors, and things that went particularly well. Videotape is very helpful in helping therapists to see how well they maintain focus on the patient's core problems, and how they lose that focus. It's particularly helpful in affect-based therapy since video of the patient's face may well reveal affect that the therapist missed during the session. Watching tapes of other therapists provide many examples of things to try (or, sometimes, things to avoid).

- Videotape is a powerful resource for supervision and training. In fact, being supervised without videotape is a little like learning to drive from a teacher who is not sitting with you in the car.
- Videotapes can be helpful when obtaining consultation.
- Videotapes provide data for objective evaluation of therapy progress.

**Patient and Therapist Fears of Videotaping**

Practitioners often cite the protection of their patients as the main objection to taping. However, our experience has been that many patients are open to taping, and that therapists themselves are often more anxious at the prospect. To reduce therapist anxiety, it's important that a positive, supportive atmosphere be maintained in groups of colleagues where tapes are reviewed. Showing videotapes of your therapy is often humbling, but it should not be humiliating. In a supervision setting it's helpful if the supervisor shows tapes as well; supervisees learn much from a supervisor's willingness to learn from their own mistakes.

**Suggestions for Approaching Patients**

Here are some suggestions that we have found helpful in approaching patients about taping:

- Tell patients at first contact that you videotape sessions, and that you strongly recommend it, if they are willing.
- Explain to patients that having the opportunity to watch the tapes may help them to improve more quickly
- Have the patient sign a consent form (a sample form is available on this web site)
- It's good to encourage the patient to keep the tape private, and to discuss it with you first if they are considering showing the tape to anyone else.

**Practical Considerations for Taping**

On the purely practical side, it is very helpful to have a video camcorder that (1) will record both date and time on the frame as taping progresses; and (2) has the ability to plug in an external microphone. We have found paddle microphones such as Crown's Sound Grabber II very effective in capturing therapy sessions. We record most of our sessions on 8mm videotape; if you are going to archive many sessions, the space saving compared to VHS cassettes is very significant.

The camera should be set to record from the patient's elbows to the top of their head. Some therapists use two cameras and "picture-in-picture" technology to capture both the therapist and patient's images. Though this can be helpful, the added benefit may not worth the cost for most therapists. A low cost VHS recorder attached to the therapist's video recorder can simultaneously make a second tape to give to the patient at the end of the session. As a general rule, we provide the initial tape to the patient, then ask the patients to provide their own tapes thereafter. Tapes are recorded on extended play so that 6 hours of sessions can be put on one VHS videotape.

## EVALUATION AND GROWTH AS A THERAPIST: RATING YOUR OWN SESSIONS

### The Achievement of Therapeutic Objectives Scale (ATOS)

The Achievement of Therapeutic Objectives Scale (ATOS) has been developed as a research tool for coding psychotherapy sessions. In addition to being a powerful instrument for measuring psychotherapy processes, coding therapy sessions is the best method we have found for training new therapists to do STDP. Every year a new group of graduate students, psychiatry residents, and research therapists comes to our research program and is trained on this scale. Also, training and research with the ATOS scale is also being conducted at the University in Trondheim, Norway, under the direction of Tore Stiles and Leigh McCullough, and in the Department of Psychology at Temple University under the direction of Michael Bridges. Almost universally, both trainees and experienced clinicians have told us that watching and coding sessions is one of the best ways they have ever experienced to learn to do psychotherapy.

The ATOS rates seven variables, each on a 1-100 scale. A Brief Rating Guide for the scales, which breaks each rating into 20-point intervals, is available on this web site. The scores reflect the the degree to which each of the therapeutic objectives has been met.

### The Coding Process

In our research program, selected sessions of therapy are coded from videotape. First, the session is divided into ten-minute segments (usually 5 or 6 per session). For each ten-minute segment, identify the adaptive affect (F pole, e.g. anger, grief, positive feelings toward the self, etc.) of the core conflict which that segment focuses on predominantly (there may be more than one, but generally a single core conflict predominates). Once this focus is identified, ratings are given for:

- **Defense Recognition**: How well does the patient see their defenses (and other parts of the D-A-I pattern on the triangle of conflict)?
- **Defense Relinquishing:** How motivated is the patient to give up their defenses?
- **Affect Experiencing:** How intensely does the patient experience the **adaptive affect** that raters identified as the focus **during the segment**?
- **Affect Expression:** How well is the patient able to express the adaptive affect to others (either to the therapist during the segment, or to someone outside the session as described by the patient during the segment).
- **Anxiety Regulation:** What degree of inhibitory affect is present in the ten-minute segment that diminishes or blocks the experience of adaptive affect. [ADD (Note that anxiety regulation is not a separate treatment objective but is a component of each of the six objectives).]

Finally, for the entire therapy session, ratings are given for:

- **Self-Restructuring:** How adaptive is the patient's inner representation of self?
- **Other-Restructuring:** How adaptive are the patient's inner representations of others?

The ratings for Self- and Other-Restructuring are given only once per session because they tend to fluctuate less from segment to segment than the five ratings for Defense and Affect Restructuring, and Anxiety Regulation.

**Valuable Feedback**

These ratings of each of these components of treatment will provide you with instant and valuable feedback about the degree to which you are helping your patient meet the objectives in short term therapy. As you learn this therapy model, rating your own sessions is a great way to focus yourself on the therapy objectives and it can give you some sense of how well you are adhering to the model.

**ATOS Manual**

A lengthy manual for detailed ATOS ratings is under development (McCullough, Larsen, Schanche, Andrews, and Kuhn, 2003) and is used predominantly for research purposes. A copy of the current version may be downloaded from this web site. However, the one-page Brief Rating Guide available there is an excellent way to start coding your own therapy sessions and quite sufficient for self-training.

**Non-Video Options**

Needless to say, we think that rating videotapes is the best way to use this scale. But audiotapes can also be rated, though it is possible to miss a great deal of affect compared to videotapes. You can even use the scale to rate yourself from memory at the end of a session. However, we are always surprised at how different our perception of a session can be from the ratings of videotapes. Even though some methods are better than others, **any** method of checking yourself and giving yourself feedback after a session is tremendously educational, in terms of how well you and your patient are working toward adaptive goals.

**Reliability**

Reliability studies have been underway on the ATOS during the past five years, and inter-rater and test-retest reliability are very good; preliminary validity data are also very good. A series of process-outcome studies is under way relating ATOS scores with outcome variables measuring change from before treatment to termination and follow-up (e.g., severity of target complaints, GAF score, etc.)

We hope that this brief introduction has piqued your curiosity about ways to learn more about STDP. You may also want to join a group of therapists learning or practicing STDP, or attend some conferences where you can watch experienced therapists in this and related models of STDP, which are listed on our web site, www.affectphobia.org.

**References**

Alpert, M. (1996). Videotaping psychotherapy. *Journal of Psychotherapy Practice and Research,* 5(2), 93-105.

McCullough, L., Kuhn, Andrews, Hatch, Valen & Osimo (2003). The Reliability of the Achievement of Therapeutic Objectives Scale: Five Studies. *Journal of Brief Psychotherapy,* in preparation.

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