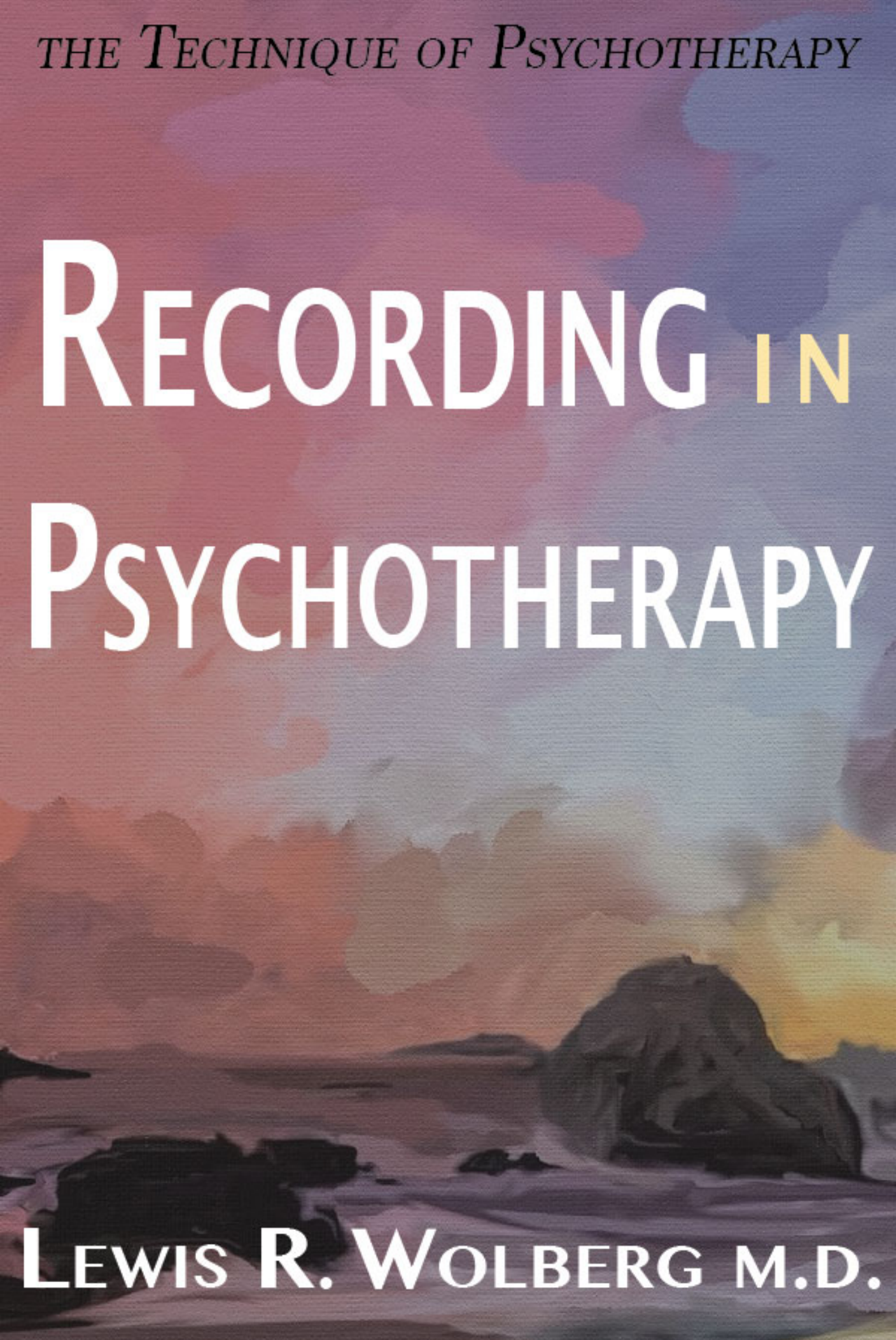
THE TECHNIQUE OF PSYCHOTHERAPY

RECORDING IN PSYCHOTHERAPY



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Recording in Psychotherapy

Satisfactory recording is conducive to good psychotherapy. It acts as discipline for the beginning therapist. It is helpful even to experienced therapists, facilitating the following of the progress of a case and helping in the rendering of a report. It is indispensible for purposes of research (Wolberg, LR, 1964b).

Except in those clinics where an ample budget provides dictating facilities and secretarial services, records of patients receiving psychotherapy are apt to be pitifully sparse. To some extent this is due to the absence of an organized routine recording system. Additionally, note taking during the treatment session is distracting to therapists and annoying to some patients. Of utmost value, therefore, would be a recording system that is both simple to follow and not too disturbing to patients.

Most patients expect that some kind of record will be kept. They usually accept note taking during the initial interview and do not object to occasional notes being written during later sessions. If objections are voiced, these may be dealt with by an explanation to the effect that the keeping of a record is helpful in following patient's progress. Should the patient continue to object to notes being taken during sessions because this is much too distracting, or should the practice distract the therapist, a note may be entered into the record following each session. If fear is expressed that confidential material may be read by another person, the patient may be informed that under no circumstances will the record be released, nor any information divulged, even to the patient's family physician, unless the patient gives written permission for this. Excellent outlines and suggestions for recording may be found in the books by Menninger (1952b) and Beller (1962).

CASE RECORD

The case record should minimally contain the following data: (1) statistical data sheet, (2) initial interview, (3) daily progress notes, (4) monthly progress notes, (5) termination note, (6) summary, and (7) follow-up note.

Statistical Data

Basic statistical data include the following:

1. Patient's name
2. Address, home and business telephone
3. Age
4. Sex
5. Marital status, how long married, previous marriages, ages and sex of children
6. Age and occupation of mate
7. Education
8. Occupation, salary, sources of income if unemployed
9. Military record
10. Referral source

These data may be entered on a separate sheet or on a form (see Appendix A), or the first sheet of the initial form interview (see Appendix C). A more complete statistical form, which is useful in clinics, is illustrated in Appendix B.

Sometimes the patient may be asked to fill out certain questionnaires to help get statistical data without taking up too much of the therapist's time. Short forms are included under Appendix D, which is a Personal Data Sheet, and Appendix E, which is a Family Data Sheet. In using these forms, the Personal

Data Sheet is given to the patient to fill out immediately prior to the initial interview. The Family Data Sheet is filled out after the therapist has accepted the patient for treatment.

Initial Interview

The data to be included in the recording of the initial interview are the following:

1. Chief complaint
2. History and development of complaint
3. Other symptoms and clinical findings
4. Patient's attitudes toward family members
5. Previous emotional upsets
6. Previous treatment
7. Estimate of existing insight and motivation
8. Tentative diagnosis
9. Tentative dynamics
10. Disposition of the case

A convenient initial interview form is included under Appendix C, the first sheet of which is for statistical data.

Daily Progress Notes

At the end of each session, the date and a brief note, which may consist of no more than one sentence, should be entered on a progress note sheet. This should contain the dominant theme of the session. Other entries may include the following:

1. Present state of symptoms or complaints (absent, improved, the same, worse)
2. How the patient feels (anxious, placid, depressed, happy)

3. Important life situations and developments since last visit and how they were handled
4. Content of the session
5. Significant transference and resistance reactions
6. Dreams

Since the wording of the patient's dreams is important, it is best to write dreams down during the session while they are related by the patient.

Appendix F is a convenient form for progress notes.

Monthly Progress Notes

A summarizing monthly progress note is of value in pulling together the events of the month. This may be a succinct recapitulation of what has been going on in treatment. In clinics where supervision of the total caseload is essential, a monthly progress summary (such as illustrated under Appendix G), which is routinely reviewed by the supervisor, may make for a more efficient kind of reporting.

Termination Note

A termination note is important and contains the following:

1. Date of initial interview.
2. Date of termination interview.
3. Reason for termination.
4. Condition at discharge (recovered, markedly improved, moderately improved, slightly improved, unimproved, worse)
5. Areas of improvement (symptoms, adjustment to environment, physical functions, relations with people)
6. Patient's attitude toward therapist at discharge

7. Recommendations to patient

8. Diagnosis

A termination form will be found under Appendix H.

Summary

The summary should contain the following information though curtailed.

1. Chief complaint (in patient's own words)

2. History and development of complaint (date of onset, circumstances under which complaint developed, progression from the onset to the time of the initial interview)

3. Other complaints and symptoms (physical, emotional, psychic, and behavior symptoms other than those of the complaint factor)

4. Medical, surgical, and, in women, gynecologic history

5. Environmental disturbances at onset of therapy (economic, work, housing, neighborhood, and family difficulties)

6. Relationship difficulties at onset of therapy (disturbances in relationships with people, attitudes toward the world, toward authority, and toward the self)

7. Hereditary, constitutional, and early developmental influences (significant physical and psychiatric disorders in patient's family, socioeconomic status of family, important early traumatic experiences and relationships, neurotic traits in childhood and adolescence)

8. Family data (mother, father, siblings, spouse, children—ages, state of health, personality adjustment, and patient's attitude toward each)

9. Previous attacks of emotional illness (as a child and later). When did patient feel completely free from emotional illness?

10. Initial interview (brief description of condition of patient at initial interview, including clinical findings)

11. Level of insight and motivation at onset of therapy (how long ago did the patient feel that treatment was needed? for what? awareness of emotional nature of problem, willingness to accept psychotherapy)

12. Previous treatments (when did the patient first seek treatment? what treatment was obtained? any hospitalization?)

13. Clinical examination (significant findings in physical, neurologic, psychiatric, and psychologic, examinations)

14. Differential diagnosis (at time of initial interview)

15. Estimate of prognosis (at time of initial interview)

16. Psychodynamics and psychopathology

17. Course of treatment:

    a. Type of therapy employed, frequency, total number of sessions, response to therapist

    b. Significant events during therapy, dynamics that were revealed, verbatim report of important dreams, nature of transference and resistance

    c. Progress in therapy, insight acquired, translation of insight into action, change in symptoms, attitudes, relationships with people

18. Condition upon discharge (areas of improvement, remaining problems)

19. Recommendations to patient

20. Statistical classification

A summary form with spaces for the above items will be found under Appendix I.

Follow-up Note

A note on follow-up visits, or the inclusion of follow-up letters from patients, helps the therapist to evaluate the effectiveness of treatment. A follow-up letter may be mailed out 1, 2, and 5 years after therapy. A form letter such as the following may be used:

Dear_____:

In the past year I have wondered how things were progressing with you. Would you drop me a note telling me how you feel, and indicating any new developments. You may perhaps want to comment on your experience in treatment and how this was of help to you.

Sincerely yours,

Case Folder

A manila folder is advisable to hold the case record of the patient. The name of the patient is written on the flap, and, if the patient is being treated in a clinic, the case number is also entered. Some therapists prefer a folder that has several pockets that may be used for correspondence in relationship to the patient, as well as for detailed notes. Under Appendix J, there is a folder the writer has found useful in private practice as well as in clinic practice. Printed on the front of an ordinary folder are spaces for entry of the date of each visit, payments made, and certain items that are pertinent to the treatment of the patient. It is a simple matter of only a few seconds to check on the total number of visits, the number of broken or cancelled appointments, the payments that have been made, and the dates of completion of the statistical data sheet, initial interview, monthly progress notes, consultations (psychiatric, medical, psychological, and casework) if these were obtained, tests administered by the therapist, or others, termination note, summary and follow-up notes. There is space also for entry of supervisory sessions if these were obtained in relation to the patient. Printed on the back of the folder are lines for entry of dates for more visits if the space on the front of the folder is not sufficient.

Miscellaneous Enclosures

Included in the case record, in addition to the above data, are other notations and forms used by the therapist, such as psychological test results, notes on medical and other consultations, detailed notes made by the therapist, written comments and notes by the patient (see Appendix S), and correspondence in relation to the patient.

The flexibility of computers in selection, orderly storage, and rapid recovery of data—beyond the capacities of human performance—puts them in the forefront as instruments for research in the mental health field, not only for the calculating of results in experiments designed around specific hypotheses but also in delineating trends and significant information and in generating new hypotheses (Cappon, 1966). Computer programs capable of carrying out principle components factor analysis with varimax rotation may measure clinical change with greater objectivity and probable reliability than other methods (Cole, 1964). By proper programming it may be possible to ask computers to make decisions between alternate futures, thus expediting the predictability of human behavior.

Electrical Recording in Psychotherapy

The employment of videotape recorders (see also Videotape Recording) has also introduced a new dimension into psychotherapeutic recording, with vast potential for teaching and the expediting of treatment (Alger and Hogan, 1969; Berger MM, 1970; Czajkoski, 1968; Danet, 1969; Melnik and Tims, 1974; Stoller, 1967, 1969; Torkelson and Romano, 1967). Therapists, viewing themselves interacting with their patients, may learn as much as they do in a good supervisory session (Geocaris, 1960; Beiser, 1966; Moore, FJ, et al., 1965). The initial shock value of seeing oneself performing inadequately, however, usually induces one to change for a limited time only. Therapists will soon adapt themselves to their television image unless there is a reworking of the material by a supervisor to reinforce learning. Observance by the supervisor of therapists in actual operation with patients is feasible by videotape, the contrast between what the therapists' reports of what they believe has been going on and the recorded events lending itself to emotional learning in the students. Supervisors also may be able to sharpen their own techniques in supervision by videotaping some of their supervisory sessions. Finally, beginning therapists may learn the process of interviewing and the management of various stages in treatment by watching videotapes (or sound movies) of expert therapists working with patients.

Although useful, written records and sound tape recordings alone are limited in bringing about an awareness on the part of patients of incongruous or paradoxical communication patterns. Sound films (Scheflen, 1963) and videotapes are more useful. Alger and Hogan (1966), employing videotape recordings in conjoint marital therapy, have pointed out that many levels of communication, as well as discrepancies between levels, become readily apparent to patients watching themselves immediately after interacting during a session. Differences between the televised actions and remembered responses are beneficially registered on patients. In individual therapy the videotaped interview may help patients see themselves as others see them. This is an excellent way of demonstrating to patients how they communicate. Use of the playback technique has proven valuable for many syndromes, including speech problems and alcoholism. A view of themselves in a drunken state may help motivate some alcoholics to stop drinking. Videotaping may be of value in group and family therapy.

Obviously, it is impossible to record all of the treatment sessions of patients even if therapists possess the proper equipment. Apart from the expense of recording materials and the problem of storage of the recordings, transcription of serial recorded sessions is costly. Occasional recordings that are saved until they have served their purpose will, however, be found valuable. From a practical viewpoint, audio recordings may serve the purpose of preserving the verbal interactions of patients and therapists. Although not nearly as valuable as videotapes, they are less expensive and are easily transcribed.

If therapists are not resistive to recording sessions, generally there will be relatively little difficulty in gaining patients' permission and cooperation. The apparatus is placed unobtrusively (it must not be concealed) in the room. When patients enter the room (usually when recordings are to be made, it is best to introduce this possibility to the patient at the initial interview), they may be approached in a way somewhat similar to this:

Th. Hello, I'm Dr._____.

Pt. Hello.

Th. Won't you sit down in this chair so we can talk things over?

Pt. Yes, thank you.

Th. (pointing to the tape recorder) Don't mind this machine. Sometimes I record an important session during therapy. It saves me the need to write everything down, so I can pay attention better to what is said.

Pt. I see.

Th. (smiling) Does this scare you?

Pt. Oh, no, if it's useful, I've never been recorded.

Th. Of course, what is recorded is completely confidential between us, but if you object for any reason, we don't really have to record.

Pt. No, I don't mind.

Th. If, for any reason, it interferes in any way or bothers you, tell me and I'll turn it off.

Pt. All right, I really don't mind.

Th. All right then, would you like to tell me about your problem so we can decide the best thing to do for you?

The recorder may be turned on at this point, or, if it has been on, no further attention should be paid to it. During later sessions it may be started prior to the patients' entering the room, so that the first comments may be recorded. If the recording is to be used for teaching purposes or transcribed for publication, a signed release is usually necessary. If, for any reason, patients object to the machine, it should immediately be turned off and not used again unless the patients' permission has been obtained.