

A STUDY EXPLORING THE FEASIBILITY AND INTEGRITY OF KEY  
STRATEGIES TRAINING

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BY

LESLIE J. KELLEY, B.A., M.A.

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## DEDICATION

To the Most Holy Trinity, whose love has graciously held us.

To Krista, my amazing wife, and my children: Charlie, Caleb, Claire, Kolbe, Gianna,  
and Thérèse, and God willing, to you who are to come.

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## ABSTRACT

LESLIE J. KELLEY

### A STUDY EXPLORING THE FEASIBILITY AND INTEGRITY OF KEY STRATEGIES TRAINING

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Many difficulties arise in training counselors to effectively utilize psychotherapeutic techniques, the least of which includes ensuring that therapeutic techniques are effectively taught, successfully learned, and reliably used. Key Strategies Training (KST) aims to teach psychotherapy trainees to understand and implement strategies from three empirically-based treatments (Cognitive Therapy, Behavioral Activation, and Emotion-Focused Therapy). This study explores the feasibility and integrity of KST by assessing trainees' knowledge of key strategies from pretest and post-test essays, and trainees' ability to demonstrate key strategies and a multidimensional survey in a standardized role-play scenario. Results indicated that students improved in their knowledge of key strategies from pretest to post-test on essays describing key strategies. After receiving KST, students were capable of differentiating between strategies belonging to the three treatment modalities across two phases of treatment. Additionally, results indicated that students were able to adhere to the KST protocol on a role-play demonstration in a competent manner. Implications and limitations of these findings are also discussed, as well as future research directions.

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## CHAPTER I

### INTRODUCTION

The effectiveness of psychotherapy training has been a concern for instructors and researchers for several decades and recently the empirical validation of training methods has emerged as an area of interest. Miller (1990) proposed a framework for the assessment of competence, performance, and clinical skill, in the field of medicine, which utilized a pyramid structure, at the base of which was placed knowledge (“knows”). From this foundation, Miller suggested that trainees should develop competence (“knows how”), the ability to perform (“shows how”), and the ability to actually use interventions (“does”). Muse and McManus (2013) reviewed methods of assessing competence in Cognitive-Behavioral Therapy, applying Miller’s framework to psychotherapy training. Ten different methods of assessing psychotherapy competence were identified and divided according to the four categories suggested by Miller as follows: (1) assessments of knowledge (“knows”), (2) practical understanding (“knows how”), (3) assessments of applied knowledge or skill (“shows how”), and (4) assessments of clinical practice (“does”) (Muse & McManus, 2013).

Researchers have emphasized the need for evidence-based psychotherapy training trials to be as rigorous as evidence-based psychotherapy trials, recognizing that the “effectiveness of interventions in mental health depends on the competence of the therapists who deliver them and in turn on the training they receive” (Graham and Milne,

2003, p. 55). Researchers have therefore begun to place emphasis on evidence-based psychotherapy training, suggesting that evidence of training effectiveness is necessary for ensuring the quality of psychotherapy (Dimeff et al., 2009; Fairburn & Cooper, 2011; Garland & Schoenwald, 2013; Graham & Milne, 2003). Fairburn and Cooper discussed this idea of therapy quality in terms of “the extent to which a psychological treatment was delivered well enough for it to achieve its expected effects” (p. 374). Some researchers have called for “a shift toward describing dissemination trials by their discrete and specific training interventions” and the “implementation of research methodologies that allow more accurate analysis and comparison of training interventions” (Ravovshik & McManus, 2010, p. 514).

Researchers of psychotherapy training have not reached a consensus on best practices for the measurement of psychotherapy training. Some researchers have held that assessments by independent raters are the gold standard for ensuring competence, but prior to this opinion, patient outcome was considered the gold standard (Ford, 1979; Muse & McManus, 2013). Sharpless and Barber (2009), reviewing competence assessment methods, stated, “No one method yet holds the distinction of being a gold standard, and many have yet to be systematically evaluated” (p. 53). With a lack of consensus regarding best practices for ensuring the effectiveness of psychotherapy training, researchers have advocated a multi-method, multi-trait, and multi-informant approach, suggesting that in order to obtain a holistic view of the effectiveness of training, research must use multiple types of assessments focused on multiple aspects of therapists’ development from multiple persons’ perspectives (Kaslow et al., 2007;

Kaslow et al., 2009; Muse & McManus, 2013; Sharpless & Barber, 2009). Recent work by Muse and McManus has suggested that utilizing the proficiency framework of Miller can aid researchers in structuring the complexity of this process. In order to establish the effectiveness of a psychotherapy training method, that method must feasibly train new therapists to understand psychotherapy principles and interventions, know how to implement the interventions, and be able to implement the interventions by demonstration and in practice with real clients (Muse & McManus, 2013).

### **Traditional Training Methods**

Researchers and psychotherapists have been studying psychotherapy training for several decades. Since the 1960's, Allen Ivey and his colleagues have studied therapists' development in the use of microskills, the most basic elements of psychotherapy. Microskills training was designed to break down complex therapeutic behaviors into smaller and more discrete units of behavior, more easily learned by psychotherapy students (Ivey & Authier, 1978). Several similar models of training have been developed, including helping skills systems such as Egan's (2013) *The Skilled Helper* and Hill's (2009) *Helping Skills*.

Empirically-based training protocols, based on specific treatment modalities, have generally used a different tactic for training. While helping skills models have sought to train therapists using small units of behaviors and working up toward a theoretical understanding of clients' issues, specific empirically-based psychotherapies have developed conceptualizations of how to treat specific psychopathologies. These conceptualizations have been formulated around whichever dimension (thoughts,

feelings, or actions) the treatment modality primarily targets. For example, Cognitive Therapy is founded on a cognitive conceptualization of psychopathology, conceiving dysfunctional thoughts and irrational beliefs as the primary cause of mental health concerns (J. S. Beck, 2011). Behavioral Activation, on the other hand, has placed emphasis on unrewarding patterns of behavior that reduce healthy positive reinforcement, as the primary cause of mental health issues (Martell, Dimidjian & Herman-Dunn, 2010). Emotion-Focused Therapy has emphasized the affective root of pathology, seeking to modify maladaptive emotional responses (Greenberg, 2002). The creators of evidence-based modalities have developed complex interventions aimed at the theoretical causes of dysfunction, and have tested the use of these interventions accordingly.

### **A Gap in Psychotherapy Training**

After decades training from these two perspectives (helping skills and evidence-based psychotherapy), a gap has evolved in the field, and this gap appears to have had negative repercussions, especially for new psychotherapists. Researchers have targeted this gap for some time without addressing one of the most crucial problems (Ivey, 1971; Ridley, Kelly, & Mollen, 2011; Rogers, 1961; Truax & Carkhuff, 1967; Weissman et al., 2006). Though this gap has become narrower, there is still a need to build a bridge between helping skills and evidence-based training modules. The psychotherapy training literature seems to have overlooked the need for an empirically-based model for training which helps new therapists transition from the use of basic skills to more complex evidence-based interventions. Learning to weave together microskills into more complex interventions has not received adequate attention.

Critics of helping skills training methods have suggested that these training methods do not “cover the full range of behaviors counselors need to practice competently” (Ridley, Kelly, and Mollen, 2011, p. 818), and that improvements are clearly needed (Baker & Daniels, 1989). Though new therapists need more and are capable of learning more than basic skills, researchers have suggested that they may not be ready to begin learning the more complex interventions of many manualized empirically-based psychotherapy modalities (Coleman, Fanelli, & Gedeon, 2009; Lawson, 1994). Further, the competence of newly trained psychotherapists has been called into question as competence in some training protocols has simply been inferred by course attendance (Reichelt, James, & Blackburn, 2003). Evidence-based treatment modalities generally have been learned through reading manuals and attending workshops, sometimes including supervision, despite research suggesting that these methods may be insufficient for the implementation of these treatments (Cucciare, Weingardt, and Villafranca, 2008; Dimeff et al., 2009; Miller et al., 2004; Sholomskas et al., 2005). As large numbers of psychotherapy students in APA-accredited programs have not received adequate coursework in specific evidence-based psychotherapy modalities (Beidas & Kendall, 2010; Karekla, Lundgren, & Forsyth, 2004), a system for introducing new therapists to empirically-tested key strategies seems to be a vital necessity.

### **The Key Strategies Training Model**

Key Strategies Training (KST) (Harris, Kelley, Campbell, & Hammond, 2014) is a new method of training psychotherapists based on a model of multitheoretical psychotherapy integration developed by Brooks-Harris (2008). The key strategies method

retains the core principles of multitheoretical integration and facilitates therapists' development in three evidence-based psychotherapy modalities: Cognitive Therapy, Emotion-Focused Therapy, and Behavioral Activation (Harris et al., 2014). KST trains psychotherapy students to gain introductory skills related to exploring and transforming cognitions, affect, and behavior, and was designed to aid new therapists in building upon a microskills foundation. Key Strategies Training has been divided into two phases of therapy (Exploration & Transformation). The exploration phase helps clients achieve a deeper awareness of cognitive, affective, or behavioral processes, and the transformation phase helps clients progress toward changes deemed important earlier in treatment. Each of these phases of KST have been specified into four intervention processes considered similar across the three treatment modalities taught by the key strategies method (cognitive, emotion-focused, and behavioral). The exploration phase consists of the following four intervention processes: (a) Focusing on a specific dimension of functioning, (b) Exploring context, function, and impact, (c) Analyzing adaptive value, and (d) Discovering patterns outside of awareness. The transformation phase consists of the following four intervention processes: (a) Experimenting, (b) Modifying, (c) Generalizing and consolidating, and (d) Assessing change and impact (Harris et al., 2014).

KST incorporates eight strategies drawn from each of three foundational theories, each with its own premise about the nature of therapeutic change. The first theory, Cognitive Therapy, relies upon a hypothesis of change suggesting that "realistic evaluation and modification of thinking produce an improvement in mood and behavior,"

and that “enduring improvement results from modification of the patient’s underlying dysfunctional core beliefs” (J. S. Beck, 1995, p. 1). The second theory, Behavioral Activation (BA) utilizes a hypothesis of change that “aims to activate clients in specific ways that will increase rewarding experiences in their lives. All of the techniques of BA are used in the service of the fundamental goal of increasing activation and engagement in one’s world” (Martell, Dimidjian, & Herman-Dunn, 2010, p. 21). Greenberg and Watson (2006), characterized the third theory, Emotion-Focused Therapy, as having a hypothesis of change in which “therapists work to enhance clients’ emotional intelligence, which involves the recognition and use of their own and others’ emotional states to solve problems” (p. 9).

Researchers and practitioners have recognized for some time parallels that exist between the interventions of different empirically-based psychotherapy modalities and these parallels are understood within the KST system of training to go beyond single interventions, pointing toward common processes of therapy underlying the therapy modalities (Kelley, 2011). Some of this parallel is quite simple, e.g., the distinction between exploration and transformation. Regardless of one’s treatment modality, one must understand the problem prior to attempting transformation. In the process of organizing KST into a system of training, a deeper parallel between cognitive, emotion-focused, and behavioral processes was discovered, which allows for the organization of KST interventions (see table 1 – Parallel Structure of KST) (Kelley, 2011). The parallel structure of KST provides beginning therapists with a framework for more easily understanding and utilizing interventions of these three treatment modalities.

Table 1.

*Parallel Structure Utilized in Key Strategies Training*

<b>Intervention Processes</b>	<b>Cognitive Strategies</b>	<b>Emotion-Focused Strategies</b>	<b>Behavioral Strategies</b>
<b>- EXPLORATION PHASE -</b>			
<b>Focusing on a Specific Dimension</b>	COG-1. Focusing on thoughts related to clients' presenting concerns	EFT-1. Focusing on feelings related to clients' presenting concerns	BHV-1. Focusing on actions related to clients' presenting concerns
<b>Exploring Context, Function, and Impact</b>	COG-2. Exploring the origins of thoughts, how they mediate experiences, and their impact on feelings and actions	EFT-2. Exploring the context and function of specific feelings and how they shape thinking and acting	BHV-2. Exploring the triggers and functions of specific actions and how they impact thoughts and feelings
<b>Analyzing Adaptive Value</b>	COG-3. Analyzing thoughts to evaluate their functional value	EFT-3. Analyzing feelings to evaluate their adaptive value	BHV-3. Analyzing actions to evaluate their effectiveness
<b>Discovering Patterns Outside Awareness</b>	COG-4. Discovering underlying core beliefs or schemas that influence conscious thought	EFT-4. Discovering unexplored emotional experiences outside of awareness	BHV-4. Discovering patterns of reinforcement that shape current actions
<b>- TRANSFORMATION PHASE -</b>			
<b>Experimenting</b>	COG-5. Experimenting with thoughts to evaluate accuracy and generate alternatives	EFT-5. Experimenting with new feelings and overcoming emotional blocks	BHV-5. Experimenting with new actions and observing results
<b>Modifying</b>	COG-6. Modifying beliefs and identifying more functional thoughts	EFT-6. Generating adaptive feelings as an alternative to problematic emotional patterns	BHV-6. Improving skills through training and behavioral rehearsal
<b>Generalizing and Consolidating</b>	COG-7. Reinforcing functional thoughts and putting these beliefs into practice	EFT-7. Generalizing adaptive feelings and reflecting on emotional responses	BHV-7. Generalizing effective actions to new environments outside of psychotherapy
<b>Assessing Change and Impact</b>	COG-8. Assessing cognitive change and multidimensional impact	EFT-8. Assessing emotional change and multidimensional impact	BHV-8. Assessing behavioral change and multidimensional impact

## **Key Strategies Training Fills the Gap**

Key Strategies Training is being implemented as a means to improve graduate psychotherapy training, so as to better prepare trainees to implement evidence-based strategies in a competent manner. KST utilizes key strategies to train students to choose between or combine interventions from three theories, recognizing that “no one intervention has the sole propriety on therapeutic change,” (Ridley, Mollen, & Kelly, 2011, p. 847). While some researchers suggest that trainees should learn a pure form of therapy first, before learning to integrate (Norcross & Halgin, 2005), the key strategies system recommends earlier integration of intermediate interventions from three modalities targeting thoughts, actions, and feelings, in order to help trainees transition from basic skills to the complexity of an evidence-based psychotherapy system. Sharpless and Barber (2009) emphasized the reasonableness of hypothesizing “that extensive knowledge in more than one type of therapeutic orientation/modality may allow a psychologist to ‘step outside’ of his/her predominant orientation in order to assume a position of evaluation for another modality” (p. 50). Consistent with this suggestion, the KST method was designed as a first step toward the development of multitheoretical competence.

The purpose of this dissertation was to test KST using three of Miller’s (1990) areas of proficiency: (a) knowledge, (b) practical understanding, and (c) demonstration or applied knowledge. The current study aimed specifically at the initial establishment of the feasibility and integrity of KST by utilizing a multi-method approach to assess the development of psychotherapy students before and after receiving KST. Assessments

included a pretest – post-test essay assignment to measure student’s knowledge (identification & differentiation) of interventions, and a post-test only standardized role-play to assess students’ adherence, differentiation, and competence demonstrating key strategies.

### **Definition of Terms**

For the current study, certain terms are operationally defined as follows:

- **Integrity:** The delivery of psychotherapy interventions on a level of adherence, competence, and knowledge, such that the intended effects of the interventions are expected (Fairburn & Cooper, 2011)
  - **Adherence:** The valid implementation of therapeutic strategies, identifiable in terms of the therapist’s employment of specific behaviors as suggested by a training procedure (Nezu & Nezu, 2008).
  - **Competence:** The quality or skill with which psychotherapeutic interventions are delivered (Muse & McManus, 2013).
    - **Competencies:** Components of competence that are able to be observed, measured, and contained, as well as being practical and flexible (Kaslow, 2004).
  - **Knowledge:** The ability to identify and differentiate between therapeutic strategies, allowing the therapist to intentionally implement strategies belonging to a specific phase and modality of treatment.

- **Identification:** The recognition of individual therapeutic strategies and their relationship to specific phases and modalities of treatment.
- **Differentiation:** The ability to distinguish between specific interventions used within different treatment modalities (thoughts, actions, and feelings) and during different phases of treatment (exploration and transformation) (Nezu & Nezu, 2008).

CHAPTER II  
LITERATURE REVIEW  
**Psychotherapist Training**

Psychotherapy training has changed significantly since its origins, and has continued to change over the past several decades. As the field of psychology has placed increased emphasis on empirical validation of treatments, the need has arisen to measure the effectiveness of counselor training as treatments must not only be effective, but also must be capable of being taught to new counselors (Milne, Baker, Blackburn, James & Reichelt, 1999). Researchers have enumerated a variety of central foci of training, though the majority of training research has strongly emphasized the ability to intervene effectively with the client as the most fundamental element of therapy. Disagreement remains about whether effectiveness is best demonstrated by patient outcome, therapist adherence and competence, or some other factor, and no method of measuring these and related psychotherapy constructs has come forward as the universally-accepted standard (Sharpless & Barber, 2009).

Helping skills training has generally assigned importance to effectively using basic interventions intentionally (Ivey & Ivey, 2009). Cognitive Therapy, on the other hand, has emphasized training individuals to conceptualize and interact with clients in terms of dysfunctional thoughts (J. S. Beck, 2011). Training in behavioral therapies, such as Behavioral Activation, has emphasized recognition of ineffective actions (Martell et

al., 2010). Emotion-Focused Therapy training has emphasized counselor awareness of maladaptive emotional responses (Greenberg & Watson, 2006). The field of psychotherapy has continually gravitated toward the study and use of these and other evidence-based psychotherapies, despite concerns regarding therapy training, its effectiveness, and the efficacy of related treatments (Lutz et al., 2006). The American Psychological Association Task Force on Evidence-Based Practice (2006) suggested that evidence-based psychology practice “is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (p. 273). Questions arise, however, as to how to identify the best research when results are often conflicting, as well as what level of clinical expertise is necessary for practice (Muse & McManus, 2013). For years, many different systems of psychotherapy have raced toward the goal of being the most empirically-supported, which has resulted in the establishment of several recognized evidence-based modalities for several different mental health problems.

Newman and J. S. Beck (2008) stated that in order to test treatment efficacy, “therapists will need to be good practitioners in general, knowledgeable about the specific treatment modality (modalities) being evaluated, [and] conscientious about following the manual and protocol” (p. 245). Fairburn and Cooper (2011) offer three reasons therapists’ delivery of evidence-based treatments is an important issue: (1) clinicians are responsible for providing the best possible treatment, (2) responsible dissemination of evidence-based psychotherapy requires that training be to the point of competence, and (3) reliable and valid assessment protocols for evidence-based training

are necessary to imply efficacy and effectiveness of an evidence-based treatment in general. Measuring the progress of training becomes hampered however, because confusion exists regarding how to assess competence, and because priority has been placed on treatment effectiveness prior to training effectiveness (Fairburn & Cooper, 2011).

Ensuring that new therapists meet competence requirements, however, necessitates that they make a transition from basic helping skills to the understanding and use of more complex evidence-based interventions. Until recently, this problem was not recognized and therefore no method had been suggested to fill the gap. Brooks-Harris (2008) developed Multitheoretical Psychotherapy to address this concern from the practice/training side of the gap, attending to the need of therapists-in-training to learn to weave together microskills into more complex evidence-based interventions. In this regard, Multitheoretical Psychotherapy and Key Strategies Training, can be understood as a modality for training new therapists specific mechanisms of treatment, a primary concern for several researchers. For example, Busch et al. (2009) explored the change mechanisms of Functional Analytic Psychotherapy on a micro-process level. Gifford et al. (2012) explored the manner in which practitioners component-level utilization of specific evidence-based intervention cluster. Gibbons et al. (2009) studied similarities and differences in mechanisms of change between dynamic and cognitive psychotherapies. In other words, whereas Busch et al., Gifford et al., and Gibbons et al. approached the problem from the perspective of figuring out how specific mechanisms of

a particular theory work in practice, KST has been designed to address how to train new therapists the mechanisms for implementing evidence-based interventions.

### **Training in Basic Helping Skills**

In 1968, Ivey, Normington, Miller, Morrill, and Haase implemented studies on microcounseling, the basic elements of therapy, by measuring three elementary skills: attending behavior, reflection of feeling, and summarization of feeling. Microskills, as microcounseling was rebranded, evolved such that by 1978, Ivey and Authier conceptualized it as “a systematic format for teaching single helping skills,” as well as “a conceptual framework and theory concerning the basic skills of the helping process” (p. 8-9). Emphasis on the microskills approach as a complete framework and theory of psychotherapy made more sense at the time when it was developed than it does today. Microskills were well-suited for the psychotherapeutic climate of the 1970’s when it became popular, as the system operationalized a common factors / person-centered approach, which was being widely used in the 70’s (Rogers, 1961). The microskills system is unable to adequately train and account for therapists’ behavior in the 21<sup>st</sup> century, however, as many of the common factors / person-centered interventions and theoretical principles are now presupposed by most current treatment modalities, and the actual mechanisms believed to bring about change both incorporate and go beyond the basic microskills.

Ivey and Authier (1978) described microcounseling as “an innovative approach to instruction in basic clinical skills which is based on the assumption that interviewer behavior is extremely complex and therefore can best be taught by breaking the interview

down into discrete behavioral units” (p. 32). Microskills training was designed to break down complex therapeutic behaviors into smaller pieces of behavior which could be more easily taught through description, demonstration, practice, and feedback (Ivey & Ivey, 2009). According to the microskills approach, how a counselor listens and responds is considered the foundation upon which all other skills are taught (Ivey & Ivey, 2009). Therefore, emphasis has been placed on the *intentionality* of counselor behaviors as well as multicultural competence. The emphasis on the *intentional* use of basic interventions in the microskills approach implies that students learn not only individual skills, but the rationale for using different skills, and when to use different helping skills (Ivey & Authier, 1978). Counselors-in-training are taught a hierarchy of interventions (attending behavior, basic listening skills, establishing the client’s story, goals and course of action, confrontation, focusing, interpreting and reflecting meaning, and influencing skills), which are to be mastered individually prior to integration and “provide specific alternatives” for counselors to adapt to clients’ presenting concerns (Ivey & Ivey, 2009, p. 14).

The microskills approach has continually developed, and Ivey and Ivey’s classic text *Intentional Interviewing and Counseling: Facilitating Client Development in a Multicultural Society* is now in its 8<sup>th</sup> edition (Ivey, Ivey, & Zalaquett, 2013). Other helping skills models have taken basic skills training in various directions. Two examples of similar helping skills models can be found in Egan’s (2013) *The Skilled Helper* and Hill’s (2009) *Helping Skills*.

Egan (2013) suggested that psychotherapist training incorporate an integration of basic helping skills divided into three stages focused on understanding the client's current scenario, exploring potentially preferred scenario, and creating action strategies to encourage change. The first of these three stages involves the exploration of clients' stories and focusing on the problem and confrontation (Egan, 2013). The second stage turns toward a focus on mentally exploring clients' possibilities for change, by interpreting and reflecting on meaning, and the setting of goals (Egan, 2013). The third stage entails strategies for influencing change by determining a course of action with the client, as well as planning action steps to bring about change (Egan, 2013). Egan (1998) enumerated two principle goals of this process, namely to: (1) "Help clients manage their problems in living more effectively and develop unused or underused opportunities more fully" and (2) "Help clients become better at helping themselves in their everyday lives" (p. 7-8).

Hill (2009) developed a model of training emphasizing psychotherapists' integration of helping skills into three theoretically-based stages of treatment involving exploration, insight, and action. Hill has conceptualized these three stages using client-centered, psychoanalytic, and cognitive-behavioral theories, respectively. During Hill's exploration stage, therapists aim at rapport-building and the utilization of the basic helping skills of attending and listening, as well as establishing the client's story and goals. Hill's second stage has emphasized the fostering of awareness and insight by the utilization of skills for confrontation, interpretation, and the reflection of meaning. The action stage was created to train therapists to develop skills related to the creation of new

possibilities by using influencing skills that focus on change (Hill, 2009). Hill's helping skills system has likewise emphasized that new therapists should learn to be aware of the intentions behind intervention use, and helps students build up to more advanced helping skills on a foundation of basic helping skills. Hill's *Helping Skills* is an example of a complex integrated model that combines specific helping skills with more developed theoretical underpinnings. Hill's system has aimed at the training of evidence-based interventions by means of basic helping skills, similar to Key Strategies Training, but teaches interventions outside of the context of the holistic theoretical picture from which they are drawn, and utilizes theories to represent stages of treatment, thereby leading to training in only certain aspects of these three theories.

### **Training in Evidence-Based Psychotherapies**

Foundational theories of psychotherapy have used a vast array of approaches to train new therapists, most of which generally involve the accomplishment of some therapeutic tasks rather than basic interventions. J. S. Beck (2011) described Cognitive Therapy as a time-limited, present-focused approach emphasizing that new therapists learn to identify and evaluate automatic thoughts and modify intermediate beliefs presumed to lead to a deeper integration with underlying core beliefs. Young and A. T. Beck (1980) developed the Cognitive Therapy Scale as a method by which observers could rate therapists according to 10 broad categories divided into two subscales (general skills and cognitive therapy skills), relying on several strategies from each category. Cognitive Therapy Scale categories include setting an agenda and working with automatic thoughts and beliefs, as well as some behavioral techniques, and can be seen as

an outline for training in Cognitive Therapy. Therapists are likewise trained in more complex strategies such as using imagery, cognitive rehearsal, and exposure techniques (Young & A. T. Beck, 1980).

Emotion-Focused Therapy “can be seen as operating according to two overarching principles: facilitating a therapeutic relationship and promoting therapeutic work” (Greenberg & Watson, 2006, p. 93). The training literature in EFT, following these principles, utilizes interventions such as focusing on emotions, expanding and validating emotions, building emotional awareness, working with primary emotions and discovering adaptive responses, managing secondary emotions and defensive responses, therapeutic enactments, transforming emotional responses, and consolidating work into new meaning (Denton, Johnson & Burlison, 2009; Greenberg & Watson, 2006; Montagno, Svatovic, and Levenson, 2011). Psychotherapists trained in the strategies of EFT would also learn more highly developed and complex interventions such as two-chair and empty-chair enactments (Greenberg & Watson, 2006).

Behavioral Activation is a brief, structured treatment, which has been developed around 10 core principles aimed at activating “clients in specific ways that will increase rewarding experiences in their lives” (Martell et al., 2010, p. 21). Training literature for Behavioral Activation is continuing to develop, and therapists are trained to observe the 10 core principles focused on motivating clients to bring about change in their lives through action. These principles guide counselors in focusing on clients’ behaviors as a means to changing their thoughts and feelings, and include interventions focused on confronting the problem and emphasizing activation rather than coping strategies,

drawing attention to behavioral antecedents and consequences as important clues for behavioral activation, creating plans that start small, using a problem-solving empirical approach, emphasizing behavioral reinforcement, troubleshooting barriers to change, acting as a coach, and assigning activities (Martell et al., 2010).

Therapist training in the use of these and other evidence-based interventions often occurs after graduate-level training, and many researchers advocate a two-stage model for therapists with the applicable level of prior training (Beidas & Kendall, 2010; Sholomskas et al., 2005; Weissman et al., 2006). This two-stage model has generally involved an initial explanation and demonstration of the treatment modality, often by means of an expert-led workshop, as well as on-going use of the treatment modality supervised by a psychotherapist proficient in the therapy (Fairburn & Cooper, 2011). Some researchers have suggested that this training model has limitations, particularly related to the inadequate exposure to experts practicing the therapy and the frequent lack of on-going supervision (Fairburn & Cooper, 2011; Sharpless & Barber, 2009). Fairburn and Cooper utilized the analogy of a surgeon, who is trained to operate without ever seeing the operation performed, to describe this situation. Sharpless and Barber (2009) have made the point that “clinical psychology has the unusual distinction of being perhaps the only helping profession in which a member could be licensed without ever having witnessed a successful treatment from beginning to end” (p. 54), and this characteristic of psychology training strongly suggests the need to clarify that training and treatment in psychotherapy work and are beneficial.

Additionally, some research suggests that many therapists who attend workshops may go on to use some of the techniques to which they were exposed, but few actually go on to receive supervision from a supervisor who is trained and proficient in the treatment modality (Fairburn & Cooper, 2011). These problems are further exacerbated by the rarity with which randomized-controlled training studies have conducted maintenance assessments post-training to demonstrate the ongoing use and competence in therapeutic skills, as well as the rarity with which they have fully assessed the importance of supervision involved during training or beyond (Fairburn & Cooper, 2011; Mannix et al., 2006; Miller, Yahne, Moyers, Martinez, & Pirritano, 2004).

Reichelt, James, and Blackburn (2003) demonstrated that supervisors with many years of experience in Cognitive Therapy, improved significantly in terms of their ability to rate therapy tapes after receiving training on a rating scale, suggesting that even trained therapists working in the field may not have fully integrated the actual, manualized interventions of empirically-based modalities. These findings may suggest that therapy protocols may not have been fully understood during training and/or that training must be on-going to maintain skills. Increased exposure to evidence-based psychotherapies during graduate training is likely to better prepare students for more intense post-graduate training and to solidify learning by lengthening exposure to these treatments.

### **Training in the Transtheoretical Approach**

The transtheoretical approach to training, developed by Prochaska and Norcross (2010) is, perhaps, the most similar system of integrative training to multitheoretical psychotherapy and key strategies training. Prochaska & Norcross (2010) attempt to

reduce confusion and organize a vast array of therapy modalities by levels of change and five stages of change (p. 2). Levels of change include symptom/situational problems, maladaptive cognitions, current interpersonal conflict, family/systems conflicts, and interpersonal conflicts. Stages of change include precontemplation, contemplation, preparation, action, and maintenance, and represent the process by which the client becomes more ready for change, enacts change, and sustains changes. According to Prochaska and Norcross, “The transtheoretical model sees therapeutic integration as the differential application of the processes of change at specific stages of change according to the identified problem level” (p. 503). While Prochaska and Norcross recognize common processes across many therapeutic modalities, they also emphasize specific theories as more effective during different stages of change and at different levels of change.

Similar to Multitheoretical Psychotherapy (MTP), Prochaska and Norcross’ (2010) transtheoretical approach also attempts to train new therapists in a vast array of therapeutic modalities, however, a new therapist is unlikely to be able to learn such a plethora of skills and theories in a single semester. The transtheoretical approach may thereby risk complicating the transitional movement from microskills into evidence-based treatments. Researchers utilizing the Key Strategies Training (KST) model agree with Prochaska and Norcross’ recognition that most integrative endeavors lack “a comprehensive model for thinking and working across systems” (p. 2). Similar to the intervention process approach of the KST model, Prochaska and Norcross (2010) recognize many commonalities among different systems of psychotherapy. However,

Prochaska and Norcross place more emphasis on the integration of common factors on a general, theoretical level across levels and stages of change. KST, on the other hand, specifically targets the development of therapists transitioning from microskills to evidence-based practice, providing a system for recognizing commonalities on the intervention process level, in addition to theoretical similarities.

Additionally, KST emphasizes targeting the focal dimension (cognitions, feelings, and behaviors) in which clients appear to be experiencing the most distress. Assessing for problems with specific focal dimensions guides intervention choice, rather than the therapist's suppositions regarding a client's stage of change. For example, whereas a therapist utilizing transtheoretical integration would be guided to use interventions of Cognitive Therapy in the preparation stage and Behavioral Therapy in the action & maintenance stages, a therapist utilizing multitheoretical integration would assess for problematic cognitions and behaviors, and then utilize interventions of Cognitive Therapy and Behavioral Therapy, respectively.

### **Multitheoretical Psychotherapy and Training in Key Strategies**

Psychotherapy training researchers have been concerned for some time with how training programs can better prepare students to use and integrate evidence-based psychotherapies, as well as assuring that a therapist has the appropriate level of training prior to practice. Some research suggests that increasing exposure to expert demonstration of skills is likely to aid in therapists' development (Sharpless & Barber, 2009). One way of increasing exposure to expert therapy is to introduce intermediate evidence-based interventions earlier in training, though doing so should be approached

with caution. Just as microskills training is not enough, advanced training in a specific treatment modality for specific disorders, is likely too much for many new students. Harris et al. (2014) have suggested that incorporating more evidence-based elements during graduate training would be helpful, particularly by integrating them with basic helping skills training as done by Key Strategies Training.

Key Strategies Training (KST) is a model of psychotherapist training based on three (cognitive, emotion-focused, and behavioral) of the seven theoretical domains (cognitive, emotion-focused, behavioral, interpersonal, biological, social systems, and cultural contexts) of Multitheoretical Psychotherapy (Brooks-Harris, 2008). Though therapists would benefit greatly by becoming proficient in a wide range of key strategies, such as that presented by Brooks-Harris, the level of integration presented in Multitheoretical Psychotherapy is more likely to occur over the course of one's entire graduate training. KST, on the other hand, is designed to be learned in a shorter period of time, over the course of a single semester class or practicum. Unlike previous training methods, KST offers a system to fill the gap between microskills and evidence-based psychotherapies, specifically in regard to the training of new therapists. KST can therefore be understood as a training corollary for researchers seeking to empirically validate a theoretical modality by exploring its specific micro-processes of change. Like Multitheoretical Psychotherapy, KST has emphasized that integrative psychotherapy should be intentional, multidimensional, multitheoretical, strategy-based, and relational (Brooks-Harris, 2008). KST advocates intentionality, suggesting that training should teach new therapists to choose one preliminary focus (thoughts, feelings, or actions)

based on collaborative dialogue with each client. Therapists, therefore, are taught to purposefully use strategies indicated to be most helpful to the client and based directly on clients' presenting concerns. Intentional integration is understood by Brooks-Harris to represent a middle ground between intuitive integration, based on clinical judgment, and technical integration, based on treatment protocols and scientific research.

KST is also multidimensional, adapting to the complex interaction of the many dimensions of clients' lives (Brooks-Harris, 2008). KST emphasizes that interventions can be utilized in an interactive way and, therefore, trains therapists to use key strategies from different treatment modalities interactively to increase the likelihood of improving therapeutic outcomes. Similarly, KST is mutitheoretical, encouraging the use of different theoretical models to conceptualize clients' presenting problems and to direct intervention choice. (Brooks-Harris, 2008). Diverse theories are understood to be different vantage points from which a therapist can develop a more comprehensive approach to therapeutic work. Cognitive Therapy has conceived of dysfunctional thoughts and irrational beliefs as the primary cause of mental health concerns, and therefore generally focuses on interventions targeting cognitions as the primary means of treating mental health problems (A. T. Beck & Weishaar, 2000; Young & A. T. Beck, 1980). Emotion-Focused Therapy, an integration of Gestalt and Person-centered therapies, has emphasized interventions targeting affect in order to aid clients in clarifying and expressing emotions and modifying affective responses that are not adaptive (Greenberg, 2002). Behavioral Activation, on the other hand, has emphasized the primary cause of mental health issues to be primarily related to clients' recurrent,

unrewarding patterns of behavior that reduce positive reinforcement for healthy behaviors (Martell, Dimidjian & Herman-Dunn, 2010).

Additionally, KST is strategy-based, relying on interventions as the key to clinical integration and change, rather than theories. Theories are utilized to guide conceptualization in KST, but reliance on key strategies clarifies integration by avoiding potentially irreconcilable differences between theories. Last of all, KST is relational, promoting that all psychotherapy should occur within the environment of a well-established therapeutic alliance (Brooks-Harris, 2008).

KST trains therapists to utilize strategies from two treatment phases, exploration and transformation, recognizing a parallel between cognitive, emotion-focused, and behavioral modalities of treatment. In the exploration phase, therapists aid clients in moving from a general to a more specific understanding of their concerns, and an awareness of elements of their lives that are in need of transformation. This progression can be seen in the four exploration processes, which are characterized by increasing awareness, e.g., (1) choosing a focal dimension and a general description of the presenting problem, (2) a function-based understanding of specific concerns, (3) an analysis of the adaptive value of thoughts, feelings, and actions in relation to the client's current situation, and finally, perhaps, (4) the recognition of patterns beyond awareness. Another way of stating this parallel is that proponents of these three treatment modalities agree that the client must move toward increasing awareness of the problem to the point of potentially recognizing unconscious processes.

A specific example of the parallel intervention involving understanding of the context and function of thoughts, actions, and feelings can be seen in the following statements. For example, Cognitive Therapy has highlighted the need to aid clients in understanding the manner in which automatic thoughts impact their “subsequent emotion, behavior, and physiological response” (J. S. Beck, 1995, p. 75). Similarly, EFT has emphasized encouraging clients toward an understanding of the emotional triggers which impact “how clients construe the events in their lives and react to those events” (Greenberg & Watson, 2006, p. 176). Comparably, Behavioral Activation has focused on aiding clients to understand the antecedents and consequences of behavior as “people generally are unaware of the connections interlocking various situations, activities, and feelings” that may be associated with maladaptive conditioned responses. (Martell et al., 2010, p. 64).

Key Strategies Training also recognizes a similar parallel progression in the transformation phase, involving bringing about change in thoughts, feelings, or actions, and this parallel is characterized by a movement from practicing possible change to solidifying changes and exploring the need for transformation in other areas. One example of this can be found in the emphasis placed by Cognitive Therapy on modifying core beliefs so “new beliefs that are more reality based and functional can be developed and learned through therapy” (J. S. Beck, 1995, p. 16). Emotion-Focused Therapy has similarly focused on modification of emotion by accessing “core dysfunctional emotion schemes” and generating “alternative emotional responses based on adaptive needs and goals” (Greenberg & Watson, 2006, p. 281). Behavioral Activation on the other hand

attempts to modify behavior through rehearsal and training. Martell et al. (2010) put it this way: “The therapist should take time to discuss a plan of implementation with the client. The more specific and detailed the plan, the better!” (p. 33).

### **Psychotherapy Training Research**

As research on the effectiveness of psychotherapy treatments became more and more focused on empirical support, researchers began focusing on dissemination, often rushing past the development of implementation protocols adequate for ensuring integrity of the treatment in training, research, or everyday clinical use (Schoenwald et al., 2011). Fairburn and Cooper (2011) found it “remarkable that in this era of enthusiasm for evidence-based psychological treatments so little research attention has been paid to therapists’ ability to deliver these treatments...and the measurement of the outcome of training has been largely overlooked” (p. 373). Despite this neglect of training methods from researchers, effectiveness research conducted on therapy training has historically proceeded in a number of ways and three key issues should be considered in this literature. First, one must determine *what* aspect of training effectiveness to rate. Differential emphasis has been placed on specific therapist traits and qualities of training, including constructs such as integrity, competence, adherence, and differentiation. Additionally, each of these concepts have been investigated in a number of different ways.

Second, one must determine *how* training effectiveness is going to be measured. Reviewing the methods used to assess Cognitive-Behavioral Therapy competence, Muse and McManus (2013) reviewed 64 articles that used 10 different methods. These 10

assessment methods were divided according to the four categories of development suggested by Miller (1990) as follows: (1) assessments of knowledge (“knows”) included multiple choice questionnaires and essays, (2) practical understanding (“knows how”) assessments included short-answer vignettes and case reports, (3) assessments of applied knowledge or skill (“shows how”) included standardized role plays, and (4) assessments of clinical practice (“does”) included treatment session rated by assessors, by supervisors, self-assessment by the therapist, client surveys, and client outcome (Muse & McManus, 2013).

Third, one must determine *who* is going to assess training effectiveness. Training measures have assessed progress by means of observer ratings, client ratings/outcomes, and/or supervisor, peer, and self-reports (Ford, 1979). Additionally, Fairburn and Cooper (2011) recommended attention to a number of important elements when assessing the quality of therapy training, including emphasis on the *content* of therapy (e.g., active change mechanisms and core principles at the heart of the treatment), *methods* of rating (e.g., instruments and assessments have appropriate reliability and validity), and *specification of important requirements* (e.g., raters’ qualifications).

### **Measuring Therapist Traits and Qualities of Training**

**Integrity in psychotherapy training.** The most commonly utilized approach to organizing important therapist traits and qualities in psychotherapy research is to conceptualize treatment integrity, which is considered synonymous with therapist fidelity, as an over-arching principle comprised of adherence, competence, and differentiation (Nezu & Nezu, 2008). At times, adherence and competence can be

difficult to operationally differentiate as they may be demonstrated by the same intervention. At other times, however, competence may not correspond with what a specific treatment modality might prescribe, at which point, remaining adherent to a treatment protocol may even be considered incompetent (Sharpless & Barber, 2009). While many researchers have suggested that effective treatment includes all three components of integrity, not all researchers utilize these concepts in the same manner. Most researchers, however, agree that adherence and competence are the most vital aspects of integrity.

**Competence in psychotherapy.** Some researchers understand competence as relying more heavily on specific skills and competencies, whereas other researchers rely on more general, holistic knowledge. Ridley, Mollen, & Kelly (2011) differentiated between competence and competencies, pointing out that competencies are elements of competence which are capable of being demonstrated and reflect proficient performance of therapeutic behaviors leading to therapeutic change. Many researchers have emphasized the importance of knowledge, suggesting that knowledge of therapeutic techniques, and even how to apply them are necessary, but not sufficient, components of competence (Miller, 1990; Muse & McManus, 2013; Roth & Pilling, 2008; Sharpless & Barber, 2009). Miller (1990) suggested that competence was equivalent to applied knowledge (“knows how”); the ability to implement what one knows. Other researchers add an emphasis on competence in terms of therapists’ ability to implement a treatment, distinguishing between limited-domain (i.e., specific evidence-based intervention) competence and general/global competence (Barber et al., 2007; Vallis, Shaw, &

McCabe, 1988). This distinction draws out the related issue of whether competence is a state reached along development, a matter of learning to utilize certain behaviors and skills, or a complex combination of both (Kaslow et al., 2007; Sharpless & Barber, 2009).

Sharpless and Barber (2009) suggested a five-stage approach to conceptualizing the development of psychotherapeutic competence. In this way, competencies are acquired over time and develop to the point that a therapist-in-training achieves competence, which Sharpless and Barber envision as the middle of the five stages, between novice and expert. Novices are generally in the process of acquiring rule-based learning that directs actions, leading to advanced beginners, who have practiced with many clients through different periods of the therapy process, and have begun to use more sophisticated rules, as well as exploring several modalities of treatment (Sharpless & Barber, 2009). Competence, on the other hand, entails treating clients according to the specific needs of the client, taking accountability and personal responsibility for one's work (rather than thinking in a rule-based manner), and increased investment and immersion in the therapy process (Sharpless & Barber, 2009). For the purposes of this dissertation, competence was contextualized in this developmental manner, as the participants in the current study likely ranged within the first three stages of development, from novice to competence. The last two stages suggested by Sharpless and Barber are proficiency and expertise, but these concepts are beyond the scope of the current study.

**Psychotherapy competencies.** Epstein and Hundert (2002), conceptualized competence in medicine as “habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for

the benefit of the individual and community” (p. 226). This definition has been widely relied upon by researchers in psychology. The exact relationship between general competence and specific therapy skills (i.e., intervention competence), is quite elusive and on-going discussions of competence qualities have led some researchers to conceptualize competence in terms of specific behaviors or competencies. Many researchers have put forward the idea of competence as determined by multiple competencies, exploring the totality of specific competencies related to general competence. Roth and Pilling (2008) developed a model of competence in Cognitive-Behavioral Therapy identifying 50 characteristics of competence categorized into general competencies, basic cognitive-behavioral competencies, specific cognitive-behavioral competencies, competencies related to specific problems, and meta-competencies.

Some authors have suggested that researchers must be careful not to reduce competence to a list of competencies (Kaslow, 2004; Ridley, Mollen, & Kelly, 2011). Kaslow et al. (2007) suggested that competencies be measured generically, holistically, and developmentally. Likewise, in the development of the American Psychological Association’s competency benchmarks, Fouad et al. (2009) suggested the measurement of competency across a variety of training levels, stating that “competence also implies performance at an acceptable level, and presumes integration of multiple competencies...conceptualized as elements or components of competence, and [consisting] of discrete knowledge, skills, and attitudes” (p. 6). Further, Fouad et al. listed necessary components comprising core competencies and illustrated behavioral anchors, which can provide operational definitions for these essential elements. Ridley, Mollen,

and Kelly developed a complex model of counseling competence, which incorporated a plethora of competencies categorized as four superordinate competencies, 12 subordinate competencies, and five metacognitions, providing a depth to the structure of their competence model, and allowing for conceptualization of the quality of therapeutic behaviors.

Despite emphasis on the connection between competence and competencies, Ridley, Mollen, and Kelly (2011) defined competence in a broad manner, for application to a variety of settings, “as the determining, facilitating, evaluating, and sustaining of intended outcomes” (p. 835). Clarifying this broad definition, Ridley, Mollen, and Kelly (2011) added that outcomes rely on more specific microskills and competencies, which must be “coordinated and integrated to determine, attain, evaluate, and sustain the intended outcomes” (p.835). Roth and Pilling (2008) pointed out an important difficulty regarding the definition of competencies, namely that if they are defined too broadly or too narrowly, then, in practice, the definitions will lead to inclusion or exclusion, respectively. Roth and Pilling (2008) emphasized that if competencies are “defined too simply, or at too general a level, pretty much everyone meets the specification – all will have won and all will have prizes, [whereas] “defined too exhaustively very few people would reach criteria” (p. 129-130). Ridley, Mollen, and Kelly (2011) appear to tackle this problem by including a broad definition of competence tied to more specific skills and competencies.

Rather than conceptualize competence in terms of the totality of its elements, Kaslow (2004) suggested that competence is a minimum threshold of a group of

competencies, and suggested that “competencies are composed of knowledge, skills, and attitudes, which, as a coherent group, are necessary for professional practice” (p. 775). Researchers investigating competence will need to reach consensus in the profession about key elements of competence, the development of assessment tools aimed at knowledge, skill, attitudes, and integration, and “determining appropriate agreed-upon minimum levels of competence for individuals at different levels of professional development” (Lichtenberg et al., 2007, p. 474). For the purposes of this dissertation, competencies include knowledge, practical knowledge, and demonstration of skills, specifically related to the 24 strategies of KST. Some researchers (Barber et al., 2007; Vallis, Shaw, & McCabe, 1988) have discussed competencies related to specific skills of a treatment modality as limited-domain competence.

**Adherence to psychotherapy training.** Some researchers, placing more emphasis on limited-domain competence, have approached the issue of competence measurement from a different perspective, placing emphasis on competence related to individual interventions. According to Muse and McManus (2013), Cognitive-Behavioral Therapy competence should be measured in terms of “the degree to which a therapist demonstrates the general therapeutic and treatment-specific knowledge and skills required to appropriately deliver CBT interventions...for treatment of the patient’s presenting problem” (p. 485). Here therapeutic knowledge and skill are both considered crucial aspects of competence. This way of conceptualizing competence, in terms of specific interventions, necessitates adherence to treatment protocol and has been utilized in various forms by other researchers (Barber, Sharpless, Klostermann, & McCarthy,

2007; McGlinchey & Dobson, 2003; Nezu & Nezu, 2008; Schoenwald et al., 2011; Sharpless & Barber, 2009; Waltz et al., 1993). This perspective generally differentiates between competence and adherence as follows: competence is the skill with which therapy techniques are utilized and adherence is delivery of interventions as presented by a specific therapy modality (McGlinchey & Dobson, 2003; Muse and McManus, 2013; Dobson & Singer, 2005). This distinction was utilized in the current study.

Competent delivery of a treatment protocol requires both skill and adherence, neither being sufficient without the other. Adherence, however, is a precondition for competence in a specific treatment modality (Dobson & Singer, 2005; Muse and McManus, 2013). Schoenwald and Garland (2013) conducted a review of psychotherapy adherence methods from 341 studies published between 1980 and 2008, in order to identify existing methods of measuring adherence to psychotherapeutic treatments. Many of the instruments identified by Schoenwald and Garland were utilized to simultaneously identify treatment differentiation between therapy conditions, as well as adherence and competence. Of the 249 adherence measurements used across these studies, almost 75% reported results related to hypothesis testing, however, only 35% reported statistical outcomes of psychometric measurements of reliability, with few validity scores reported.

The current study was particularly mindful of the following conceptualization from Sharpless and Barber (2009):

“The crucial difference between adherence and competence is that adherence demonstrates knowledge of “how” to intervene (i.e., one possesses knowledge of how to implement a particular technique and is capable of doing so) and “what” to

intervene on (viz., the therapist has the knowledge to identify particular problems requiring intervention such as depressive symptoms), whereas competence is knowledge of “when and where (and possibly why or why not) to intervene” (p. 49).

This conceptualization is considered important because it helps demarcate a more definite line between adherence and competence, particularly vital in the creation of an adherence and competence rating system for a training method.

**Differentiation of treatment modalities.** Treatment differentiation becomes important when researchers are comparing different treatment modalities (Fairburn & Cooper, 2011; Nezu & Nezu, 2008; Schoenwald & Garland, 2013). Fairburn and Cooper suggested that treatment differentiation is an aspect of adherence, which clarifies the crucial role of differentiation in comparative psychotherapy studies. Specifically, for this dissertation, treatment differentiation requires that trainees who are learning multiple treatment modalities be capable of telling the difference between strategies belonging to the correct treatment phase and modality of treatment. Though the concept of differentiation is most often utilized in studies comparing the effectiveness of different therapy modalities (Fairburn & Cooper, 2011), it is especially important in this study as some researchers suggest that therapists early in their training should learn a single modality before learning to integrate (Norcross & Halgin, 2005).

**Feasibility of training: Treatment integrity in practice.** Several researchers have suggested that in regard to psychotherapy practice and training, researchers should explore competence and adherence components together (Dobson & Singer, 2005;

Fairburn & Cooper, 2011; Muse and McManus, 2013). Waltz, Addis, Koerner, and Jacobson (1993) suggested that one way to show that training is effective is to use a measure of competence which can also simultaneously assess adherence to designated techniques and level of skill implementing these techniques. Fairburn and Cooper (2011) suggested that the competence-adherence distinction is valuable and meaningful for psychotherapy research, but in the context of daily clinical practice one is more concerned with the overall quality of treatment, requiring both adherence and competence. In other words, in practice with real clients, it is not helpful for a therapist to do incompetent therapy, but follow protocol, anymore than it would be useful for the therapist to do an ineffective therapy well (Fairburn & Cooper, 2011). While this concept of therapy quality may appear at first hand not to differ from the concept of competence, Fairburn and Cooper (2011) further distinguished therapy quality from therapist competence, describing competence not as a characteristic of the therapy, but of the therapist. Fairburn and Cooper described competence as “the extent to which a therapist has the knowledge and skill required to deliver a treatment to the standard needed for it to achieve its expected effects” (p. 374).

Feasibility involves issues related to the cost and labor constraints of assessing treatment, training, and dissemination of a therapeutic modality, as well as the initial development of treatment and training by pilot testing to discover whether more involved research is warranted, which to some degree may help explain the rare use of validated measures of competence in applied and training settings (Muse and McManus, 2013; Perepletchikova, Hilt, Chereji, & Kazdin, 2009). Certain feasibility challenges were

reported as central by Schoenwald et al. (2011), including whether professional and financial resources are available to measure the method of treatment or training in question, whether changes to established routines (clinical and administrative) can be adequately altered, and whether conflicts will arise in relation to practice norms and observation and evaluation protocols for integrity measurement.

Schoenwald et al. (2011) identified “key characteristics of scientifically validated integrity instruments, and of the feasibility of their use in routine care” (p. 32), in an effort to identify ways to improve the effectiveness (scientific validity) and efficiency (feasibility and usefulness) of psychotherapy in clinical settings. Pointing out that development and use of a treatment manual does not ensure intervention practice and rather that the integrity of intervention delivery or “application” is necessary, Schoenwald et al. (2011) instead suggested a focus on indices of implementation integrity as the only way “to determine whether client improvement or lack thereof is a function of the failure of the treatment (or treatment element) or of its application” (p. 33).

### **Methods of Measuring Psychotherapy Training**

The method researchers use to assess the progress of trainees may be as important as the creation of clear operational definitions of the aspects of training being investigated. Knowledge-based assessments are widely used in practice, but often are not used in research or are not validated. Role-play and skill demonstrations are also used more frequently in practice than in research, with even fewer published studies available than with knowledge-based assessments. Researchers have used many other methods of measuring treatment integrity in clinical work, including assessments by supervisors,

patients, therapist self-assessment, and patient outcome (Muse & McManus, 2013). These methods can be categorized as direct or indirect methods, with direct methods referring to observational methods requiring a trained observer to rate video- or audio-recorded, in-vivo, or transcribed therapy sessions (Schoenwald et al., 2011). Indirect methods include self-reports or questionnaires completed by clients, therapists, or experts, as well as review of written case notes and/or clients' homework (Schoenwald et al., 2011). Schoenwald and Garland (2013), reviewed psychotherapy adherence studies conducted from 1980 to 2008, reporting that research methods most often included observational coding of audio-recorded, video-recorded, and in vivo therapy sessions, and instruments written and verbally administered.

**Essay and knowledge-based assessments.** Essay and knowledge-based assessments are underrepresented in the psychotherapy training literature compared to many other types of knowledge and competence assessments. Most research studies that have aimed at measuring knowledge have done so by utilizing self-report measures, rather than essays or multiple-choice tests. In fact, Muse and McManus (2013), who conducted a systematic review of methods of Cognitive-Behavioral Therapy competence assessment, stated that they identified no published “studies examining the relationship between therapists’ essay performance and patient outcome” (p. 488). Despite common usage of essays in training settings to measure learning and integration of knowledge into practice, essays remain less commonly researched and validated than multiple choice questionnaires (Muse & McManus, 2013). While multiple choice questionnaires have

been more frequently used in the measurement of knowledge acquisition and utilization of skills, few have been tested for reliability and validity (Muse & McManus, 2013).

**Research on essay and knowledge-based assessments.** Psychotherapy research that has focused on measuring knowledge by means of essays has often incorporated essays into a larger multi-method assessment strategy. For example, Muse and McManus (2013) pointed out a conference presentation by McManus et al. (2010), who reported a significant relationship between essays and an improvement in depression. Levenson and Svatovic (2009) developed the Emotion-Focused Therapy Knowledge and Competency Scale (EFT-KACS), a 12-item self-report scale based on the Emotion-Focused Therapy – Therapist Fidelity Scale (EFT-TFS), in order to assess the short-term and long-term effect of training in Emotion Focused Couples Therapy. The EFT-KACS contains the first 12 items of the EFT-TFS, each to be rated twice by the therapist on a 7-point Likert scale from (1) not at all to (7) quite a bit, once for knowledge and once for competence (Montagno et al., 2011). Montagno (2009) conducted a principal axis factor analysis with 10 of 12 items loading on the knowledge subscale and 10 of 12 items loading on the competence subscales. Additional items loaded under a third factor which was labeled Alliance. Montagno et al. (2011) collected data, using the EFT-KAC, from clinicians who attended a 4-day externship training in Emotion-Focused Couples Therapy at pre-test, post-test, and 8 months post training. Internal consistency was calculated and reported as high, and results indicated that clinicians were able to learn and retain the treatment modality with knowledge and competence scores increasing from pre-training to

immediately post-training, and retention of knowledge and competence scores at 8 months post-training (Montagno et al., 2011).

Barnfield, Mathieson, and Beaumont (2007) investigated the development of competence in postgraduate mental health professions by conducting a multi-method study utilizing assessments including a modified version of the Behavior Therapy Scale – Revised, the Cognitive-Therapy Scale – Revised, and two self-report forms, one completed by the supervisor and one completed by the student, parallel forms which could be used to compare the perspectives of therapists-in-training and supervisors. These researchers suggested that counselor “competency has been defined in various ways, but there are common factors...theoretical knowledge, ability to conceptualize, and skillful use of intervention techniques” in various descriptions and associated measures (Barnfield et al., 2007, p. 141). In order to research competence in a more holistic manner, Barnfield et al. utilized four different measures. The self-report forms assessed the development of 24 therapeutic skills (14 Cognitive-Therapy Scale - Revised items and 10 additional items) measured on a 6-point Likert scale with (0) indicating *poor performance* and (5) indicating *excellent performance*. Additional items included assessment of key behaviors, linking appropriate strategies to presenting problems, adhering to the agenda, assessment of patient’s presenting problems, active listening, ability to explain the model to clients, ability to select and employ appropriate strategies within a session, ability to communicate rationales for treatment, and appropriate review of homework (Barnfield, 1999).

The Behavioral Therapy Scale (Freiheit & Overholser, 1997) and the Behavioral Therapy Scale – Revised (Barnfield et al., 2007) contain three sections for measuring trainees’ knowledge, attitudes toward Cognitive-Behavioral Therapy, and use of cognitive-behavioral interventions with clients. The knowledge section of the Behavior Therapy Scale – Revised is a multiple-choice questionnaire with 20 questions designed to determine whether students possess sufficient knowledge of basic principles and interventions, and Barnfield et al. used the knowledge section of Behavioral-Therapy Scale – Revised with 13 experienced post-graduate therapists before and after a 30-week course in Cognitive-Behavioral Therapy to assess competence. Barnfield et al. demonstrated statistically significant improvement on knowledge competence scores from pretest to post-test.

Keen and Freeston (2008) conducted a training study utilizing three written case studies, two observer-rated therapy sessions with real clients, and three written essay assignments. These essays were rated on four content dimensions including accessing literature, interpreting literature, integration of knowledge with clinical practice, and original thought and discussion. Keen and Freeston reported sufficient reliability levels for essays, improvement between pretest and post-test on essays, and improvement from pretest to post-test on observer-ratings utilizing the Cognitive Therapy Scale – Revised. Keen and Freeston also noted that the “more examinations reflected practical skills, the less reliable they became. Thus essay examinations were more reliable than case study examinations, which were in turn more reliable than efforts to assess practical therapeutic skills” (p. 63).

General knowledge assessments have been utilized for a variety of other applications. Bishop and Kenzer (2012) conducted a study on training in a Behavioral Therapy assessment technique for recognizing paired-stimulus preference, utilizing a written test with five questions to measure general knowledge, and raters to observe sessions with actual clients. Additionally, role-plays were utilized during group classroom training, but were not assessed. Written tests and therapy sessions were rated by two raters, achieving high levels of agreement on both assessments. Post-test scores indicated an increase in knowledge and intervention implementation for most participants.

**Role-play and demonstration assessments.** Muse and McManus (2013) defined role-plays as “artificial simulations of clinical scenarios in which a therapist interacts with an individual playing the role of standardized patient... [and] performance-based tasks (e.g., set an agenda or complete a thought record) within the role-play are then rated by an observer...using pre-defined criteria” (p. 490). Role-plays offer a variety of benefits including their ability to be used to assess a plethora of skills and patient issues. Role-plays permit replication, by-passing research concerns related to confidentiality and informed consent, and can be used with new trainees to assess abilities prior to clinical work (Muse & McManus, 2013). Standardized role-plays have been well-established in research on medical training programs, wherein the term objective structured clinical examination (OSCE) is generally used (Fairburn & Cooper, 2011; Newble, 2004). In regards to psychotherapy, role-play studies are limited, despite having the potential of directly measuring the impact of training (Fairburn & Cooper, 2011). Role-plays have

been utilized for training in a number of ways, though not often to formally assess student progress.

Fairburn and Cooper (2011) suggested that current therapist training methods are not well-suited to train new therapists, due both to cost-effectiveness issues, as well as the need for expert raters and insufficient assessments. Evaluation of trainees' progress, including understanding of the treatment, how to use it appropriately, and actual application of the treatment in a clinical setting, should be taken into account by new training procedures, and standardized role-plays are likely to provide a means of assessing many of these aspects (Fairburn & Cooper, 2011). Muse and McManus (2013) suggest that "standardized role-plays have the potential to provide a sensitive, focused and practical assessment of therapists' skill and are thus a priority for further investigation," despite the fact that "little progress has been made in assessing therapists' CBT skills within clinical role-plays" (p. 495). Fairburn and Cooper also suggested that role-plays may be a better method to assess therapist competence than rating actual therapy sessions.

Puspitasari, Kanter, Murphy, Crowe, and Koerner (2013) asserted that role-play assessments may actually be more efficient than observer-ratings of therapy sessions because role-plays "can guarantee that key skills are assessed by prompting the therapist to use specific skills during the role-play, rather than relying on the hit-or-miss occurrence of skills in sessions, potentially requiring a wide range of sessions to be coded" (p. 260). Role-play assessments often require trainees to act out structured clinical scenarios that can be chosen from among a battery of different scenarios so as to be

“representative of the treatment’s core strategies and procedures, and to involve patients of varying difficulty” (Fairburn & Cooper, 2011, p. 377). Standardized role-play assessments may be an important means to assessing ability to apply knowledge of treatment prior to work with real clients, despite some criticism regarding the feasibility of role-plays related to the resource requirements of developing and implementing role-play assessments (Kaslow et al., 2009).

**Research on role-play and demonstration assessments.** Despite a renewal of interest in the use of role-plays for training, this method of training assessment is not new. Some of the earliest helping skills training protocols utilized role-play and mock client assessments. Ivey, Normington, Miller, Morrill, and Haase (1968) concluded that new therapists just beginning graduate training could learn three basic microskills, including attending behavior, reflection of feeling, and summarization of feeling. Each of these microskills was measured independently in three separate mock client interviews, assessing separate modules aimed at training new therapists each skill (Ivey et al., 1968). Mock interviews for each training module were conducted pretest and post-test utilizing students as mock clients. Mock clients were given a brief description regarding how to present problems in each session. Five-minute pretest videos were followed for the training group, but not the control group, by extensive training including self-study of a training manual, effective and ineffective video modeling, and additional recordings of short (3-5 minutes) role-play practice videos were conducted, followed by critique sessions for each video (Ivey et al., 1968). The training group and the control group conducted a five-minute post-test video with the original client, and raters evaluated the

study (Ivey et al., 1968). Various reliability techniques were used, including inter-rater reliability, interjudge reliability, and test-retest reliability, with moderate to high results for all three studies, and rater-agreement of microskill use or non-use based on rating of a transcript was found to be significant for all three studies (Ivey et al., 1968). Utilizing trend analysis on the second and third studies, trainees mean-ratings were shown to increase significantly from pretest to post-test (Ivey et al., 1968). A self-report measure was also conducted to measure counselor effectiveness from the client's perspective in the second and third study, and a counselor self-report was also conducted in the third study, demonstrating increasing means for both self-report forms in both studies (Ivey et al., 1968). Other studies followed this initial investigation and began adding more interventions including open-ended questions, paraphrasing, and activity skills, as well as re-testing methods of the initial study (Ivey & Authier, 1978). Studies have continued to reiterate that the microskills approach is an effective means of training basic helping skills to new counselors.

In the context of psychotherapy, role-plays are commonly used for training and the demonstration of developing skills, but have been used less often as a means of formally assessing competence. For example, Muse and McManus (2013) found only one study utilizing role-plays to assess Cognitive-Behavioral Therapy competence. This study, conducted by Sholomskas et al. (2005), used a multi-method approach to determine the development of core Cognitive-Behavioral Therapy interventions among three training conditions, (1) manual review, (2) manual review plus internet training, and (3) manual review plus didactic seminar and supervised casework. The one-hour role-

play portion of this study was conducted by trained therapists who used a script to play the role of a client with substance abuse concerns in order to video-record trainees' demonstrations of interventions, which were later rated by an independent rater trained to rate sessions utilizing an item scale drawn from the Yale Adherence and Competence Scale (Sholomskas et al., 2005). Unfortunately, reliability and validity were not adequately established for this role-play assessment, though outcomes indicated that participants in condition 3 (manual + didactics + supervision) demonstrated statistically significant improvement in adherence and skills competence on two out of three role-plays compared with condition 1 (manual only), with condition 2 (manual + web-based training) demonstrating intermediate results (Sholomskas et al., 2005).

Sholomskas and Carroll (2006) conducted a similar study which utilized a role-play assessment to measure the impact of two conditions of therapist training in twelve-step facilitation, (1) manual only and (2) manual plus computer assisted training. In this study, Sholomskas and Carroll utilized mock-clients simulating specific scenarios in which trainees had to demonstrate five core twelve-step facilitation skills. Further, role-play assessments were video-recorded prior to training and three-weeks post training, and were assessed by raters utilizing the Yale Adherence and Competence Scale, who were blind to training protocol. Participants were also given a knowledge test drawn from the Twelve-Step Facilitation manual pretest and post-test. The outcome of this study suggested that participants in condition 2 (manual + computer-assisted training) demonstrated significantly higher adherence, skill competence, and knowledge scores

post-training than participants in condition 1 (manual only) (Sholomskas & Carroll, 2006).

Puspitasari et al. (2013) conducted two studies to determine newly-trained therapists' adherence to Behavioral Activation skills and the feasibility of disseminating online training of three core mechanisms of Behavioral Activation. In the first study, eight experienced post-graduate trainees reported on their use of skills in clinical practice with real clients and their satisfaction with training procedures, reporting increased in-session use of Behavioral Activation strategies (Puspitasari et al., 2013). In the second study, self-report procedures were replaced with an objective role-play assessment, Behavioral Activation Skills Assessment (BASA), measuring skill implementation of nine post-graduate trainees, seven of whom were experienced, licensed therapists, and one was a therapist-in-training. Measurements for both studies were conducted before, immediately after, and several weeks post-training. Results from the first study indicated that students use of two out of the three core Behavioral Activation strategies improved significantly, as did overall Behavioral Activation skill use immediately post-training, and was maintained at two week follow-up (Puspitasari et al., 2013).

In the second of these trials, Puspitasari et al. (2013) utilized role plays to train and to assess Behavioral Activation skill development, utilizing a "rapid-fire" role-play activity during which students were asked to act in the role of a therapist for short one-minute segments to rehearse strategies which they had learned as complex behaviors broken down into sets of microskills. A standardized role-play, lasting one hour, was developed to assess the acquisition and maintenance of these behavioral interventions,

and was conducted by phone (Puspitasari et al., 2013). Trained research assistants acted as depressed individuals and prompted trainees, by means of comments natural to a therapy setting, to employ specific skills. The research assistants later rated audio recordings of the therapists' demonstration of skills utilizing the BASA rating scale (Puspitasari et al., 2013). Results indicated evidence of reliability of the BASA, and improvement in behavioral interventions for the majority of trainees, and "gains were either maintained or increased for 50% of the participants" at six week follow-up (Puspitasari et al., 2013, p. 262). Participants likewise reported increased use of Behavioral Activation interventions with their actual clients in the second trial (Puspitasari et al., 2013).

Pomerantz (2003) conducted a study in which students studying theatre played clients with psychotherapy students. Results from two consecutive cohorts indicated that students highly valued the both participation and observation of the role-plays as a positive educational experience (Pomerantz, 2003). DiMino (2009) suggested the use of an experiential role-play technique called mimesis for training in countertransference, during which psychotherapy trainees acted out scenes from works of literature that portray psychotherapeutic dilemmas. A group role-play training exercise has been described by de Shazer (2005) to help students work with a key intervention in Solution-Focused Brief Therapy. With one student as an observer and another student role-playing a client, three or four additional students ask a few follow up questions to the key intervention, "What needs to happen here—in our work together—so that you know that

coming here has been worth it to you?” preceded or followed by another variation on the same question (de Shazer, 2005, p. 71).

Role-play assessments may additionally help prevent major ethical problems related to the readiness of trainees for practicum and internship, and the responsibility of training programs to properly assess trainees’ competence prior to allowing them to begin work with real clients, so as to avoid harming clients. The failure of programs to utilize reliable and valid measures to ensure that trainees are ready for work with clients would place the responsibility for client harm on the training program. Though evaluating actual therapy sessions is the only way researchers can obtain a direct assessment of the quality of treatment (Fairburn & Cooper, 2011), role-plays may function as an important preliminary assessment, mimicking actual treatment sessions, and providing trainers with the ability to judge trainees readiness to begin treating actual clients.

### **Methods of Rating Psychotherapy Training**

Therapists’ competence and acquisition of specific therapy skills has traditionally been measured in a variety of ways, each containing benefits and risks. Many training programs utilize an observer rating system with either real or simulated clients. Observer-ratings, particularly those in which the therapists being rated are unknown to the observers, have been deemed by many researchers as the most scientifically rigorous approach (Barber, Sharpless, Klostermann & McCarthy, 2007; Chevron & Rounsaville, 1983; James, Blackburn, Milne & Reichfelt, 2001; Miller, 1990; Roth & Pilling, 2008). Muse & McManus (2013) characterized the assessment of a therapist’s ability to deliver cognitive-behavioral interventions as aimed at determining whether a trainee can

demonstrate “independent judgment and critical thinking to appropriately and effectively deliver CBT interventions within the cultural and organizational context of clinical practice settings” (p. 490). Of all the assessment methods, direct independent assessments by raters have been most often considered to be the gold standard of assessing clinical competence (Muse & McManus, 2013).

**Observer-rated training methods.** In addition to commonly being understood as the gold standard of competence assessment, observer-rating systems are one of the most commonly used means of assessing therapist competence (Muse & McManus, 2013). For example, many observer-rating scales have been constructed to measure competence in Cognitive-Behavioral Therapy, including the Cognitive Therapy Adherence and Competence Scale (Barber et al., 2003), the Multicenter Collaborative Study for the Treatment of Panic Disorder – Global Competence Item (Huppert et al., 2001), the Manual-Assisted Cognitive Behaviour Therapy Rating Scale (Davidson et al., 2004), the Yale Adherence and Competence Scale (Carroll et al., 2000), the Cognitive Therapy Scale (Young and A. T. Beck, 1980) and several variations of the Cognitive Therapy Scale, e.g., the Cognitive Therapy Scale – Revised (Blackburn et al., 2001) and the Cognitive Therapy Scale – Psychosis (Haddock et al., 2001).

According to Muse and McManus (2013), however, despite the fact that assessor ratings of therapists’ clinical skills are the most widely utilized means of assessing competence and adherence, many of the standardized instruments continue to have problems, including issues with reliable and valid use in applied settings, confusion regarding the concept of competence, and problems with poor inter-rater reliability and

feasibility. Fairburn and Cooper (2011) further stated that using the observer rating method “has proved difficult to define, operationalize, and demarcate the aspects of treatment of interest with the result that inter-rater reliability has been less than satisfactory” (p. 374). Additionally, establishing validity has been problematic such that rating scales may not be measuring what researchers are designing them to measure, and formal protocols and thresholds for competence on most scales likewise have not been adequately established (Fairburn & Cooper, 2011). These issues lead to conclusions about treatments, drawn from limited data, being generalized and possibly misleading future researchers and therapists (Fairburn & Cooper, 2011). Muse and McManus (2013) noted that even with the widely used Cognitive Therapy Scale, minimum scores for competence are generally arbitrary, and empirically-validated cut-offs are needed based on item means instead of total scores. While some researchers have placed adequate emphasis on the psychometrics of rating scales, the use of experts for establishing content validity, and protocol for establishing predictive validity, but more research is needed (Muse & McManus, 2013).

Despite these limitations, the use of observer-ratings has many potential benefits, including identification of global and item-specific competence, utilizing cut-off standards for competence that can be helpful in establishing the results of training, to offer feedback for trainees, and assessments of competence by ratings are less likely to be influenced by practice effects (Muse & McManus, 2013). Assessment of not only prescribed, but also proscribed therapeutic behavior, is another benefit of observer ratings. In their explanation of proscribed procedures, Schoenwald et al. (2011) offers the

following example: Though dream interpretation is not expressly forbidden in manuals of Cognitive-Behavioral Therapy for anxiety, since it is not listed by the manual as a technique for anxiety treatment, dream interpretation can clearly be understood to be proscribed, a deviation from manualized treatment, reducing integrity. Research using other forms of assessment (e.g., therapist or client report) is likely to overlook these proscribed behaviors.

On the other hand, reliability and validity of rating methods have not always been adequately established beyond research settings, some confusion still remains about what competence entails and what are appropriate cut-offs for competence, though adding assessors, standardizing assessment items and procedures, and in-depth assessor training can aid in reducing the impact of these issues (Muse & McManus, 2013). Further, no consensus exists regarding whether adherence and competence should be measured simultaneously or separately, and this is reflected in many of the assessment scales (Muse & McManus, 2013). Schoenwald et al. (2011) suggested that two issues are vital when considering the measurement of integrity by means of observer-ratings of treatment, namely “the accuracy of the coding or rating of therapeutic interactions in accordance with the treatment components and the coding or rating, ordinal or categorical, must be turned into interval scale measures” (p. 36). Additionally, many sources of variance go into observers scores, including scale items, therapists, clients, client-therapist interactions, factors related to raters and rating methods, and the context in which the therapy is conducted, among other factors, and these sources of variance should be taken into account when using an observer rating system (Schoenwald et al., 2011).

**Client-rated and client-outcome assessments of training.** While rated training sessions have been considered by many to be the standard for measuring training effectiveness, some researchers have emphasized client-report and client outcome measures as crucial. Some researchers argue that clients' perspectives have been overlooked (McCarthy & Barber, 2009) and that clients' evaluation of the therapy has a direct impact on the effectiveness of therapy and the types of interventions that will be most beneficial (James et al., 2001; Paivio, Holowaty & Hall, 2004; Pesale & Hilsenroth, 2009). Client outcome measures were once considered the standard and client improvement is still an expected outcome after the completion of training (Ford, 1979). However, as variables other than therapeutic interventions could be responsible for client improvement, many researchers have emphasized the need for more research aimed at connecting intervention to outcome. (Barber et al., 2007; Barnfield et al., 2007; Milne et al., 1999). Researchers who have utilized patient outcomes to assess trainees' competence generally do so by inferring that counselors with higher levels of competence are more likely to bring about better client outcomes (Muse & McManus, 2013). Some concerns related to inferring competence from client outcome include the inability of current outcome methods to account for idiosyncratic characteristics and the process of change undergone by clients, and generally outcome results have only been available for a small number of clients of individual therapists at any given time, therefore competence has been based on only a few clients' outcomes (Fairburn & Cooper, 2011; Muse & McManus, 2013).

## **Helping Skills Training Research**

Lee, Zingle, Patterson, Ivey, and Haase (1976) developed the Microcounseling Skill Discrimination Scale (MSDS) which was designed to measure trainees' ability to differentiate between effective and ineffective verbal (reflection of feeling and paraphrasing) and nonverbal interventions (eye contact, leaning-in, facial expression, and distance from client) used within the context of microskills training. This measure used a 7-point Likert scale ranging from ineffective skill usage to effective skill usage, and students rated transcripts and video recordings of therapy skills deemed effective or ineffective by microskills experts (Lee et al., 1976). Overall, significant differences between trained and untrained groups indicated that it is possible to teach new therapists to "discriminate between effective and ineffective helping responses" (Lee et al., 1976, p. 469). Further, results indicated that trainees were specifically more capable of recognizing the effectiveness of nonverbal interventions and reflection of feeling, whereas both trained and untrained raters scored similarly on recognition of the effectiveness of paraphrasing, generally considered a more elementary skill (Lee et al., 1976).

Baker and Daniels (1989) conducted a meta-analysis of microskills training research which identified 146 studies, 81 of which were considered sufficiently constructed to accurately yield an effect size, utilizing a variety of rating instruments. Results indicated that microskills were effective as a therapy education program, as indicated by mean effect size differences in comparison to other forms of training (e.g. Interpersonal Process Recall, empathy training, sensitivity training), and all studies in the

analysis displayed a significant overall effect size. The studies identified in this review utilized the microskills approach incorporating teaching specific skills with integrated practice, modeling of skills, and microskills session practice with review and feedback to reinforce learning (Baker & Daniels, 1989).

Russell-Chapin and Sherman (2000) developed the Counseling Interview Rating Form in order to “provide a means to quantify the counselor’s effective use of microcounseling skills...as an essential part of the training process” (p. 116). The Counseling Interview Rating Form has been used as a tool for evaluation by supervisors and peers, as well as for self-evaluation. Interventions are rated on a 3-point scale (1- basic mastery, 2- active mastery, 3-teaching mastery) with higher scores reflecting higher competence. Frequency of intervention use is also recorded. The interventions included in the scale were adopted from Ivey’s microskills model and one category was added for rating the counselor’s level of professionalism. Five psychotherapy educators were asked to determine the validity of the scale and content validity index coefficients were calculated for each section of the form based on their responses to a 5-point Likert scale indicating whether each section was (1) not representative to (5) very representative of the necessary interventions in microskills training, with all sections except professionalism found to demonstrate significant validity scores (Russell-Chapin & Sherman, 2000). Reliability was tested by five therapists-in-training rating four videotapes of microskills counseling sessions and analyzed with agreement coefficients suggesting that the form could be reliably used (Russell-Chapin & Sherman, 2000). The researchers concluded that the preliminary validation data suggested that the Counseling

Interview Rating Form is adequate for measuring microskills used by new therapists (Russell-Chapin & Sherman, 2000).

### **Empirically-Based Psychotherapy Training Research**

**Cognitive Therapy.** In order to measure the integrity of Cognitive-Behavioral Therapy, Young and A. T. Beck (1980) developed the Cognitive Therapy Scale, which can help researchers and supervisors ascertain therapists' strengths and weaknesses related to specific therapeutic interventions as rated by observers on a 7-point Likert scale, 0 indicating failure to utilize cognitive interventions and 6 indicating proficiency with cognitive interventions. The psychometric properties of the scale were investigated by Vallis, Shaw, and Dobson (1986) who demonstrated that the scale could accurately be used to evaluate therapy competence and was "sensitive to variations in the quality of therapy" (p. 318). Item-total correlations were moderate to high for items in relation to both the general skills subscale and the cognitive therapy skills subscale and the two subscales were found to have significant, high correlations (Vallis et al., 1986). Interrater reliability of five raters showed mixed results as only one rater produced significant reliability, and correlations for individual items remained low to moderate, leading to questioning of subscales (Vallis et al., 1986). In summary, Vallis et al. suggested that the Cognitive Therapy Scale is generally used with moderate reliability.

Updating the Cognitive Therapy Scale, so as to more reliably measure the integrity of Cognitive Therapy, Blackburn et al. (2001) developed the Cognitive Therapy Scale – Revised. The aim of the Blackburn et al. (2001) study was to update the Cognitive Therapy Scale so as to be more useful for measuring skill acquisition,

therapeutic alliance, and to better establish the psychometric properties of the scale. Observers viewed taped sessions and rated trainees pre-training and post-training on 14 items using a 7-point Likert scale. The Cognitive Therapy Scale – Revised eliminated some overlap between items by collapsing subscales, more clearly distinguishing between identifying key cognitions and focusing on key cognitions (which overlapped with the general application of cognitive techniques subscale), as well as adding two new items including counselor charisma and facilitation of emotional expression and an optional 14<sup>th</sup> item, use of non-verbal behaviors (Blackburn et al., 2001). Trainees demonstrated significant improvement in adherence and competence scores from before to after training. Evidence also suggested adequate reliability and validity for the measure. Cronbach’s alpha coefficient was calculated for 13-item and 14-item versions with high internal consistency for both versions, though higher when excluding the non-verbal behavior item (Blackburn et al., 2001). Interrater reliability of four raters indicated significant reliability, and correlations averaged for four raters were found significant, further suggesting the reliability of the scale (Blackburn et al., 2001).

**Emotion-focused therapy.** Paivio and Nieuwenhuis (2001) investigated the effectiveness of Emotion Focused Therapy (EFT) for child abuse survivors, using the EFT-checklist to measure adherence to interventions from EFT for adult survivors of child abuse protocol. The checklist, which was developed by Paivio (1996), included 11 categories of EFT interventions such as focusing on internal experience, symbolizing the meaning of events, increasing arousal, and evoking memory; and one category for non-EFT interventions such as collecting information, interpretations, and skills training

(Paivio & Nieuwenhuis, 2001). Twenty therapists worked with 34 clients over the course of approximately 20 sessions. Four 20-minute video segments were randomly selected for each therapist-client dyad from sessions at different points spread over the course of treatment, and raters assessed treatment to demonstrate high levels of adherence. Additionally, interrater reliability of two coders independently rating 37 sessions was analyzed, with high, significant agreement reported for the checklist, suggesting reliable use (Paivio & Nieuwenhuis, 2001). Outcome assessments were conducted pretreatment, post-treatment, and at 9-month follow-up, with significant results compared to a waitlist group, suggesting the effectiveness of EFT for child abuse survivors (Paivio & Nieuwenhuis, 2001).

Denton, et al. (2009) developed and validated the Emotion-Focused Therapy-  
Therapist Fidelity Scale (EFT-TFS) to measure the integrity of Emotion-Focused Couples  
Therapy and for use “in training settings to assess therapist development and provide  
feedback to therapists” (p. 227). Each of 13 items of the EFT-TFS are rated on a 5-point  
Likert-type scale with anchor points and each item represents a skill, including alliance  
building, validating each partner, reframing problems in terms of the cycle, managing  
interactions, processing emotion, working with primary responses and defensive  
responses, placing new emotions into the cycle, using enactments, maintaining focus,  
addressing attachment needs and fears, following the stages of Emotion-Focused Couples  
Therapy and consolidating change and new narratives (Denton et al., 2009). Copies of the  
EFT-TFS were distributed to EFT-trained counselors who were asked to rate how  
essential, important, and necessary they considered items of the scale using a 7-point

Likert-type scale, and results indicated that the three questions were understood in “a very similar fashion” (Denton et al., 2009, p. 229). These scores were then averaged and overall mean scores for the 13 items of the EFT-TFS indicated that all items were regarded by participants as significantly important (Denton et al., 2009).

**Behavioral therapy.** Busch, et al. (2009) investigated the micro-process of Functional Analytic Psychotherapy, from which Behavioral Activation is derived, conducting a case-study and developing the Functional Analytic Psychotherapy Rating Scale (FAPRS) in order to rate “every client and therapist turn of speech over the course of successful treatment” (p. 280). The FAPRS consisted of four client codes: (1) statement of a functional problem; (2) statement of a functional improvement; (3) focus on the therapeutic relationship; (4) other client talk; and six counselor codes: (1) evoking clinically relevant behavior; (2) shaping a functional problem; (3) shaping a functional improvement; (4) ineffective response to client’s relevant behavior; (5) focusing on the therapeutic relationship, and (6) other counselor talk (Busch et al., 2009). Client codes were utilized due to the claim of Functional Analytic Psychotherapy that “client problem behaviors will be displayed in the therapeutic relationship” (Busch et al., 2010, p. 11). Results from the case study indicated that the use of functional analytic techniques improved the client’s in-session behavior, and that client behavior in general was influenced by functional analytic strategies. Reliability was established using kappa scores with counselors codes, indicating acceptable levels of agreement between coders (Busch et al., 2009). Busch et al. (2010) replicated and extended the previous study on FAPRS, for the purpose of drawing particular emphasis to Functional Analytic

Psychotherapy's key mechanism of change in the therapy session, namely that changing client's behaviors in session can be generalized to behaviors out of session. Using the FAPRS, results indicated that therapist interventions led to client improvement and behavior change beyond treatment (Busch et al., 2010).

**Cognitive-behavioral therapy.** Rakovshik and McManus (2010) conducted a review of the theoretical underpinnings and the empirical research of Cognitive-Behavioral Therapy training, in order to demonstrate the relationship between training and client outcome. This review included 41 studies from 35 clinical trials over the previous 10-year period utilizing a variety of different measures to assess competence in cognitive and behavioral techniques, including the Cognitive Therapy Scale, Cognitive Therapy Scale – Revised, Yale Adherence and Competence Scale, and other related scales, most of which utilized observer-rated scales for competence and/or adherence, as well as client outcome measures (Rakovshik & McManus, 2010). One significant finding related to length of training and client outcome. Studies were divided according to amount of training administered and client outcome. Client outcome was divided into the following three categories: (1) Achieving outcome comparable to efficacy trials; (2) Significant positive impact; or (3) No significant patient outcome (Rakovshik & McManus, 2010). Hours of training decreased with client outcome category, such that more training was indicative of better client outcomes (Rakovshik & McManus, 2010). Limitations recognized in this review related to clarifying definitions and methods, and most importantly, the need to utilize a more scientific approach to researching Cognitive-Behavioral Therapy training (as done in treatment studies), and using the evidence

collected regarding mechanisms of change to inform dissemination practices (Rakovshik & McManus, 2010).

**Motivational interviewing.** Motivational Interviewing (MI) is a psychotherapy model which was first applied to problem drinking in 1983 and has since become the subject of extensive amounts of research on training and this research provides many exemplary lessons that can be applied to the current study (Arkowitz, Westra, Miller, and Rollnick, 2008). Training in Motivational Interviewing begins with basic helping skills and focuses on building client awareness of discrepancies between their actions and values without the use of confrontation, thereby supporting self-efficacy and increasing the desire to change (Arkowitz et al., 2008; Miller et al., 2002; Rosengren, 2009). Barsky and Coleman (2001) developed the Motivational Interviewing Process Code to evaluate the competence of trainees acquisition of a set of Motivational Interviewing skills for the treatment of drug addiction. The scale was developed through the collection of data from Motivation Interviewing experts and focus group discussions. The completed measure consisted of a list of functional skills (e.g. expresses faith that client will make the right decisions, helps client with goals, and helps client identify barriers to change) and a list of dysfunctional skills (e.g. argues with client, confronts denial or resistance with advice, blames client for problems or lack of change) rated on a 5-point scale, with higher scores indicating higher competence and avoidance of dysfunctional skills, respectively (Barsky & Coleman, 2001).

Moyers, Martin, Manuel, Hendrickson, and Miller (2005) developed and evaluated the Motivational Interviewing Treatment Integrity scale, which assesses

Motivational Interviewing competence by rating therapists' in-session behaviors. Exploratory factor analysis was used to divide interventions from the skills code into 10 global dimensions such as the spirit of Motivation Interviewing, empathy/understanding and complex reflections (Moyers et al., 2005). Inter-rater reliability was analyzed, resulting in moderate to excellent levels of reliability across all domains, suggesting adequate level of reliability for use of the Motivational Interviewing Treatment Integrity scale (Moyers et al., 2005). Madson, Campbell, Barrett, Brondino, and Melchert (2005) developed and evaluated the Motivation Interviewing Supervision and Training Scale (MISTS), a scale for observers or supervisors to rate trainees according to 16 items divided into three categories including listening skills, spirit of Motivational Interviewing skills, and overall ratings. The MISTS "includes two components: (a) behavioral count of the types of counselor responses uttered during sessions and (b) a 16-item global rating of the quality, Motivational Interviewing integrity, and effectiveness of therapist interventions" (Madson et al., 2005, p. 305). Scores from three raters were calculated from a 7-point Likert scale, and interrater reliability of the MISTS was satisfactorily established (Madson, Campbell, Barrett, Brondino, et al., 2005).

MI training has also undergone a recent systematic review conducted by Madson, Loignon, and Lane (2009), which included 28 studies from the previous 10 year period. A variety of different measures to assess the integrity of Motivational Interviewing were used, with most studies using a knowledge measure, an observer-rating system to measure integrity, and some type of client outcome measure (Madson et al., 2009). This review indicated limitations in the research related to workshop training formats and skill

maintenance over time, lack of thorough descriptions and potential difficulties with construct and test validity, evaluation of only a limited repertoire of Motivational Interviewing skills, the need for further research concerning Motivation Interviewing training in practicum settings, and the need for psychometrically evaluated measures of Motivation Interviewing knowledge, attitude, self-confidence, and self-efficacy as it relates to the application of interventions (Madson et al., 2009). The research on Motivational Interviewing training suggests the importance of investigating functional or target skills as well as dysfunctional or non-target skills. This line of research also suggests the importance of investigating integrity in a variety of ways, establishing the reliability and validity of scales, using multiple sources to rate trainees, and measurement of both global and intervention specific competence.

**Process-oriented rating.** Another method of therapy assessment, focusing on the overall process of therapy sessions, is the Psychotherapy Process Q-set. The Q-set is a 100-item rating system, which was designed as a descriptive measure for illuminating the process of psychotherapy at an individual session level (Albon, Levy, & Smith-Hansen, 2011). This system forces raters to categorize cards representing 100 characteristics of psychotherapy, understood to be essential components of a variety of different psychotherapy modalities, in one of nine categories ranging from (1) extremely uncharacteristic or negatively salient to (9) extremely characteristic or salient, with pre-set numbers of cards which must be utilized in each category; for example, category five – relatively neutral or unimportant must have 18 cards, whereas categories one and nine, must have five cards (Albon, Levy, & Smith-Hansen, 2011). Evidence of adequate

reliability and validity has been demonstrated in a number of studies with many treatment modalities including psychodynamic, client-centered, gestalt, cognitive-behavioral, rational-emotive behavior therapy, and interpersonal psychotherapies (Ablon & Jones, 1999, 2002; Albon, Levy, & Smith-Hansen, 2011; Jones, Hall, & Parke, 1991; Jones & Pulos, 1993; Serralta et al., 2010).

**Integrative Psychotherapy.** McCarthy and Barber (2009) developed the multitheoretical list of therapeutic interventions (MULTI), which “assesses interventions from eight different psychotherapy orientations and from the perspective of clients, therapists, and observers,” and can be used for a variety of applications (p. 96). The MULTI is comprised of 60 items divided into 8 subscales according to theoretical orientations; example items include visualizing specific scenes in detail (Behavioral), exploring alternative explanations for events (Cognitive), becoming aware of aspects of life without judging them (Dialectical-Behavior), focusing on relationship conflict or loss of a loved one (Interpersonal Psychotherapy), showing interest in understanding client’s experience (Person Centered), focusing on childhood experiences (Psychodynamic), focusing on disagreements between certain parts of client’s personality (Process-Experiential), and offering hope and encouragement (Common Factors) (McCarthy & Barber, 2009). Items of the MULTI (e.g. “I worked to give my client hope or encouragement.”) are rated on a 5-point Likert scale ranging from 1 (Not at all typical of the session) to 5 (Very typical of the session) (McCarthy & Barber, 2009, p. 111). Reliability of the scale was assessed using Cronbach’s  $\alpha$  and confirmatory factor analysis showing moderate to high significant reliability results and adequate fit for all factors

(McCarthy & Barber, 2009). Predictive discriminant analysis was also used to evaluate validity in terms of the scale's ability to predict a counselor's theoretical orientation with an apparent error rate for classification ranging between 10% and 12% (McCarthy & Barber, 2009).

### **A Multi-Method Approach to Assessment**

Many of the studies reviewed above have utilized multiple methods, at times simultaneously, in order to assess integrity thoroughly. Muse and McManus (2013) stated that the “paucity of research examining the reliability and validity of current methods of assessing CBT competence...means that it is currently not possible to make evidence-based recommendations about how best to assess CBT competence” (p. 495). Of particular importance, according to Muse and McManus, is establishing the predictive validity of these assessments, and they suggested assessing CBT competence by means of a multi-method approach addressing the domains delineated by Miller (1990). According to Muse and McManus, “Given the complex, multi-faceted nature of CBT competence, multi-method assessments may ultimately be necessary in order to provide adequate assessment of all aspects of CBT competence, with limited packages being implemented in different settings according to resource availability” (p. 496).

Other researchers reject the idea that observer ratings or client outcome are simply the best methods for assessing training integrity, and as Sharpless and Barber (2009) pointed out, since no method has consensus across the field, many researchers advocate a multi-method, multi-trait, and multi-informant methods (Kaslow et al., 2007; Kaslow et al., 2009; Sharpless & Barber, 2009). Many of these methods for measuring training

effectiveness have been combined in order to assess the training process. Clemence, Hilsenroth, Ackerman, Strassle, and Handler (2005) investigated client and counselor perspectives of therapy in relation to client outcome. Barber et al. (2007) studied observer-rated intervention competence in relation to client outcome. Barnfield et al. (2007) researched the relationship of observers, trainees, and supervisors' assessments of trainees' competence. McCarthy and Barber (2009) examined the perception of counselors, observers, and clients on interventions utilized by counselors.

Further, evidence has suggested that the more complex therapeutic interventions being rated, the harder they are to distinguish, and therefore, the greater the need for more experienced assessors (Muse & McManus, 2013). Muse and McManus suggested that the "level of independence and expertise...required by those making the ratings" is not known (p. 493). Some research suggests that supervisors may even rate trainees more highly than independent raters, but which are more accurate remains to be established, as does the minimum number of sessions needed to reliably assess competence (Dennhag, Gibbons, Barber, Gallop, & Crits-Cristoph, 2012).

### **Assessing KST using a Multi-Method Approach**

The Key Strategies Training (KST) method was designed to train therapists to develop intermediate proficiencies for psychotherapeutic practice, including foundational knowledge of three empirically-based treatments (Cognitive Therapy, Behavioral Activation, and Emotion-Focused Therapy), knowledge of how to use interventions drawn from these evidence-based psychotherapies, and initial performance of strategies in preparation for utilizing key strategies with clients. KST trains new therapists in all

four of Miller's (1990) suggested areas of proficiency, though KST only assesses the first three areas as trainees do not begin practice with actual clients until after KST is complete. The current study therefore aims at establishing the feasibility of KST as a training program by utilizing a multi-method approach to discover whether students can understand, know how, and demonstrate (three of Miller's areas of proficiency) the interventions of KST after receiving the training. The second of Miller's categories, which he called competence (practical understanding – "knows how") is understood here to be implicitly established by demonstrating the movement from understanding ("knows") to demonstration ("shows how").

In order to establish that KST is accomplishing what it was designed to accomplish, a reliable and valid measure for assessing knowledge and integrity must be developed. Ford (1979) suggested standards for establishing the validity and reliability of measures for assessing training, stating that "it will be essential to demonstrate that the changes in trainees' functioning that are generated by training interventions do, in fact, produce therapists who consistently provide effective therapy" (p. 90). In some ways, one might conclude that the reliability, and particularly the validity, of integrity assessments depends in large part on how assessments are developed, who is assessing, and the standards developed for assessing thresholds. Ford suggested that split-half or observer correlations should be used to establish reliability of scales, whereas validity should be established by correlation with a previously validated measure or by a sample representative of the population in question (e.g. trainees, counselors). In both cases, it is important to utilize exact operational definitions which do not contain several,

functionally different subcategories, and demonstrating significant effects within each subcategory.

Another major concern related to feasibility, is whether to assess protocols generically, i.e., assessing the basic skills that are the foundation of most techniques within the treatment modality, or in a disorder-specific manner, which more closely follows evidence-based treatment studies but is likely unfeasible as trainees often work with a variety of clients experiencing a variety disorders, not just clients with one disorder (Fairburn & Cooper, 2011; Muse & McManus, 2013). More importantly, perhaps, trainees would seemingly benefit from learning how to apply the intermediate skills of a particular evidence-based treatment before learning the more developed ability of how to apply them to specific disorders, which would suggest that assessments would be beneficial at both points in training, not just one. KST provides an answer to this dilemma, as it aims at developing a system of training to teach new trainees an approach to psychotherapy that targets the developmental level of students in their first semester or year of training, and brings them beyond microskills to evidence-based techniques, thereby filling an important gap in the theory/practice literature.

Along these lines, Muse and McManus (2013) discussed the need for establishing different assessment methods for different points in training, suggesting that a major difference in this regard is between formative assessments, which offer ongoing feedback for self-reflection and learning, and summative assessments, which provide an overall evaluation of competence for a variety of purposes related to accreditation and

qualification, and therefore need to have validity and reliability more strongly established.

The current project goes beyond the suggestion that different training assessment methods are needed throughout training to suggest that an additional type of training is needed to help new therapists connect microskills with evidence-based interventions, ensuring that new therapists know how to deliver strategies prior to work with real clients. This dissertation, therefore, aims at measuring KST at this early stage of development in a multi-trait manner (knowledge, applied knowledge, and ability to demonstrate), utilizing multiple methods (essays and role-plays), with multiple informants (raters and a KST expert rater).

### **Rationale for the Current Project**

The current project was similar to a variety of research studies and methods utilized in the psychotherapy training literature to measure psychotherapy students' development in a holistic fashion, and as such, this project is divided into two studies. The first study was designed to measure students' knowledge (identification and differentiation) of key strategies from pre-training to post-training. The second study was designed to measure students' adherence, practical differentiation, and competence in demonstrating key strategies post-training. Both of these studies rely upon the development of a reliable and valid rating protocol to measure knowledge, adherence, and competence. The Key Strategies Rating Scale (KSRS) is similar to other rating systems in that Section A (KSRS-A) has been designed to measure knowledge acquisition of Key Strategies Training principles through written essays. Section B

(KSRS-B) was designed to measure adherence, practical differentiation, and competence with individual key strategies demonstrated on a role-play assignment. Through these methods, the current study was intended to provide initial evidence of the feasibility and integrity of the KST method. KST was designed to offer a conceptual framework through which a new therapist can intervene from more than one theoretical perspective using practical strategies, and the KSRS aims at tracking the acquisition of these skills, which were drawn from three treatment modalities (cognitive, emotion-focused, and behavioral) targeting the three different areas of functioning within the person (thoughts, feelings, and actions).

### **Support from the Literature**

Researchers have emphasized the need to examine the particulars of treatment and training over the past few decades. Particularly, researchers have attempted to look beyond *if* a treatment works and focus rather on *how* it works. For example, Busch et al. (2009) investigated specific change mechanisms under the supposition that general effectiveness studies have left unanswered questions such as which strategies are capable of being learned, and which strategies are more efficacious for client change. Other researchers have called for evidence-based training as rigorous as evidence-based therapy trials, focusing on discrete training interventions, and suggesting the creation of methodologies more capable of accuracy and comparison of specific interventions of training (Ravovshik & McManus, 2010).

Basic helping skills researchers (Ivey & Ivey, 2009; Ivey, Ivey, & Zalaquett, 2013) have dissected the pieces of common factors therapy for many decades, however,

these studies have not thoroughly integrated their deconstructive efforts with the strategies of popular evidence-based psychotherapy modalities. And while studies have provided evidence of the effectiveness of training in specific microskills and the general microskills system, “students perform better on the basic skills than on the advanced skills,” which requires further training in order to achieve competency in these advanced skills (Kuntze, van der Molen, & Born, 2009). The current study aimed at providing initial evidence for the feasibility of KST as a system of psychotherapy training which can fill the gap between helping skills training and evidence-based interventions by helping trainees connect the dots between the two. Specifically, students in this study were trained to use microskills in the construction of specific strategies for recognizing and exploring maladaptive cognitive, affective, and behavioral processes, as well as transforming these processes. KST was designed to utilize a parallel structure (see Table 1), which provides trainees with a framework for transitioning from microskills to evidence-based modalities, easy access to 24 strategies from three widely-used evidence-based psychotherapy modalities, and a flexible structure to help new therapists understand process in treatment, thereby guiding clients progressively from exploration toward transformation. The key strategies of KST, however, should be understood as intermediate, foundational strategies drawn from these three evidence-based modalities. As such, the key strategies represent intermediate strategies between microskills and the strategies of full evidence-based psychotherapy systems. These strategies target a vital gap, which researchers of KST understand as a crucial oversight in the current psychotherapy training.

The KSRS was developed as an assessment tool for measuring trainees' development in KST, i.e., the KSRS was designed to measure therapists' development of intermediate skills, which are understood to bridge the gap between basic helping skills and evidence-based strategies. Specifically, the KSRS was used to gather data, by means of observer-ratings, to measure the knowledge, adherence, and competence of interventions taught by KST. Further, the KSRS was designed specifically for rating essays and therapy with role-play clients.

Researchers have continually expressed the need to measure individual interventions rather than stop at the measurement of general efficacy in treatment and training, creating rating-scales and other types of measures by which this may be accomplished (Denton et al., 2009; Freiheit & Overholser, 1997; McCarthy & Barber, 2009; Young & A. T. Beck, 1980). Some researchers have developed assessment tools specifically for the collection of data from trainees in order to more adequately understand the actual experience of new therapists in training programs (Freiheit & Overholser, 1997; Levenson and Svatovic, 2009; McCarthy & Barber, 2009). Emphasis has likewise been placed on gathering multiple aspects of trainees' development during training, including measures of knowledge, confidence, self-efficacy, intended use, adherence, and/or competence (Freiheit & Overholser, 1997; Levenson and Svatovic, 2009). Researchers have also developed measures for investigating trainees' development of basic helping skills (Lee et al., 1976; Russell-Chapin & Sherman, 2000), as well as complex skills from specific psychotherapy modalities (Busch et al., 2009; Denton et al., 2009; Freiheit & Overholser, 1997; Levenson and Svatovic, 2009; Madson et al., 2005;

McCarthy & Barber, 2009; A. T. Young & Beck, 1980). Fewer scales have integrated strategies from a variety of EBPs (Carroll et al., 2000; Freiheit & Overholser, 1997; McCarthy & Barber, 2009), and only one scale discovered in this research (McCarthy & Barber, 2009) has incorporated core interventions from all the empirically-based modalities taught by KST.

### **Purpose of the Current Project**

Carroll and Rounsaville (2008) suggested that researchers conduct preliminary feasibility and efficacy treatment studies, prior to conducting larger efficacy and effectiveness trials. The current study was considered a pilot study aimed at establishing the feasibility of using KST to train new therapists, and the ability of trainees to competently adhere to key strategies guidelines. The development of a reliable and valid rating protocol for assessing trainees' knowledge, adherence, and competence was considered to be an important endeavor related to the establishment of the feasibility of KST. Particularly, an assessment tool, which was capable of measuring graduate students' ability to learn interventions drawn from multiple evidence-based psychotherapy modalities, was considered important in the construction of the KSRS, consistent with suggestions offered in previous research (McCarthy & Barber, 2009; Busch et al., 2009).

The purpose of the current project, therefore, was to provide preliminary evidence of the feasibility of KST to train new psychotherapy students to understand and utilize the intermediate interventions of three evidence-based psychotherapy modalities (Cognitive Therapy, Emotion-Focused Therapy, and Behavioral Activation) and a therapeutic

process across two phases of treatment (exploration and transformation) in a competent manner. The development of the KSRS was undertaken as a necessary first step for measuring trainees' understanding and demonstration of skills taught in the KST model. This study contributed to the psychotherapy literature by testing a training and rating protocol measuring trainees' progress in knowledge, adherence, and competence, assessed by raters' focusing on individual interventions of an integrative model of psychotherapy training. Most importantly, the current research supported the feasibility of a new model of integrative psychotherapy training. The KSRS can be used to provide a strategy-level and holistic view of trainee development as well as identifying specific areas of competence related to different phases and modalities of treatment. In this way, the current study addressed the concern in the psychotherapy literature related to individual change mechanisms, by assessing growth on individual interventions. This dissertation also addressed concerns related to measuring trainees' development in a holistic manner over time, while remaining specified to the level of development at which students are currently practicing. By assessing trainees' use of individual interventions, development, and overall performance (holistically), the current study was aimed at establishing the feasibility of the KST model to train new therapists to understand and utilize interventions from three therapy modalities, while addressing the concerns in the psychotherapy training literature related to similar studies.

### **Study A Hypotheses - Essays**

**Identification knowledge.** Study A (essays): Hypothesis one. Students will be able to describe skills from the target modality and phase of KST. The term target was

operationally defined as strategies belonging to the modality and phase of treatment that students were asked to describe or demonstrate. Students will display increased ability to accurately describe key strategies belonging to specific treatment phases (exploration and transformation) and treatment modalities (cognitive, emotion-focused, and behavioral) after receiving KST. Identification ratings of essays will improve from pretest to post-test; students will improve significantly on their essay ratings, indicating increased identification knowledge of key strategies post-training.

**Differentiation knowledge.** Study A (essays): Hypothesis two. Students will describe the target (strategies belonging to the modality and phase students were asked to describe) phase and modality of KST without using descriptions of strategies from the non-target phase or modalities. The term non-target was operationally defined as strategies belonging to a phase or modality other than students were asked to describe. Students will display the ability to differentiate between strategies belonging to cognitive, emotion-focused, and behavioral therapies (modality), as well as strategies belonging to the exploration and transformation phases of treatment on written essays after receiving KST. The post-test KSRS-A scores for the target phase and mode of KST will be significantly higher than non-target scores. In order to ensure the adequate testing of participants' knowledge (identification and differentiation), the raters using KSRS-A will be evaluated for reliability and validity.

**Inter-rater reliability.** Study A (essays): Hypothesis three. Raters utilizing the Key Strategies Rating Scale – A will demonstrate inter-rater reliability. Raters trained to

use the measure will demonstrate consistent performance as indicated by an Intraclass Correlation Coefficient (ICC) demonstrating substantial consistency.

**Criterion-related validity.** Study A (essays): Hypothesis four. Raters utilizing the Key Strategies Rating Scale – A will demonstrate criterion-related validity. Raters' combined scores will demonstrate consistency with the scores of a KST expert on select essays, as indicated by an Intraclass Correlation Coefficient (ICC) demonstrating substantial consistency.

### **Study B Hypotheses – Role-Plays**

**Multidimensional Survey Adherence/Competence.** Study B (role-plays): Hypothesis five. Students will be able to demonstrate specific multidimensional survey skills in a role-play scenario. Students will display the ability, in a role-play, to demonstrate specific skills related to inquiring about three dimensions of client functioning (thoughts, feelings, actions), the interaction of these dimensions, and choosing a focal dimension. The Multidimensional Survey Adherence and Competence Rating Scale (MSACRS) post-test scores for the specific skills will be significantly higher than the scale mid-point, representing a minimal adherence/competence threshold.

**Multidimensional Survey Inter-rater reliability.** Study B (role-plays): Hypothesis six. Raters utilizing the Multidimensional Survey Adherence and Competence Rating Scale (MSACRS) will demonstrate inter-rater reliability. Raters trained to use the measure will demonstrate consistent performance, as indicated by an Intraclass Correlation Coefficient (ICC) demonstrating substantial consistency.

**Multidimensional Survey Criterion-related validity.** Study B (role-plays): Hypothesis seven. Raters utilizing the Multidimensional Survey Adherence and Competence Rating Scale (MSACRS) will demonstrate criterion-related validity. Raters' combined scores will be consistent with the scores of a KST expert on select transcripts, as indicated by an Intraclass Correlation Coefficient (ICC) demonstrating substantial consistency.

**Key Strategies Adherence.** Study B (role-plays): Hypothesis eight. Students will be able to demonstrate skills from the target (strategies belonging to the modality and phase students were asked to demonstrate) phase and modality of KST in a role-play scenario. Students will display the ability to demonstrate key strategies belonging to both treatment phases (exploration and transformation) and a specific treatment modality (cognitive, emotion-focused, and behavioral) during a role-play demonstration. The KSRS-B post-test scores for the target phase and mode of KST will be significantly higher than the scale mid-point, representing a minimal adherence threshold.

**Key Strategies Differentiation.** Study B (role-plays): Hypothesis nine. Students will not demonstrate skills from a non-target (strategies from a modality or phase other than the students were asked to demonstrate) phase or modality of KST on a role-play demonstration. Students will display the ability to practically differentiate between strategies belonging to cognitive, emotion-focused, and behavioral therapies (modality), as well as strategies belonging to the exploration and transformation phases of treatment during a role-play demonstration after receiving KST. The post-test KSRS-B scores for the target phase and modality of KST will be significantly higher than non-target scores.

**Key Strategies Competence.** Study B (role-plays): Hypothesis ten. Students will demonstrate skills from the target phase and modality of KST in a competent manner. Students will display a minimal level of competence demonstrating key strategies belonging to both treatment phases (exploration and transformation) and a specific treatment modality (cognitive, emotion-focused, and behavioral) on role-plays. Students' competence scores on the KSRS-B will be compared to a threshold of competence designated as the scale mid-point. The KSRS-B post-test scores for the target phase and modality of KST will be significantly higher than the scale mid-point, representing minimal competence. In order to adequately test adherence and competence, raters using the KSRS-B will be evaluated for reliability and for validity.

**Key strategies inter-rater reliability.** Study B (role-plays): Hypothesis eleven. Raters utilizing the Key Strategies Rating Scale – B will demonstrate inter-rater reliability. Raters trained to use the measure will demonstrate consistent performance when using the measure, as indicated by an Intraclass Correlation Coefficient (ICC) demonstrating substantial consistency.

**Key strategies criterion-related validity.** Study B (role-plays): Hypothesis twelve. Raters utilizing the Key Strategies Rating Scale – B will demonstrate criterion-related validity. Raters' combined scores will demonstrate consistency with the scores of a KST expert on select transcripts, as indicated by an Intraclass Correlation Coefficient (ICC) demonstrating substantial consistency.

## CHAPTER III

### METHOD

This dissertation utilized two methods to test different aspects of Key Strategies Training (KST). Essays were used to measure two aspects of knowledge (identification and differentiation) (Study A). Role-plays were used to measure adherence, differentiation, and competence in demonstrating key strategies (Study B). Key strategies are defined as any intentional act taken by mental health professionals to “intervene therapeutically with their clients” (Brooks-Harris, 2008, p. 57). In order to measure knowledge, adherence, and competence in KST, the Key Strategies Rating Scale (KSRS) was developed by consulting previous work related to KST (Harris et al., 2014; Kelley, 2011). The KSRS is comprised of two sections. KSRS-A measures students’ knowledge of the KST model, as well as their ability to differentiation key strategies by treatment phase and modality. KSRS-B measures students’ adherence, differentiation, and competence in demonstrating key strategies.

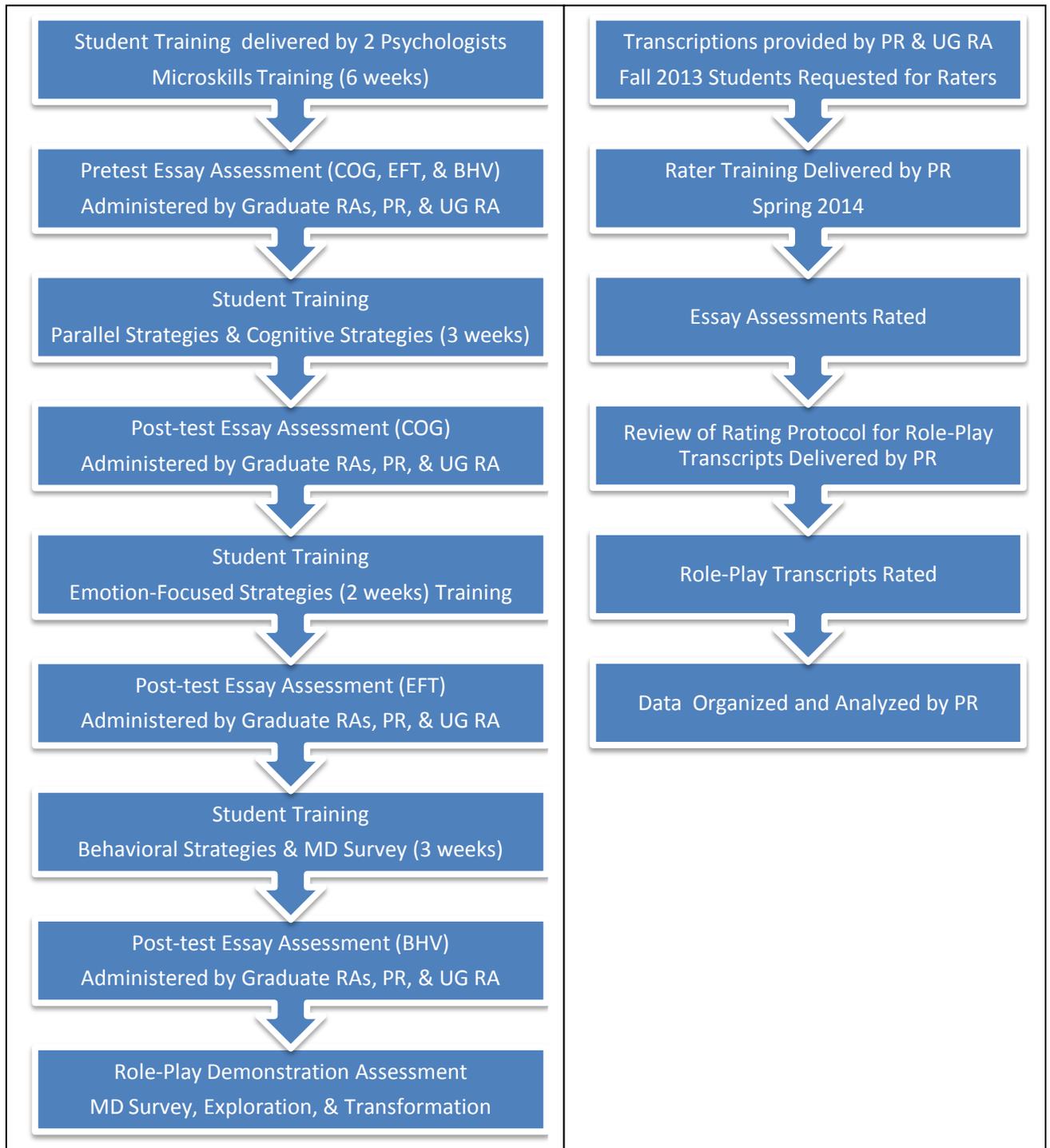


Figure 1. Flow chart for training and rating portions of the current study

## **Study A: Essays Measuring Knowledge**

### **Study A: Essays – Student Participants**

Student participants in the current study included 24 master's-level (M.A.) and doctoral-level (Ph.D.) students in counseling psychology and school psychology recruited from two introductory graduate-level theory and practice of psychotherapy courses at a university in the Southwest U.S. in Fall 2012 and Fall 2013. Participants included females ( $n = 21$ ) and males ( $n = 3$ ), who identified racially/ethnically as White/Caucasian ( $n = 12$ ), Black/African American ( $n = 5$ ), Hispanic/Latina/o ( $n = 4$ ), South Asian/Asian Indian ( $n = 2$ ), and Bi/Multi-racial/ethnic ( $n = 1$ ). Participants included M.A. Counseling Psychology students ( $n = 14$ ), Ph.D. Counseling Psychology students ( $n = 4$ ), and Ph.D. School Psychology students ( $n = 6$ ). The age of participants in the study ranged from 22 to 56 years, with 27.5 years as the mean age of the sample.

Convenience sampling was utilized and selection criteria included enrollment in a graduate-level psychotherapy course that incorporates theory and practical training in KST. A course devoted to training students who were beginning studies in psychotherapy was selected, as this study aimed at establishing the feasibility of KST to train students to understand and demonstrate therapeutic interventions. Participants were expected to vary in regards to their preferences for and exposure to particular treatment modalities, including previous education in different theories and interventions. Graduate students participating in this study were also expected to vary in their amount of therapeutic experience, including semesters of practicum, and additional practice in the field beyond practicum. For example, some first-year masters-level students had no experience

providing psychotherapy, while some doctoral students had more extensive experience in the delivery of psychotherapy.

### **Study A: Essays – Training and Assessment Procedure**

**Key strategies training procedure.** Training for the current study was provided by two licensed psychologists, one of whom is a male professor of counseling psychology at a University in the Southwest U.S., and the other of whom is a female clinician at the counseling center of the same university. The professor is also the originator of the KST model and provided expert ratings for the current study to aid in the analysis of criterion-related validity. The principal investigator in the current study is a doctoral student in the counseling psychology program of the same university, and did not participate in training student participants in KST. After receiving six weeks of training in microskills, a pretest essay assessment was administered. This essay assessment, which is more thoroughly discussed in the following section, asked students how counselors can use therapeutic strategies to (1) explore and (2) transform clients' thoughts, feelings, and behaviors. After completion of microskills training and the pretest assessment, students received 24 hours of KST over the final eight weeks of the semester. The key strategies method of training is described in more detail in Harris, Kelley, Campbell, & Hammond (2014). Students were given one lesson each week, beginning with a lesson discussing the parallel strategies and phases of treatment which provide the framework of the KST system. Next, they spent one week learning cognitive strategies for exploring thoughts (lesson 2), one week learning cognitive strategies for transforming

thoughts (lesson 3), and concluded training with the completion of a post-test essay assessment over strategies for exploring and transforming thoughts.

This process of training and assessment was repeated over the following two weeks with students learning emotion-focused strategies and completing an essay assessment asking them how a counselor can use emotion-focused strategies to explore (lesson 4) and transform (lesson 5) feelings. The process was repeated again with students learning behavioral strategies and completing an essay assessment asking them how a counselor can use behavioral strategies to explore (lesson 6) and transform (lesson 7) actions. The final week of KST training was devoted to a lesson describing how to use a multidimensional survey to help clients choose a focal dimension (thoughts, feelings, or actions). For lessons 2-7, which focused on interventions of specific treatment modalities, students were taught intermediate theoretical and practical principles of the evidence-based psychotherapies for the appropriate module, followed by training in the specific key strategies that comprised the modality and phase being learned in that weekly lesson. Additionally, students witnessed in-class demonstrations of strategies and were given time in class to practice strategies in mock therapy sessions. As an additional class requirement, students were required to participate outside of class in practice groups for one hour each week, and to video record these practice sessions for personal reflection and review.

**Essay assessment procedure.** This study was approved by the Institutional Review Board (IRB) of Texas Woman's University. A copy of the IRB approval letter is provided in Appendix E. Participants were informed that their responses, videos, and

other assessment materials would be confidential and that no record of personal information would be connected with their assessments. The consent form included an explanation about potential risks, as well as contact information for the Texas Woman's University's IRB, the principal investigator, and the dissertation advisor. Participants were informed prior to data collection that they could communicate any concerns regarding the study to the researcher or dissertation committee chair.

Study A utilized a pre-test/post-test essay assessment (see questions below) to measure trainees' knowledge of KST and their ability to differentiate which key strategies should be used within a particular treatment phase (exploration or transformation) and modality (cognitive, emotion-focused, or behavioral). Data for this study was collected from two cohorts in Fall 2012 and Fall 2013. The author was not involved in the collection of data from the first cohort of this study. Data from the second cohort was collected by the author and an undergraduate research assistant. Participants completed informed consent before beginning this study, which stated that participation was voluntary, participation and responses were confidential, and that the study was being conducted to assess trainees' development in order to explore the effectiveness of the Key Strategies Training model. Potential risks, including discomfort while completing assessments, feeling at risk of coercion, and loss of confidentiality or anonymity were discussed in the informed consent process, and participants were given researchers' contact information so as to address any questions or concerns, as well as an opportunity to provide their contact information should participants want to learn about the results of the study. Written instructions for essays were distributed and students

completed essay assessments during normal class time. Demographic information was collected, including participant gender, race, age, and current program of study. A copy of the demographic information form can be found in Appendix F.

After informed consent was completed, participants were issued code names to keep their identities separate from assessments. Participants were given a sheet a paper with several possible code names, and were asked to select one code name. Participants indicated their name, email, and phone number beside that code name. While anonymity can be difficult to maintain in a small classroom setting, sufficient steps were taken to ensure that participants' information remained confidential. Only the principal researcher and research assistants helping with data collection and transcription accessed code names. Essay transcriptions were completed by two undergraduate research assistants. Prior to receiving any training on KST interventions, participants received six essay questions asking them to explain how a counselor could help a client (a) explore thoughts, and (b) transform thoughts, (c) explore feelings, and (d) transform feelings, (e) explore actions, and (f) transform actions. For example, students were asked to respond in essay format to the following questions:

- (a) "How can a counselor help clients *explore* their *thoughts*?"
- (b) "How can a counselor help clients *transform* their *thoughts*?"
- (c) "How can a counselor help clients *explore* their *feelings*?"
- (d) "How can a counselor help clients *transform* their *feelings*?"
- (e) "How can a counselor help clients *explore* their *behaviors*?"
- (f) "How can a counselor help clients *transform* their *behaviors*?"

### **Study A: Essays – Rater Participants**

Students from the Fall 2013 cohort were asked by the principal researcher to participate as raters. These raters were tasked with providing item-level ratings for each of the essays completed by the student participants described in the previous paragraph. In the Spring 2014 semester, following the completion of a graduate-level theory and practice of psychotherapy course, three M.A. Counseling Psychology students volunteered as raters. These three raters provided scores measuring student participants' knowledge of KST, assessing the degree to which students' pretest/post-test essays represented strategies belonging to the two treatment phases and three treatment modalities of KST. These ratings allowed researchers to determine whether students understood the differences between key strategies according to the treatment phase and modality in question.

Students from the Fall 2013 cohort, having recently completed KST, were sent a recruitment email, asking them to participate as raters. These students were recruited because of their familiarity with the KST system, taking into consideration that some rating manuals have major feasibility issues as a result of requirements of up to 40 to 60 hours of rater training, a substantial burden in terms of time and funding (Schoenwald & Garland, 2013). The current study attempted to approximate suggestions of intense rater training as much as feasible by utilizing trainees who are already familiar with the system and have spent 24 hours over eight weeks in training and approximately 8-10 hours in mock practice.

Raters were given an additional one-hour training session, conducted by the principal researcher, for the purpose of explaining and demonstrating the use of the KSRS. An example of the definitions explained and discussed as anchor points for ratings with essays is provided below:

- (a) An essay which is *Extremely Representative* of the Transforming Actions phase/modality will contain written information describing all four of the following strategies.
- (b) An essay which is *Somewhat Representative* of the Transforming Actions phase/modality will contain written information describing 2-3 of the following strategies.
- (c) An essay which is *Not At All Representative* of the Transforming Actions phase/modality will contain written information describing none of the following strategies.

More information regarding the rater training protocol utilized in this study can be found in the Key Strategies Rating Manual (Kelley & Harris, 2014). A copy of this manual can be found in Appendix G. As part of this training, raters were asked to rate a variety of practice transcripts, which differed in quality, and covered each phase and modality of KST. Raters reviewed these practice ratings with the principal researcher, and received additional training accordingly. With this training protocol in mind, raters could be considered independent, because they are not otherwise involved in the treatment protocol, but partially-trained, because “they may not be trained in the intended

definition and use of items, rating scales, administration methods, and rating reliability of the measure” (Schoenwald et al., 2011, p. 37). More specifically, these raters were trained in the therapeutic definitions and use of key strategies, as well as the rating scales and administration, but not in the reliability rating of the measure. Further, evidence has suggested that the more complex the therapeutic interventions being rated, the harder they are to distinguish, and therefore, the greater the need for more experienced raters (Muse & McManus, 2013). Being that KST strategies are intermediate, introductory strategies of evidence-based psychotherapies, the use of expert raters would be unnecessary and impractical.

#### **Study A: Essays – Rating Procedure**

Raters were given transcripts of twelve essay responses for each student, including six pretest and six post-test responses, covering each treatment phase and each treatment modality of KST. These transcripts were counterbalanced and presented one at a time. Randomizing the order of transcripts allowed for the researchers to ensure that raters were blind to which treatment phase and modality the essay was meant to describe, as well as which essays were conducted pre-training and which were conducted post-training. Raters scored the essays based on how well each essay represented the key strategies belonging to each treatment phase and modality on a 7-point Likert-type scale. This scale ranged from (1) “not at all representative” to (7) “extremely representative,” with a median score of (4) “somewhat representative.” Rating guidelines can be found in the Key Strategies Rating Manual (Kelley & Harris, 2014). A copy of this manual can be found in Appendix G. An increase in scores from pretest to post-test is understood to

represent students increased ability to identify strategies belonging to the appropriate modality and phase of treatment. Additionally, a comparison of post-test target scores (the modality and phase the students were asked to write about) and non-target scores is understood to represent the ability to differentiate between strategies belonging to different treatment phases and modalities.

### **Study A: Essays – Instrumentation**

**Key strategies rating scale - A.** KSRS-A contains six items, which were questions designed to rate students' written descriptions of strategies belonging to three treatment modalities (cognitive, emotion-focused, and behavioral) and two treatment phases (exploration and transformation). Essays were presented with these six items. The items were presented in a matrix such that questions regarding the phases of KST were presented in two columns, and questions regarding the modalities of KST were presented in three rows. Each item of the KSRS-A was presented with a Likert-type scale asking raters, "Does this essay represent the key strategies belonging to this treatment phase and modality (see KST strategy list)?" A list of key strategies belonging to each phase and modality of KST was also provided to raters. Raters scored how well each essay represented the strategies of each of the phases and modalities of KST, from (1) "not at all representative" to (7) "extremely representative", with a midpoint of (4) "somewhat representative." A copy of the KSRS-A is provided in Appendix A.

### **Study A: Essays – Statistical Analyses**

To determine whether students' essay scores differed significantly from pretest to post-test, and between target (interventions belonging to the phase and modality that

students were asked to describe) and non-target (interventions belonging to other phases or modalities) items, a 2 x 2 analysis of variance (ANOVA) was conducted. This analysis was conducted for the essay portion of this study to determine whether students improved in their description of key strategies from pre-training to post-training, suggesting that students understood these strategies better after training, compared to before receiving KST. Additionally, three follow-up paired-sample *t*-tests were conducted to confirm these results. One of these *t*-tests was conducted on post-training essays between strategies belonging to the target treatment phase/modality and an average of non-target scores in order to determine if students possessed the ability to differentiate between different modes and phases of treatment after receiving KST.

Interrater reliability was also calculated utilizing intraclass coefficients, comparing the scores of single raters to each other for consistency. Similarly for criterion-related validity, an average of raters' KSRS-A scores, and individual raters' KSRS-A scores, were compared with selected essays rated by a KST expert utilizing intraclass coefficient.

### **Study B: Role-Plays Measuring Demonstration of Skills**

#### **Study B: Role-Plays – Student Participants**

Post-test only role-play assessments were conducted following KST training, and participants included counseling psychology students who participated in study A, and who were also willing to participate in study B. School psychology students were not required to video record their role-play assignment for completion of the *Theory and Practice of Counseling and Psychotherapy* course, and were accordingly not included in

study B. Participants in study B included 15 Counseling Psychology graduate students at a public university in the Southwestern United States. Participants included females ( $n = 13$ ) and males ( $n = 2$ ), who identified racially/ethnically as White/Caucasian ( $n = 9$ ), Hispanic/Latina/o ( $n = 3$ ), Black/African American ( $n = 1$ ), South Asian/Asian Indian ( $n = 1$ ), and Bi/Multi-racial/ethnic ( $n = 1$ ). Participants included either M.A. Counseling Psychology students ( $n = 12$ ) or a Ph.D. Counseling Psychology students ( $n = 3$ ). The age of participants in study B ranged from 22 to 56 years, with 28.3 years as the mean age of the sample.

### **Study B: Role-Plays – Training and Assessment Procedure**

**Key strategies training procedure.** The training procedures for study B were the same as study A. The same IRB-approved consent process was used in study B, as in study A.

**Role-play assessment procedure.** Study B utilized a post-test only role-play assessment to measure trainees' adherence to and competence in utilizing key strategies. As a final assignment for the semester, and after receiving the complete KST package, the counseling psychology students in both cohorts were required to record a role-play practice session with another member of the class. This standardized role-play scenario required each student to conduct a multidimensional survey to discover which treatment modality to use. After determining which treatment modality was indicated, students proceeded first to demonstrate the exploration of either thoughts, feelings, or actions, and then repeated this process for the transformation phase.

Students received one of the following three possible role-play scenarios: (1) depression focusing on thoughts, (2) substance abuse focusing on emotion, (3) anxiety focusing on actions. Each of these role-play scenarios provided the mock-client with a background to be read to the counselor, and contained three statements to be used with the counselor (e.g., “Sometimes I can’t get out of bed in the morning and go to work late”). Behavioral instructions were given to the mock clients, along with examples of vague and specific responses (e.g., vague: “It’s easier just to stay at home.”; specific: “I don’t want to get hurt again. If I stay at home, I’m safe.”), and one example of a deeper pattern (e.g., fear leads to withdrawal and isolation, which leads to guilt for not being more socially involved). A copy of these role-play scenarios is provided in Appendix D. The role-plays utilized in this study, therefore, were aimed specifically at measuring trainees’ use of one treatment modality across both phases of treatment. For students who provided consent, their videos were labeled with code names to ensure confidentiality, and participants were informed that their videos could be deleted by request. Student videos were destroyed after transcription to further ensure confidentiality.

### **Study B: Role-Plays – Rater Participants**

Study B utilized the same raters as study A, previously described in this dissertation. Raters utilized the KSRS-B to rate transcripts of post-test only role-play assessments.

### **Study B: Role-Plays – Rating Procedure**

The principal researcher and two undergraduate teaching assistants transcribed video-recorded role-play demonstrations, and were the only persons to view these

recordings as part of this study. Transcriptions utilized code names to ensure confidentiality. The same raters provided ratings for studies A and B. In addition to exposure to the KST system, as previously discussed, raters were given an additional one-hour training session for the purpose of explaining and demonstrating the use of the KSRS. Raters were given transcripts of these video demonstrations and asked to rate them for adherence and competence utilizing the KSRS-B. Multidimensional survey demonstrations were rated with the Multidimensional Survey Adherence and Competence Rating Scale (MSACRS), which is described below. Raters were blinded to which treatment phase (exploration or transformation) and treatment modality (cognitive, emotion-focused, or behavioral) they were rating.

Role-plays were rated for adherence based on how well each video transcript represented the key strategies belonging to the treatment phase and modality the rater believed was being demonstrated. These ratings were understood to signify students' ability to demonstrate a selection of strategies belonging to the appropriate modality and phase of treatment. Raters also provided ratings for the non-target phase and modalities of KST to measure strategies potentially used from a modality or phase other than the students were asked to demonstrate. These ratings were understood to signify students' ability to practically differentiate between the phases and modalities of KST.

Additionally, raters rated each transcript for competence in order to measure how well the strategies belonging to a specific treatment phase and modality were demonstrated. These ratings were understood to represent the quality or skill with which trainees delivered key

strategies and to determine how students performed in relation to minimal levels of competency.

### **Study B: Role-Plays – Instrumentation**

#### **Multidimensional Survey Adherence and Competence Rating Scale**

**(MSACRS).** The MSACRS consists of five items aiming at the measurement of adherence/intervention competence of five multidimensional survey skills. A copy of the MSACRS is provided in Appendix C. Raters read role-play transcripts and rated the content of these transcripts utilizing the MSACRS, by indicating the extent to which they agreed that the therapist demonstrated certain multidimensional survey skills. Raters assessed adherence/intervention competence of KST by identifying the degree to which they agreed that transcripts are representative of five interventions, including (1) “The counselor explored how the client’s thoughts were related to the presenting concern,” (2) “The counselor explored how the client’s feelings were related to the presenting concern,” (3) “The counselor explored how the client’s actions were related to the presenting concern,” (4) “The counselor explored how these three dimensions interact with one another,” and (5) “The counselor asked the client which dimension would be the best place to focus their attention.” These five questions were used to rate each transcript according to a 7-point Likert-type quality scale. In this study, raters using the MSACRS can be understood to be simultaneously rating both the adherence and intervention competence with which trainees demonstrate key strategies with mock clients.

**Key strategies rating scale – B.** KSRS-B contains the first six items of KSRS-A, described in more detail above, as well as one additional competence question (e.g.,

“How competently did the therapist perform?”). A copy of KSRS-B is provided in Appendix B. KSRS-B was utilized in study B in order to establish adherence and competence scores. Raters read role-play transcripts and rated the content of these transcripts utilizing the KSRS-B by indicating the extent to which each role-play transcript represents the treatment phase and modality which it was supposed to represent. Raters assessed adherence to KST by identifying the degree to which transcripts were representative of key strategies belonging to the treatment phase and modality required by the role-play scenario. The KSRS-B also allowed for identification of additional strategies not representative of the treatment phase and modality required by the role-play scenario by having raters rate the presence or absence of strategies not belonging to the target treatment phase and mode, thereby allowing for the calculation of differentiation scores.

The KSRS-B was also used by raters to judge the competence of therapists' demonstration of key strategy undertaken by trainees in a role-play setting. Each transcript was judged on a 7-point Likert-type quality scale, based on a provided description of performance from (1) “highly incompetent or inappropriate performance” to (7) “exemplary performance, high level of mastery for strategy,” with a median representing (4) “adequate delivery / minimally competent”. In this study, raters using the KSRS-B can be understood to be rating both the adherence and competence or quality with which trainees demonstrate key strategies with mock clients.

## **Study B: Role-Plays – Statistical Analyses**

Multidimensional Survey Adherence/Competence Scale (MSACRS) ratings were analyzed using five one-sample *t*-tests to determine whether students could demonstrate the five therapeutic behaviors comprising the Multidimensional Survey. These scores were compared to the scale midpoint, representing minimal level of adherence/competence. Additionally, another one-sample *t*-test was conducted on all MSACRS results as a whole.

Intraclass coefficients were used to analyze interrater reliability, comparing the scores of single raters to each other for consistency. Similarly for criterion-related validity, raters' MSACRS scores for selected video transcripts were compared to the scores of a KST expert utilizing intraclass coefficients to determine how an average of all three raters' scores and raters' individual scores compared with transcripts rated by a KST expert.

Adherence and competence ratings of the post-test only role-play ratings were analyzed by a one-sample *t*-tests, comparing the scores of psychotherapy trainees to a minimum threshold of adherence and competence, determined to be the midpoint of the scale. Additionally, differentiation was analyzed utilizing a paired-samples *t*-test to compare the adherence scores for the target phase/modality against an average of non-target scores. Non-target scores represented strategies participants were not asked about for a particular question. Higher non-target scores (i.e., with equal or lower target scores) indicated that a participant failed to differentiate between strategies. In other words, instead of demonstrating target strategies (e.g., exploring feelings), the participant

demonstrated non-target strategies (e.g., transforming feelings, thoughts, or actions; exploring thoughts or actions). Lower non-target scores (i.e., with higher target scores) indicated that a participant successfully differentiated between target and non-target strategies.

Interrater reliability was also calculated utilizing intraclass coefficients, comparing raters' individual KSRS-B scores for each role-play transcript to determine whether raters performed consistently. Similarly for criterion-related validity, intraclass coefficients was used to analyze a random selection of raters' individual KSRS-B scores, and an average of raters' scores, compared with role-play transcripts rated by a KST expert. It should be stressed that though these research methods may demonstrate that students performed key strategies well after training, one should be careful drawing a causal link to training, as the current statistical methods do not allow this inference.

## CHAPTER IV

### RESULTS

#### **Study A: Essay Results**

##### **Study A: Essays – Demographics**

Participants in study A included 24 graduate students taking a *Theory and Practice of Counseling and Psychotherapy* course at a public university in the Southwestern United States. This course included a three-hour skills lab and a three-hour lecture component each week. Thirty-nine students were enrolled in the skills lab during the Fall 2012 and Fall 2013 semesters, during which data was collected, and 61% of students ( $n = 24$ ) agreed to take part in this portion of the study. Participants included 21 females and 3 males, who identified racially/ethnically as White/Caucasian ( $n = 12$ ), Black/African American ( $n = 5$ ), Hispanic/Latina/o ( $n = 4$ ), South Asian/Asian Indian ( $n = 2$ ), and Bi/Multi-racial/ethnic ( $n = 1$ ). Participants were enrolled in either a Counseling Psychology ( $n = 18$ ) or School Psychology ( $n = 6$ ) program, and included M.A. Counseling Psychology students ( $n = 14$ ), Ph.D. Counseling Psychology students ( $n = 4$ ), and Ph.D. School Psychology students ( $n = 6$ ). The age of participants in the study ranged from 22 to 56 years, with 27.5 years as the mean age of the sample.

##### **Study A: Essays – KSRS-A Knowledge Results**

To measure knowledge of key strategies, each participant wrote pretest and post-test essays describing how a counselor can use cognitive, emotion-focused, and behavioral strategies (modality) to explore and transform (phase) thoughts, feelings, and

actions. These essays were rated by three raters, who utilized the Key Strategies Rating Scale – A (KSRS-A), providing both target scores (the phase and modality participants were asked to describe in the essay) and non-target scores (the phases and modalities participants were not asked to describe in the essay) for each essay. Raters were blind to the phase and modality participants were asked to describe in each essay.

In order to ascertain whether participants' knowledge of key strategies increased before and after training, a 2 x 2 repeated measures analysis of variance (ANOVA) was conducted to assess significant differences from pretest to post-test and for target and non-target items. Means and standard deviations are reported in Table 2. Results indicated a significant main effect of time (pretest/post-test) on mean rater scores,  $F(1, 134) = 119.675, p < .001, \text{partial } \eta^2 = .472$ . Likewise, results indicated a significant main effect of strategy (target/non-target) on mean rater scores  $F(1, 134) = 626.209, p < .001, \text{partial } \eta^2 = .824$ . The interaction of time and strategy was also significant,  $F(1, 134) = 90.167, p < .001, \text{partial } \eta^2 = .402$ . A review of the means and the profile plot (See Figure 1) indicated that these effects are likely carried by variance between the pretest target and post-test target scores and the variance between target scores and non-target scores, but no similar variance appeared between pretest non-target and post-test non-target scores. Three follow-up paired-samples  $t$ -tests confirmed this interpretation. Mean target scores increased from pretest ( $M = 2.75, SD = 1.05$ ) to post-test ( $M = 4.06, SD = 1.34$ ), and this increase was statistically significant,  $t(134) = 10.311, p < .001, d = 1.09$ . Cohen (1988) classified effects sizes as follows: small ( $d = .2$ ); medium ( $d = .5$ ); large ( $d = .8$ ). The large effect size of this  $t$ -test indicated the strong likelihood that students actually

described key strategies better after receiving KST, compared to pretest scores. These results supported hypothesis one; participants increased in their identification knowledge of key strategies from before to after receiving KST.

Mean target scores were also found to differ between post-test non-target strategies ( $M = 4.06$ ,  $SD = 1.34$ ) and post-test target strategies ( $M = 1.18$ ,  $SD = 0.20$ ); this difference was statistically significant,  $t(134) = 23.139$ ,  $p < .001$ ,  $d = 3.74$ . The large effect size for this  $t$ -test indicated the strong likelihood that students actually described the target strategies, without describing the non-target strategies. This result supported hypothesis two. After receiving KST, participants were rated as differentiating between the target and non-target strategies, indicating that participants discriminated between interventions belonging to specific phases and modalities of KST on written essays.

These results help to explain the significance of the main and interaction effects of the ANOVA, and the interpretation that the difference in variance between target and non-target scores and between pretest and post-test scores, carry the significance of the interaction of time x strategy. This interpretation was further confirmed by a paired samples  $t$ -test between pretest non-target scores ( $M = 1.16$ ,  $SD = 0.18$ ) and post-test non-target scores ( $M = 1.18$ ,  $SD = 0.20$ ), which was not found to be statistically significant,  $t(134) = 0.689$ ,  $p = .492$ ,  $d = .08$ . This result, though not hypothesized, indicated participants' non-target scores did not significantly differ from pretest to post-test.

Table 2.

*KSRS-A Descriptive Statistics*

	Mean	Std. Deviation	N
(PRETEST MEAN) Target	2.7506	1.05466	135
(PRETEST MEAN) Non-Target	1.1615	.18347	135
(POST-TEST MEAN) Target	4.0617	1.34459	135
(POST-TEST MEAN) Non-Target	1.1768	.19755	135

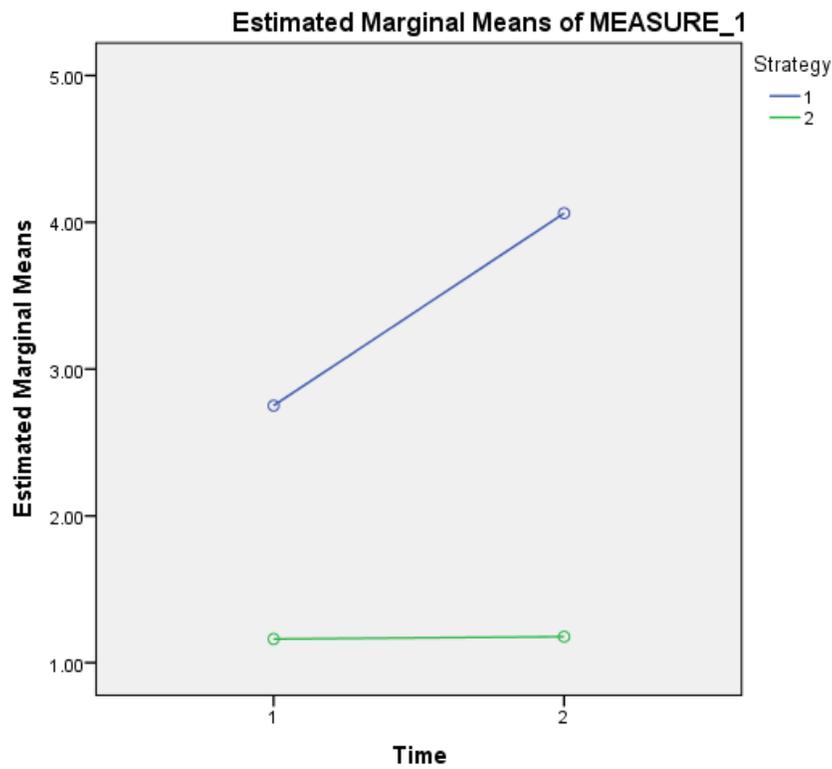


Figure 2. KSRS-A profile plot

### Study A: Essays – KSRS-A Reliability and Validity

Inter-rater reliability was evaluated using a two-way random effects Intraclass Correlation Coefficient (ICC) and consistency on all ratings. Rater’s scores using the KSRS-A demonstrated significant substantial results for consistency on average measures,  $ICC = 0.887, p < 0.001$ . Shrout (1998) classified the reliability coefficients of the ICC as follows: virtually none ( $ICC = 0.00-0.10$ ); slight ( $ICC = 0.11-0.40$ ); fair ( $ICC = 0.41-0.60$ ); moderate ( $ICC = 0.61-0.81$ ); substantial ( $ICC = 0.81-1.0$ ). Pearson correlations indicated very strong, positive, significant relationships between raters, ranging from  $r = 0.742$  to  $r = 0.793, p < 0.001$ , further suggesting strong inter-rater reliability of raters using the KSRS-A. Reliability correlations are presented in table 3. These results supported hypothesis three, indicating that raters demonstrated significant substantial consistency using KSRS-A to rate essays.

Table 3.

*KSRS-A Reliability Correlation Matrix*

	Rater #1	Rater #2	Rater #3
Rater #1 Pearson Correlation	1	.742**	.767**
Rater #1 Sig. (2-tailed)		.000	.000
Rater #1 N	1680	1680	1680
Rater #2 Pearson Correlation	.742**	1	.793**
Rater #2 Sig. (2-tailed)	.000		.000
Rater #2 N	1680	1680	1680
Rater #3 Pearson Correlation	.767**	.793**	1
Rater #3 Sig. (2-tailed)	.000	.000	
Rater #3 N	1680	1680	1680

Note. \*\* Correlation is significant at the 0.01 level (2-tailed).

Criterion-related validity was evaluated using a two-way mixed effects ICC and consistency on a subset of rater's scores and a KST expert's ratings. Results indicated significant substantial results for consistency on average measures,  $ICC = 0.903$ ,  $p < 0.001$ . Pearson correlations indicated very strong, positive, significant relationships between the individual raters' scores and the KST expert's scores, rater #1 ( $r = 0.761$ ); rater #2 ( $r = 0.705$ ); rater #3 ( $r = 0.797$ ), all significant at  $p < 0.001$ . A Pearson correlation was also conducted on an average of raters' scores and the KST expert, with results indicating a very strong, positive, significant relationship between the average raters' scores and the KST expert's scores,  $r = 0.832$ ,  $p < 0.001$ . Criterion-related validity correlations are reported in Table 4. These results supported hypothesis four, indicating strong criterion-related validity for raters using the KSRS-A.

Table 4.

*KSRS-A Criterion-Related Validity Correlation Matrix*

		Rater #1	Rater #2	Rater #3	KST Expert	Raters (MEAN)
Rater #1	Pearson Correlation	1	.702**	.731**	.761**	.914**
	Sig. (2-tailed)		.000	.000	.000	.000
	N	432	432	432	432	432
Rater #2	Pearson Correlation	.702**	1	.800**	.705**	.896**
	Sig. (2-tailed)	.000		.000	.000	.000
	N	432	432	432	432	432
Rater #3	Pearson Correlation	.731**	.800**	1	.797**	.918**
	Sig. (2-tailed)	.000	.000		.000	.000
	N	432	432	432	432	432
KST Expert	Pearson Correlation	.761**	.705**	.797**	1	.832**
	Sig. (2-tailed)	.000	.000	.000		.000
	N	432	432	432	432	432
All Raters (MEAN)	Pearson Correlation	.914**	.896**	.918**	.832**	1
	Sig. (2-tailed)	.000	.000	.000	.000	
	N	432	432	432	432	432

Note. \*\* Correlation is significant at the 0.01 level (2-tailed).

### Study B: Role-Play Results

#### Study B: Role-Plays – Demographics

Participants in study B included 15 Counseling Psychology graduate students taking a *Theory and Practice of Counseling and Psychotherapy* course at a public university in the Southwestern United States. This course included a three-hour skills lab and a three-hour lecture component each week. Participants in this portion of the study were a subset of students from study 1, as School Psychology students in this class were not required to be video recorded for the role-playing assignment. Participants included

13 females and two males, who identified racially/ethnically as White/Caucasian ( $n = 9$ ), Hispanic/Latina/o ( $n = 3$ ), Black/African American ( $n = 1$ ), South Asian/Asian Indian ( $n = 1$ ), and Bi/Multi-racial/ethnic ( $n = 1$ ). Participants were enrolled in either a M.A. Counseling Psychology program ( $n = 12$ ) or a Ph.D. Counseling Psychology program ( $n = 3$ ) program. The age of participants in the study ranged from 22 to 56 years, with 28.3 years as the mean age of the sample.

### **Study B: Role-Plays – MSACRS Adherence/Competence Results**

To determine whether participants who had completed KST could competently adhere to the Multidimensional Survey protocol in a role-play demonstration, five one-sample  $t$ -tests were conducted for mean ratings of the five behaviors required for the Multidimensional Survey. Each participant recorded three videos demonstrating: (1) multidimensional survey, (2) exploration phase utilizing one focal dimension (cognitive, emotion-focused, or behavioral), and (3) transformation phase utilizing the same focal dimension utilized in the exploration phase. These videos were transcribed, and for the multidimensional survey demonstrations, raters utilized the Multidimensional Survey Adherence/Competence Scale (MSACRS), providing ratings for: (1) exploring thoughts related to presenting concern; (2) exploring feelings related to presenting concerns; (3) exploring actions related to presenting concerns; (4) exploring the interactions of thoughts, actions, and feelings; (5) establishing a focal dimension.

Mean scores of the three raters were compared to the scale midpoint (4), which represented minimal adherence/competence. Results of the two-tailed  $t$ -tests were found to be significant for all five behaviors, (1) Exploring thoughts related to presenting

concern ( $M = 5.76$ ,  $SD = 0.72$ ),  $t(14) = 9.471$ ,  $p < .001$ ,  $p < .001$ ,  $d = 2.44$ ; (2) Exploring feelings related to presenting concerns ( $M = 5.80$ ,  $SD = 0.68$ ),  $t(14) = 10.311$ ,  $p < .001$ ,  $p < .001$ ,  $d = 2.65$ ; (3) Exploring actions related to presenting concerns ( $M = 5.73$ ,  $SD = 0.66$ ),  $t(14) = 10.217$ ,  $p < .001$ ,  $p < .001$ ,  $d = 2.62$ ; (4) Exploring the interactions of thoughts, actions, and feelings ( $M = 5.44$ ,  $SD = 0.61$ ),  $t(14) = 9.127$ ,  $p < .001$ ,  $p < .001$ ,  $d = 2.36$ ; (5) Establishing a focal dimension ( $M = 5.69$ ,  $SD = 0.98$ ),  $t(14) = 6.677$ ,  $p < .001$ ,  $p < .001$ ,  $d = 1.72$ . An additional one-sample  $t$ -test was conducted for the overall scale, including all five questions together as a whole, with similar results, ( $M = 5.68$ ,  $SD = 0.56$ ),  $t(14) = 11.585$ ,  $p < .001$ ,  $d = 3.00$ . These results indicated that students performed significantly above the minimal adherence threshold. Large effect sizes for all five behaviors, and the overall scale, indicated that students likely adhered to the multidimensional survey protocol in a competent manner. These results supported hypothesis five. After receiving KST, students were able to competently adhere to a Multidimensional Survey protocol during a standardized role-play demonstration.

### **Study B: Role-Plays – MSACRS Reliability and Validity**

Inter-rater reliability for the Multidimensional Survey Adherence/Competence Scale (MSACRS) ratings was evaluated using a two-way random effects Intraclass Correlation Coefficient (ICC) and consistency on all ratings. Rater's scores using the MSACRS demonstrated significant fair results for consistency on average measures,  $ICC = 0.473$ ,  $p = .001$ , but failed to support hypothesis six at the substantial level of consistency. Pearson correlations indicated a strong, positive, significant relationship between rater #1 and rater #2 ( $r = 0.545$ ,  $p < 0.001$ ), but a non-significant relationship

between rater #3 and the other raters; rater #1 ( $r = 0.053$ ); rater #2 ( $r = 0.036$ ). Reliability correlations are presented in Table 7. Exploratory analyses indicated that removing the scores of rater #3 would result in significant moderate results for consistency, ICC = 0.703,  $p < .001$ , but again failed to reach substantial consistency, though more closely approaching a substantial level of consistency. Item-total statistics for reliability are reported in Table 8. Rating differences were also evident in rater's mean scores, further demonstrating this discrepancy: rater #1 ( $M = 6.56$ ,  $SD = 1.06$ ); rater #2 ( $M = 6.32$ ,  $SD = 1.16$ ); rater #3 ( $M = 4.17$ ,  $SD = 0.91$ ). These differences indicated that removing rater #3 from mean scores would not negatively impact the significance of  $t$ -tests, but would increase the difference between the scale midpoint and mean raters' scores.

Table 5.

*MSACRS Reliability Correlation Matrix*

	Rater #1	Rater #2	Rater #3
Rater #1 Pearson Correlation	1	.545**	.053
Rater #1 Sig. (2-tailed)		.000	.654
Rater #1 N	75	75	75
Rater #2 Pearson Correlation	.545**	1	.036
Rater #2 Sig. (2-tailed)	.000		.757
Rater #2 N	75	75	75
Rater #3 Pearson Correlation	.053	.036	1
Rater #3 Sig. (2-tailed)	.654	.757	
Rater #3 N	75	75	75

*Note.* \*\* Correlation is significant at the 0.01 level (2-tailed).

Table 6.

*MSACRS Reliability Item-Total Statistics Matrix*

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
Rater #1	10.4933	2.253	.454	.298	.068
Rater #2	10.7333	2.036	.426	.297	.099
Rater #3	12.8800	3.810	.050	.003	.703

Additional exploratory *t*-tests were conducted using raters' means with rater #3 removed, to demonstrate that these scores would not impact the significance of results. Five one-sample *t*-tests were conducted again with a mean of the ratings of rater #1 & rater #2. Mean scores were compared to the scale midpoint (4), which represented minimal adherence/competence. Results of the two-tailed *t*-tests were significant for all five behaviors: (1) Exploring thoughts related to presenting concern ( $M = 6.53$ ,  $SD = 0.79$ ),  $t(14) = 12.423$ ,  $p < .001$ ,  $d = 3.20$ ; (2) Exploring feelings related to presenting concerns ( $M = 6.70$ ,  $SD = 0.65$ ),  $t(14) = 16.108$ ,  $p < .001$ ,  $d = 4.15$ ; (3) Exploring actions related to presenting concerns ( $M = 6.43$ ,  $SD = 0.78$ ),  $t(14) = 12.143$ ,  $p < .001$ ,  $d = 3.12$ ; (4) Exploring the interactions of thoughts, actions, and feelings ( $M = 6.10$ ,  $SD = 0.81$ ),  $t(14) = 10.088$ ,  $p < .001$ ,  $d = 2.59$ ; (5) Establishing a focal dimension ( $M = 6.43$ ,  $SD = 0.67$ ),  $t(14) = 5.924$ ,  $p < .001$ ,  $d = 3.63$ . An additional one-sample *t*-test was conducted for the overall scale, including all five questions together as a whole, with similar results, ( $M = 6.44$ ,  $SD = 0.67$ ),  $t(14) = 14.159$ ,  $p < .001$ ,  $p < .001$ ,  $d = 3.64$ . Again, these results

indicated that students performed significantly above the minimal adherence threshold, with large effect sizes, providing partial support for hypotheses five and six.

Criterion-related validity was evaluated using a two-way mixed effects ICC and consistency on a subset of rater's scores and a KST expert's ratings. Results indicated significant moderate results for consistency on average measures,  $ICC = 0.745$ ,  $p < 0.001$ , but failed to support hypothesis seven at a substantial level of consistency. Pearson correlations indicated strong, positive, significant relationships between the KST expert's scores and the scores of raters #1 & #3, rater #1 ( $r = 0.653$ ); rater #3 ( $r = 0.443$ ), both significant at  $p < 0.01$ . The relationship of the scores of rater #2 to those of the KST expert was found to be weak and non-significant, ( $r = 0.288$ ,  $p = 0.093$ ). Validity correlations are presented in Table 9. Exploratory analyses indicated that despite the lack of a significant relationship between the scores of rater #2 and the KST expert, removing this rater's scores would negatively impact the overall ICC results, thereby reducing the consistency coefficient. Item-total statistics for criterion-related validity are reported in Table 10. A Pearson correlation was also conducted on an average of raters' scores and the KST expert, with results indicating a strong, positive, significant relationship between the average of raters' scores and the KST expert's scores, ( $r = 0.599$ ,  $p < 0.001$ ). Though the ICC was approaching a substantial level of consistency, taken together these results were not sufficient to establish criterion-related validity in support of hypothesis seven.

Table 7.

*MSACRS Criterion-Related Validity Correlation Matrix*

		Rater #1	Rater #2	Rater #3	Raters (MEAN)	KST Expert
Rater #1	Pearson Correlation	1	.403*	.378*	.773**	.653**
	Sig. (2-tailed)		.016	.025	.000	.000
	N	35	35	35	35	35
Rater #2	Pearson Correlation	.403*	1	.449**	.780**	.288
	Sig. (2-tailed)	.016		.007	.000	.093
	N	35	35	35	35	35
Rater #3	Pearson Correlation	.378*	.449**	1	.784**	.443**
	Sig. (2-tailed)	.025	.007		.000	.008
	N	35	35	35	35	35
Raters (MEAN)	Pearson Correlation	.773**	.780**	.784**	1	.599**
	Sig. (2-tailed)	.000	.000	.000		.000
	N	35	35	35	35	35
KST Expert	Pearson Correlation	.653**	.288	.443**	.599**	1
	Sig. (2-tailed)	.000	.093	.008	.000	
	N	35	35	35	35	35

Note. \* Correlation is significant at the 0.05 level (2-tailed).

\*\* Correlation is significant at the 0.01 level (2-tailed).

Table 8.

*MSACRS Validity Item-Total Statistics Matrix*

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
Rater #1	16.8286	4.499	.591	.477	.656
Rater #2	17.0571	5.232	.482	.269	.718
Rater #3	19.2571	4.844	.527	.309	.695
KST Expert	17.0571	5.703	.600	.473	.674

## **Study B: Role-Plays – KSRS-B Demonstration Results**

In order to ascertain whether participants who had completed KST could adhere to protocol in a role-play demonstration, a one-sample *t*-test was conducted on raters' scores of video transcripts of the role-play demonstrations. Each participant recorded three videos demonstrating: (1) multidimensional survey, (2) exploration phase utilizing one focal dimension (cognitive, emotion-focused, or behavioral), and (3) transformation phase utilizing the same focal dimension utilized in the exploration phase. These videos were transcribed, and for the exploration and transformation demonstrations, raters utilized the Key Strategies Rating Scale – B (KSRS-B), providing both target scores (the phase and modality participant was meant to demonstrate in the video) and non-target scores (the phases and modalities participant was not meant to demonstrate in the video) for each video. Raters were blind to the phase and modality participants were meant to demonstrate in each video.

Mean target scores were compared to the scale midpoint (4), which represented minimal adherence. Results were significant ( $M = 4.84$ ,  $SD = 1.25$ ),  $t(29) = 3.711$ ,  $p = .001$ ,  $d = .672$ , indicating that students performed significantly above the minimal adherence threshold, with an effect size indicating a moderate association suggesting that students may have adhered to KST protocol. This result supported hypothesis eight. After receiving KST, students were able to adhere to KST strategies on a standardized role-play demonstration.

A paired-samples *t*-test was conducted to determine whether participants could adequately differentiate, in practice, between the different therapeutic modalities of KST

(i.e., Cognitive, Emotion-Focused, and Behavioral Therapies). Mean target scores were compared to mean non-target scores, indicating that target scores ( $M = 4.84$ ,  $SD = 1.25$ ) were higher than non-target scores ( $M = 2.42$ ,  $SD = 0.71$ ), and this difference was statistically significant,  $t(29) = 8.636$ ,  $p < .001$ ,  $d = 2.47$ . The large effect size of this analysis indicated a strong likelihood that students demonstrated the target strategies without demonstrating the non-target strategies. These results supported hypothesis nine. After receiving KST, participants were capable of demonstrating key strategies from a particular modality and phase of KST, without demonstrating strategies from the non-target phase or modalities.

KSRS-B also contained a rating for overall competence for each video transcript. To test whether participants demonstrated key strategies above a minimal level of competence, mean competence ratings were compared to the scale midpoint (4) using a one-sample  $t$ -test. Results were significant ( $M = 5.11$ ,  $SD = 0.64$ ),  $t(29) = 9.520$ ,  $p < .001$ ,  $d = 1.73$ , indicating a strong likelihood that students performed significantly above the minimal competence threshold. This result supported hypothesis ten. After receiving KST, students were able to competently deliver key strategies during a standardized role-play demonstration.

### **Study B: Role-Plays – Rater Reliability and Validity**

Inter-rater reliability for Study B was evaluated using a two-way random effects Intraclass Correlation Coefficient (ICC) and consistency on all ratings. Rater's scores using the KSRS-B demonstrated significant substantial results for consistency on average measures,  $ICC = 0.818$ ,  $p < 0.001$ . Pearson correlations indicated strong, positive,

significant relationships between raters, ranging from  $r = 0.578$  to  $r = 0.661$ ,  $p < 0.001$ , further suggesting strong inter-rater reliability of raters using the KSRS-B. Reliability correlations are presented in table 5. These results supported hypothesis eleven, indicating that raters demonstrated significant substantial consistency using KSRS-B to rate video transcripts.

Table 9.

*KSRS-B Reliability Correlation Matrix*

	Rater #1	Rater #2	Rater #3
Rater #1 Pearson Correlation	1	.578**	.622**
Rater #1 Sig. (2-tailed)		.000	.000
Rater #1 N	210	210	210
Rater #2 Pearson Correlation	.578**	1	.661**
Rater #2 Sig. (2-tailed)	.000		.000
Rater #2 N	210	210	210
Rater #3 Pearson Correlation	.622**	.661**	1
Rater #3 Sig. (2-tailed)	.000	.000	
Rater #3 N	210	210	210

Note. \*\*. Correlation is significant at the 0.01 level (2-tailed).

Criterion-related validity was evaluated using a two-way mixed effects ICC and consistency on a subset of rater's scores and a KST expert's ratings. Results indicated significant substantial results for consistency on average measures,  $ICC = 0.874$ ,  $p < 0.001$ . Pearson correlations also indicated strong, positive, significant relationships between the individual raters' scores and the KST expert's scores, rater #1 ( $r = 0.560$ ); rater #2 ( $r = 0.789$ ); rater #3 ( $r = 0.744$ ), all significant at  $p < 0.001$ . A Pearson correlation was also conducted on an average of raters' scores and the KST expert, with

results indicating a very strong, positive, significant relationship between the average raters' scores and the KST expert's scores ( $r = 0.796, p < 0.001$ ). Criterion-related validity correlations are presented in Table 6. These results supported hypothesis twelve, indicating strong criterion-related validity for raters using KSRS-B.

Table 10.

*KSRS-B Criterion-Related Validity Correlation Matrix*

		Rater #1	Rater #2	Rater #3	KST Expert	Raters (MEAN)
Rater #1	Pearson Correlation	1	.596**	.558**	.560**	.859**
	Sig. (2-tailed)		.000	.000	.000	.000
	N	84	84	84	84	84
Rater #2	Pearson Correlation	.596**	1	.704**	.789**	.876**
	Sig. (2-tailed)	.000		.000	.000	.000
	N	84	84	84	84	84
Rater #3	Pearson Correlation	.558**	.704**	1	.744**	.854**
	Sig. (2-tailed)	.000	.000		.000	.000
	N	84	84	84	84	84
KST Expert	Pearson Correlation	.560**	.789**	.744**	1	.796**
	Sig. (2-tailed)	.000	.000	.000		.000
	N	84	84	84	84	84
All Raters (MEAN)	Pearson Correlation	.859**	.876**	.854**	.796**	1
	Sig. (2-tailed)	.000	.000	.000	.000	
	N	84	84	84	84	84

Note. \*\* Correlation is significant at the 0.01 level (2-tailed).

## CHAPTER V

### DISCUSSION

The current study provides initial empirical support for the Key Strategies Training method of teaching counselors-in-training an integrative approach to bridging the gap between microskills and three empirically-based treatment modalities. In the training portion of this study, counseling students received eight weeks of KST, which was preceded by a pre-test essay asking students how a counselor can use cognitive, emotion-focused, and behavioral strategies to explore and transform thoughts, feelings, and actions. A post-test essay was administered at three separate periods of time, after students received training in each therapeutic modality. Students also video-recorded an administration of a multidimensional survey with a mock client, determining whether to begin utilizing interventions from cognitive, emotion-focused, or behavioral modalities. Based on the outcome of the multidimensional survey, students then video-recorded their use of interventions from the indicated modality for exploring the mock client's presenting concern, followed by a video-recording of their use of interventions for transforming thoughts, feelings, or actions related to the mock client's presenting concern. Students who completed the full course of KST were asked to participate as raters, and a group of three students agreed to participate. After receiving additional training on the rating process, these three students rated the essays and video transcripts of all students who had agreed to participate in the study.

## **Study A: Discussion of Hypotheses**

### **Hypothesis One: Essays – Identification Knowledge**

The first hypothesis aimed at demonstrating that students would be able to describe therapeutic skills for exploring and transforming thoughts, feelings, and actions. Students' written essays were hypothesized to more accurately describe key strategies belonging to specific treatment phases (exploration and transformation) and treatment modalities (cognitive, emotion-focused, and behavioral) after receiving KST, when compared to essays written prior to receiving KST. Essay results indicated that students described the cognitive, emotion-focused, and behavioral interventions comprising KST better after receiving the training, compared to descriptions written before training. These results appear to indicate that students increased in their identification knowledge, which supports the first hypothesis, and provides support for the interpretation that students are capable of learning interventions from multiple theoretical modalities within a given semester.

### **Hypothesis Two: Essays – Differentiation Knowledge**

The second hypothesis proposed that students would learn to differentiate between the modalities (cognitive, emotion-focused, and behavioral), and between the phases (exploration and transformation) of KST. Students' post-test essays were hypothesized to consistently describe the specific phase and modality of KST the students were asked to describe, without describing the phase or modalities students were not asked to describe. Post-test essay results indicated that students were able to differentiate between the phases and modalities of KST. This result supported the second hypothesis,

suggesting that students did not appear to confuse interventions from three empirically-based treatments, despite learning these interventions conjointly.

### **Hypothesis Three: Essays – Inter-Rater Reliability**

The third hypothesis predicted that raters, utilizing the Key Strategies Rating Scale - A to score essays describing KST strategies across both phases of treatment, would demonstrate consistent performance when using the measure. Raters' scores for Study A demonstrated strong inter-rater reliability, in support of the third hypothesis. This finding suggested that psychotherapy students in this study, having recently completed KST and a training on KST rating protocol, were capable of consistently rating essays written by other students.

### **Hypothesis Four: Essays – Criterion-Related Validity**

The fourth hypothesis proposed that raters would demonstrate significant consistency with the scores of a KST expert, suggesting that students would be able to use the Key Strategies Rating Scale – A to rate student essays in a similar manner to the expert. Raters' scores for Study A demonstrated strong criterion-related validity, in support of the fourth hypothesis. This finding suggested that psychotherapy students in this study, having recently completed KST and a training on KST rating protocol, were capable of rating essays similarly to a KST expert. This result may suggest that KST adequately targeted the appropriate level of training (i.e., that of new psychotherapy students), and that the KST rater-training procedure utilized in this study clearly delivered the protocol necessary for rating student essays. These results imply that research emphasizing the use of expert raters or lengthier rater-training protocols may not

be necessary. Using expert raters with longer training protocols may decrease the feasibility of research on psychotherapy-related essays.

Taken together, findings related to hypotheses 1-4 suggested the feasibility and integrity of KST to train new therapists to understand and differentiate between intermediate interventions from three empirically-based treatments. These results may imply that some psychotherapy training programs may be shortchanging student learning by initially exposing new trainees to microskills alone and/or to a single empirically-based treatment modality.

### **Study B: Discussion of Hypotheses**

#### **Hypothesis Five: Role-Plays - MSACRS Adherence/Competence**

The fifth hypothesis proposed that students would demonstrate specific multidimensional survey skills in a role-play scenario. Students Multidimensional Survey Adherence and Competence Rating Scale post-test scores were hypothesized to be significantly higher than the scale mid-point, representing a minimal adherence/competence threshold. For Study B, video transcript ratings indicated that after receiving KST, students were able to successfully conduct a multidimensional survey with a mock client, by which they identified problematic thoughts, actions, and feelings for the mock client, looked at the interaction of these dimensions, and established a focal dimension. This survey resulted in identifying whether cognitive, emotion-focused, or behavioral interventions were indicated as an appropriate entry point for working with the mock client. As the multidimensional survey involves limited-domain competence, raters did not give separate adherence scores. Competence/adherence results indicated that

students performed the multidimensional survey according to the appropriate protocol, supporting the fifth hypothesis.

### **Hypothesis Six: Role-Plays – MSACRS Inter-Rater Reliability**

The sixth hypothesis was aimed at the measurement of rater consistency using the Multidimensional Survey Adherence and Competence Rating Scale to measure multidimensional role-play transcripts. Raters' scores for the multidimensional survey portion of Study B demonstrated fair inter-rater reliability, and significant, moderate results with one rater's scores deleted, failing to support the sixth hypothesis. However, two of the three psychotherapy students in the current study, trained in the KST model and the KST rating protocol, demonstrated consistency approaching, but not achieving, the substantial level hypothesized.

### **Hypothesis Seven: Role-Plays – MSACRS Criterion-Related Validity**

The seventh hypothesis proposed that raters, utilizing the Multidimensional Survey Adherence and Competence Rating Scale, would rate multidimensional survey role-play transcripts commensurate with a KST expert. Raters' scores for the multidimensional survey portion of Study B demonstrated strong criterion-related validity for two out of three raters, but failed to support the seventh hypothesis at the substantial level of consistency. These results may be interpreted to suggest that with further training psychotherapy students may be capable of sufficiently rating multidimensional surveys, similarly to a KST expert.

These results may suggest that after students have completed KST and the KST rater-training procedure in this study, they may be capable of achieving a clear and

adequate practical knowledge of KST, so as to be able to consistently and competently rate multidimensional surveys. These results provide further support that researchers may not need to achieve an expert level of training or attend considerably lengthier rater-training sessions. Researchers would do well to adequately match their raters to the research tasks pursued within their study, thereby protecting the integrity of future studies and maximizing the feasibility of conducting training studies.

### **Hypothesis Eight: Role-Plays – KSRS-B Adherence**

The eighth hypothesis posited that students will be able to adhere to KST protocol by demonstrating skills from a specific phase (exploration and transformation) and modality (cognitive, emotion-focused, and behavioral) of KST in a role-play scenario. After completing the video-recordings of the multidimensional surveys, students video-recorded demonstrations of interventions from the therapeutic modality identified in the multidimensional survey. Students recorded two videos for this portion of Study B, demonstrating exploration strategies in the first video and transformation strategies in the second video. Raters' scores of video transcripts indicated that students were able to adhere to KST protocol when demonstrating exploration and transformation interventions with a mock client, supporting the eighth hypothesis. Students' ability to adhere to the KST protocol during the two phases of treatment (i.e., exploring & transforming) for the identified therapeutic modality (i.e., cognitive, emotion-focused, or behavioral) may be interpreted to indicate that the KST protocol was sufficiently understood such that students could replicate interventions in practice with mock clients.

### **Hypothesis Nine: Role-Plays – KSRS-B Practical Differentiation**

The ninth hypothesis proposed that students would demonstrate skills from the appropriate phase and modality of KST, without demonstrating skills from the other phase or modalities of KST. Students were expected to differentiate in practice between strategies belonging to cognitive, emotion-focused, and behavioral therapies, as well as strategies belonging to the exploration and transformation phases of KST on a role-play demonstration. In support of the ninth hypothesis, Key Strategies Rating Scale – B results indicated that students less frequently used the phase and modalities not indicated by the multidimensional survey, suggesting that students were able to sufficiently differentiate between the treatment phases and modalities in practice.

### **Hypothesis Ten: Role-Plays - KSRS-B Competence**

The tenth hypothesis posited that students would be capable of practically demonstrating skills from a specific phase (exploration and transformation) and modality (cognitive, emotion-focused, and behavioral) of KST in a manner rated as competent by KST raters. Key Strategies Rating Scale – B results were expected to demonstrate a minimal level of competence compared to a threshold of competence designated by the scale mid-point. Raters provided an overall competence rating for each transcript, and results indicated that students were rated as performing competently during the two phases of KST, in support of the tenth hypothesis. These findings suggest the feasibility and integrity of utilizing KST to train new therapists to know how to implement and to demonstrate key strategies from three empirically-based treatments. Implications of these results potentially could be far-reaching, and may include the importance of introducing

psychotherapy students to empirically-based treatment modalities earlier in training, as well as further supporting the possibility of adequately training students in multiple modalities conjointly in a single semester.

#### **Hypothesis Eleven: Role-Plays - KSRS-B Inter-Rater Reliability**

The eleventh hypothesis proposed that raters would be able to consistently use the Key Strategies Rating Scale – B to score role-play demonstrations of a specific phase and modality of KST. Raters were expected to demonstrate consistent performance when using the measure. Raters' scores for this portion of Study B indicated strong inter-rater reliability, in support of the eleventh hypothesis. This finding suggested that psychotherapy students, having recently completed KST and trained with the KST rating protocol, were capable of consistently rating transcripts of interventions demonstrated by other students.

#### **Hypothesis Twelve: Role-Plays - KSRS-B Criterion-Related Validity**

The twelfth hypothesis posited that raters, utilizing the Key Strategies Rating Scale – B, would rate role-play demonstrations of a specific phase and modality of KST commensurate with a KST expert. Raters' scores for this portion of Study B also demonstrated strong criterion-related validity, in support of the twelfth hypothesis. This finding suggested that psychotherapy student raters were able to sufficiently rate video transcripts, similarly to a KST expert.

Taken together, these results may be interpreted to suggest that KST and the KST rater-training protocol adequately trained new psychotherapy students to sufficiently perform as raters in the current study. These results further imply the need for researchers

to appropriately balance integrity and feasibility, rather than erring on the side of integrity and thereby decreasing feasibility. These findings are particularly important in light of previous research suggesting the need for expert raters or increased training for raters scoring demonstration and practice interventions (Schoenwald & Garland, 2013). The current study suggests the viability of utilizing psychotherapy students in the rating of video transcripts of demonstrated interventions.

### **Contribution to Psychotherapy Training Research**

The current study sought to add to the existing research by providing support for an integrative approach to training new therapists to move from microskills to key strategies from three evidence-based treatments. This study further addresses concerns that research into psychotherapy training may not be as rigorous as research into psychotherapy treatment (Dimeff et al., 2009; Fairburn & Cooper, 2011; Garland & Schoenwald, 2013; Graham & Milne, 2003). This study has utilized a multi-method, multi-trait, and multi-informant method to achieve a more holistic analysis of KST with a variety of assessments, across a period of therapist development, from multiple perspectives, targeting multiple areas of therapist activity (Kaslow et al., 2007; Kaslow et al., 2009; Muse & McManus, 2013; Sharpless & Barber, 2009). Miller (1990) suggested that “no single assessment method can provide all the data required for judgment of anything so complex as the delivery of professional services by a successful physician” (p. 63). The current study addressed three of the four areas of measurement described by Miller, and adapted by Muse and McManus (2013) to psychotherapy.

The current results compare favorably to several other studies related to psychotherapist training. Similar to Keen and Freeston's (2008) study, which utilized written case studies, observer-rated therapy sessions with real clients, and written essay assignments, the current study found that reliability of scores decreased as assessments involved more practical skills, i.e., essay ratings were found to be more reliable than role-play transcript ratings. These findings likely point to the increased difficulty of rating the practical implementation of interventions, compared to the written description of interventions. Additionally, the current study found improvement on essay descriptions of interventions from pretest to post-test, similar to Keen and Freeston.

The current study utilized a multi-method approach to measuring training outcomes by assessing students' essays and role-play demonstrations. Sholomskas et al. (2005) and Sholomskas and Carroll (2006) conducted similar multi-method studies, utilizing role-plays assessed by independent raters, to compare participants in multiple training conditions on adherence, competence, and knowledge. These studies found that didactic seminars aided students' review of manuals, such that improved outcomes on the role-play and knowledge assessments were found when didactics were included. The current study supports these findings and adds to the therapy training literature suggesting that training by means of didactic seminars and manual review of therapeutic protocols is likely to increase students' knowledge of interventions, as well as students' competence and adherence to therapy protocols on mock demonstrations of therapeutic interventions.

Puspitasari, Kanter, Murphy, Crowe, and Koerner (2013) conducted two studies to determine newly-trained therapists' adherence to behavioral activation skills and the

feasibility a training procedure for three core mechanisms of behavioral activation. Similar to the training protocol of the current study, Puspitasari et al. (2013) taught strategies as complex behaviors comprised of sets of microskills, and a standardized role-play utilized research assistants acting as depressed individuals, and prompting trainees to employ specific skills. Ratings were found to be reliable, similar to the current study, and most trainees improved in their demonstration of behavioral interventions. Therefore, the current research strengthens previous findings by providing further support that students can learn interventions of evidence-based treatments by combining microskills into more complex interventions. The current research also adds to the existing literature by providing evidence suggesting that students may be able to make this transition in a multitheoretical manner, such that students conjointly learn interventions from three evidence-based treatment modalities.

### **Implications for Theory, Research, and Practice**

The feasibility of KST has a wide variety of applications to the theory, research, and practice of counselor training. Regarding theories of counselor training, trainers of new therapists would do well to consider the need to link initial microskills to the interventions of evidence-based treatments. KST offers a systematic way to accomplish this task, and the current research offers support for the potential benefits of placing more emphasis on counselor training during this transitional period.

This research also suggests that counselor training programs and theorists can place greater emphasis on the transition from microskills to evidence based interventions so that students do not fall through the cracks during their early training. KST likewise

provides theorists with a model for further investigation into the manner in which microskills are combined into evidence-based interventions and theory, particularly in light of the parallel structure of intervention processes delineated in KST. More specifically, theorists of integrative and single-theory models, recognizing the parallel structure of cognitive, emotion-focused, and behavioral therapies explicated in KST, can utilize this system as a meta-theoretical model, potentially leading to further awareness and research of the manner in which a variety of evidence-based treatments are related. If, for example, the underlying intervention processes are similar between several theories, as suggested within the KST model, then training and research may be more productive by focusing on the underlying processes (Harris, Kelley, Campbell, & Hammond, 2014; Busch et al., 2009). As explicated in the KST model, these underlying processes include two phases of treatment. The exploration phase includes focusing on a specific area of functioning, exploring the context, impact, and function of this area, analyzing the adaptive value of clients' functioning, and discovering patterns of thinking, feeling, or acting that are beyond awareness. The transformation phase includes experimenting, modifying, generalizing and consolidating, and assessing therapeutic change and impact. Key Strategies Training, therefore emphasizes the consideration of these underlying processes as they are expressed in clients' thoughts, feelings, behaviors, and other areas of functioning, thereby providing a holistic framework of the person, rather than constructing theory and intervention primarily around a specific area of functioning.

The feasibility of KST has similar implications for research, contributing to knowledge regarding the integrative training of new therapists, and potentially research

on mechanisms of change. Particularly, the current research supports the feasibility of teaching therapists-in-training psychotherapy integration at earlier stages of therapeutic development, rather than starting with training in a single-theory. The connection of helping skills to evidence-based interventions in KST is also likely to aid research in teasing apart how specific therapeutic behaviors are related to more advanced interventions. The current research supports the value of utilizing a multi-method, multi-trait, and multi-informant approach across a span of therapeutic development (Kaslow et al., 2007; Kaslow et al., 2009; Sharpless & Barber, 2009). Particularly, by creating a system of training and measuring new therapists' knowledge, understanding of application, and demonstration of skills, the current research provides an example for future researchers measuring training development in a similarly holistic manner. A similar application is likely to be beneficial in regard to training.

The current study has also attempted to advance the practice of integrative psychotherapy by addressing the gap between helping skills and empirically-based interventions through the development of a feasible method of training, with the integrity to produce therapists with the knowledge, skills, and competence to implement interventions capable of reaching the intended treatment effects. Emphasizing preparation targeting the gap between helping skills and evidence-based interventions is likely to have implications for the practice of evidence-based psychotherapy, which typically requires more training in order to achieve levels of competency comparable to basic skills (Kuntze, van der Molen, & Born, 2009). Perhaps most importantly, students who are aided specifically in this transition from basic helping skills into the interventions of

evidence-based treatments are likely to be more prepared to begin learning the evidence-based systems of psychotherapy they will acquire through additional courses, practicum, internship, and post-graduate trainings.

### **Limitations**

Students in the current study were selected primarily due to their participation in a psychotherapy skills course, and as such, participants could neither be randomly selected for the study nor randomly assigned to training conditions. The students who participated in this study received microskills training and the entire protocol for KST, such that a control group could not be separated within the sample. While an outside group could have received an alternative training for the sake of comparison, this was not considered feasible for the current study. Additionally, assessments were administered before, during, and immediately after students received KST, and long-term maintenance of training gains were not measured. Future KST research would do well to randomly select students who had previously received KST, randomly assign students to a variety of conditions, utilize a control group of students who had not received training in the key strategies model, and incorporate follow-up assessments several months post-training to determine whether student learning was maintained.

The current study also aimed at establishing the inter-rater reliability and criterion-related validity of raters, rather than the establishment of reliability and validity of the instruments utilized in the assessment and rating procedures. Future KST research would benefit from an investigation into the psychometrics of these assessments, exploring their reliability and validity, and making necessary changes to the instruments

to reach this end. Another limitation, related to statistical analyses, may be the possible violation of assumptions of the ANOVA, due to a possible floor effect impacting non-target scores. Students were not able to be rated below a rating of one, which resulted in an inability to detect possible decreases in students descriptions of strategies from pretest to post-test.

Another important limitation to be found in the current study was that the participants did not utilize interventions with real psychotherapy clients. As the final means of verifying competence, according to some researchers (Miller, 1990; Muse & McManus, 2013), and once considered the gold standard of ensuring competence (Ford, 1979), further research into the KST system of training will need to verify the transportability of the knowledge and skills demonstrated in the current study into use with actual clients. This limitation is particularly important as knowledge and application of therapeutic techniques are considered necessary but not sufficient elements of competence (Miller, 1990; Muse & McManus, 2013; Roth & Pilling, 2007; Sharpless & Barber, 2009).

A similar limitation involves the use of role-plays. “An issue here is that the role-play may demonstrate skill at implementing rehearsed skills, but it remains unknown whether trainees can implement the skills flexibly and in the context of various client difficulty levels” (Puspitasari et al., 2013, p. 263). Sharpless & Barber (2009) emphasized the potential for oversimplification of clinical scenarios, leading to “less authentic subjective experience that is not representative of clinical practice” (p. 490). Utilizing role-play assessments may also fail to highlight the importance potentially contributed by

common factors, which is especially important as trainee characteristics potentially predictive of positive clients outcome are not fully understood (Fairburn & Cooper, 2011; Rakovshik & McManus, 2010). While role-play assessments appear to be an up-and-coming area of research, many of these considerations should be taken into account.

Fairburn and Cooper (2011) noted another difficulty related to role-play assessments, namely the importance of developing reliable scenarios, and a reliable rating system built upon treatment manuals, comparison with experts and therapists whose levels of ability are known, and well-developed thresholds for competence. And though treatment manuals and the view of an expert in KST were utilized as criteria in the current study, trainees' performance was not compared to the performance of various therapists whose levels of ability were known. Future KST research would do well to create more standardized and complex role-play scenarios, utilize real clients and mock clients at various levels of difficulty, and more thoroughly establish competence levels. Additionally, future research may benefit from the assessment of common factors, in addition to knowledge and demonstration of specific interventions.

The use of raters in the current study also contributed to additional limitations. Raters in the current study were volunteers self-selected by the researcher based on their availability and willingness to participate in research. Raters may have had previously constructed ideas or confusion regarding how particular rating systems function (Young & Beck, 1980), and scores have been shown to vary in some studies based on the rater's own level of experience (Barber et al., 2007). Researchers have not established the level of expertise and independence raters need to sufficiently score the work of therapists

(Muse & McManus, 2013), though the current study suggests the feasibility of utilizing student raters. Additionally, some research suggests that the relationship between the raters and participants may be an intervening factor. For example, supervisors ratings of trainees have been found to be higher than independent raters, though the accuracy of each has not been established (Dennhag, Gibbons, Barber, Gallop, & Crits-Cristoph, 2012). Future research would do well to measure raters' preconceived notions regarding point systems and to improve the accuracy of ratings in relation to the expertise level and the type of relationship between raters and participants.

The current study is also limited by the fact that students, who recently completed KST, rated the essays and video transcripts of other students, potentially in their own class, though their ratings compared favorably to those of a KST expert. Raters did not rate their own responses as part of this study, and written transcripts were utilized, rather than the actual video-recordings, in order to protect the anonymity of participants. Additionally, rating systems often suffer from a few risks, including the halo effect, wherein raters score counselors' interventions based on previously observed behaviors, based on the rater's general impression of the counselor, and/or based on rating comparisons with other counselors (Madson, Campbell, Barrett, Brondino, & Melchert, 2005). This may have been particularly impactful with students rating other students, though the identity of participants were kept from the raters, and raters were provided training to guard against the halo effect. Future research may benefit from the utilization of raters who were not part of the class being rated, or by utilizing both raters from the class and raters from outside the class, allowing for comparison between two groups of

raters. Additionally, it should be noted that the KST expert, who provided training for students and ratings for criterion-related validity analyses, is the originator of the KST model, and is arguably more informed and proficient at utilizing the model than anyone else. Results may be different were another therapist providing the training or the criterion-related validity ratings.

### **Summary**

The purpose of this study was to explore the feasibility and integrity of utilizing Key Strategies Training (KST) to teach new therapists an integrative system for learning and practicing interventions from three empirically-based treatments. Results supported the utilization of KST for the development of knowledge of cognitive, emotion-focused, and behavioral interventions, as participants' essays describing these interventions were rated higher in the post-test when compared to pretest. Essay results also indicated that after receiving KST, participants were able to differentiate between the interventions of these three therapeutic modalities. Additionally, results supported that participants were able to competently adhere to the multidimensional survey protocol of KST. Last of all, participants were rated as adhering to and differentiating between the two phases of KST (exploration and transformation) and the three treatment modalities of KST (cognitive, emotion-focused, and behavioral) on a role-play demonstration. Results from ratings of role-play demonstrations also indicated that students performed above minimal levels of competence. While further exploration is needed regarding the efficacy of KST with actual clients, this study provides initial evidence of the feasibility and integrity of KST for teaching new therapists an integrative approach to utilizing cognitive, emotion-

focused, and behavioral interventions for exploring presenting problems commonly presented in a therapeutic setting, and for transforming maladaptive thoughts, feelings, and behaviors to bring about desirable outcomes.

### **Conclusion**

The findings of the current research contributes to previous psychotherapy training literature by supporting the use of a new method of integrative training to assist therapists-in-training transitioning from basic helping skills to evidence-based practice of psychotherapy. Based on the research methods utilized in this study, further KST research regarding the assessment of knowledge and the demonstration of interventions may make it possible for researchers to more deeply understand the mechanisms of change and therapeutic processes that comprise effective integrative psychotherapy training and practice.

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APPENDIX A  
Key Strategies Rating Scale - A (KSRS-A)

Rater Name: \_\_\_\_\_

**Key Strategies Rating Scale – A**

Written Essay Here.

<p><u>Exploring Thoughts</u> Does this essay represent the key strategies belonging to this treatment phase and modality (see KST strategy list)?</p> <p>1      2      3      4      5      6      7 Not at all                  Somewhat                  Extremely</p>	<p><u>Transforming Thoughts</u> Does this essay represent the key strategies belonging to this treatment phase and modality (see KST strategy list)?</p> <p>1      2      3      4      5      6      7 Not at all                  Somewhat                  Extremely</p>
<p><u>Exploring Feelings</u> Does this essay represent the key strategies belonging to this treatment phase and modality (see KST strategy list)?</p> <p>1      2      3      4      5      6      7 Not at all                  Somewhat                  Extremely</p>	<p><u>Transforming Feelings</u> Does this essay represent the key strategies belonging to this treatment phase and modality (see KST strategy list)?</p> <p>1      2      3      4      5      6      7 Not at all                  Somewhat                  Extremely</p>
<p><u>Exploring Actions</u> Does this essay represent the key strategies belonging to this treatment phase and modality (see KST strategy list)?</p> <p>1      2      3      4      5      6      7 Not at all                  Somewhat                  Extremely</p>	<p><u>Transforming Actions</u> Does this essay represent the key strategies belonging to this treatment phase and modality (see KST strategy list)?</p> <p>1      2      3      4      5      6      7 Not at all                  Somewhat                  Extremely</p>

**APPENDIX B**  
**Key Strategies Rating Scale - B (KSRS-B)**

### Key Strategies Rating Scale – B

Rater name: \_\_\_\_\_

Role-Play Transcript Here.

<p><u>Exploring Thoughts</u>            COG-1. Focusing on thoughts related to clients' presenting concerns            COG-2. Exploring the origins of thoughts, how they mediate experiences, and their impact on feelings and actions            COG-3. Analyzing thoughts to evaluate their functional value            COG-4. Discovering underlying core beliefs or schemas that influence conscious thought</p>	<p>Does this transcript represent the key strategies belonging to this treatment phase and modality (see list in left column)?</p> <p>1    2    3    4    5    6    7            Not at all                  Somewhat                  Extremely</p>
<p><u>Transforming Thoughts</u>            COG-5. Experimenting with thoughts to evaluate accuracy and generate alternatives            COG-6. Modifying beliefs and identifying more functional thoughts            COG-7. Reinforcing functional thoughts and putting these beliefs into practice            COG-8. Assessing cognitive change and multidimensional impact</p>	<p>Does this transcript represent the key strategies belonging to this treatment phase and modality (see list in left column)?</p> <p>1    2    3    4    5    6    7            Not at all                  Somewhat                  Extremely</p>
<p><u>Exploring Feelings</u>            EFT-1. Focusing on feelings related to clients' presenting concerns            EFT-2. Exploring the context and function of specific feelings and how they shape thinking and acting            EFT-3. Analyzing feelings to evaluate their adaptive value            EFT-4. Discovering unexplored emotional experiences outside of awareness</p>	<p>Does this transcript represent the key strategies belonging to this treatment phase and modality (see list in left column)?</p> <p>1    2    3    4    5    6    7            Not at all                  Somewhat                  Extremely</p>
<p><u>Transforming Feelings</u>            EFT-5. Experimenting with new feelings and overcoming emotional blocks            EFT-6. Generating adaptive feelings as an alternative to problematic emotional patterns            EFT-7. Generalizing adaptive feelings and reflecting on emotional responses            EFT-8. Assessing emotional change and multidimensional impact</p>	<p>Does this transcript represent the key strategies belonging to this treatment phase and modality (see list in left column)?</p> <p>1    2    3    4    5    6    7            Not at all                  Somewhat                  Extremely</p>

<p><u>Exploring Actions</u>          BHV-1. Focusing on actions related to clients' presenting concerns          BHV-2. Exploring the triggers and functions of specific actions and how they impact thoughts and feelings          BHV-3. Analyzing actions to evaluate their effectiveness          BHV-4. Discovering patterns of reinforcement that shape current actions</p>	<p>Does this transcript represent the key strategies belonging to this treatment phase and modality (see list in left column)?</p> <p>1    2    3    4    5    6    7          Not at all                  Somewhat                  Extremely</p>
<p><u>Transforming Actions</u>          BHV-5. Experimenting with new actions and observing results          BHV-6. Improving skills through training and behavioral rehearsal          BHV-7. Generalizing effective actions to new environments outside of psychotherapy          BHV-8. Assessing behavioral change and multidimensional impact</p>	<p>Does this transcript represent the key strategies belonging to this treatment phase and modality (see list in left column)?</p> <p>1    2    3    4    5    6    7          Not at all                  Somewhat                  Extremely</p>

How competently did the therapist demonstrate this treatment phase and modality?

1            2            3            4            5            6            7

Not at all competent                  Minimal competence                  Extremely competent

APPENDIX C  
Multidimensional Survey Adherence and Competence Rating Scale



APPENDIX D  
Role-Play Scenarios

## **Role Play Scenario 1. Depression**

### Background to be read to Counselor

During the first half of the first session, the client reports he or she has been feeling bad for the last few months. Here are some of the things the client reported to the therapist:

- I don't want to do the things I used to do like going out with friends or participating in sports.
- Sometimes I can't get out of bed in the morning and go to work late.
- This all started a few months ago when my roommate/best friend moved away.

### Instructions for the Role-Play Client

When the counselor asks questions about your thoughts, actions, and feelings, you should respond at first with something a bit vague but if the counselor asks more questions you can give them more details. As you talk with your counselor, please feel free to embellish this basic outline and fill in ideas about this character and his or her background.

### Thoughts

Vague: Life stinks since my friend left town.

Specific: Nobody else understands me like my best friend.

### Actions

Vague: I don't do anything anymore.

Specific: It seems like I am paralyzed.  
I don't go out any more because I never have a good time.

### Feelings

Vague: Crappy

Specific: Lonely

### Focal Dimension

If asked, the client reports that he or she would like to focus on THOUGHTS.

### Deeper Pattern

My friend really appreciated and affirmed me. Without this friend, I'm more vulnerable to deeper beliefs that I am not loveable.

## **Role Play Scenario 2. Anxiety**

### Background to be read to Counselor

During the first half of the first session, the client reports he or she has been feeling increasingly nervous for the past month. Here are some of the things the client reported to the therapist:

- I was in a car wreck about a months ago
- I stayed home for a couple weeks to recover from minor injuries
- Now I'm afraid to leave the house and have been missing work
- At first I was just afraid of driving, now I seem to be afraid of everything

### Instructions for the Role-Play Client

When the counselor asks questions about your thoughts, actions, and feelings, you should respond at first with something a bit vague but if the counselor asks more questions, you can give them more details. As you talk with your counselor, please feel free to embellish this basic outline and fill in ideas about this character and his or her background.

### Thoughts

Vague: It's easier just to stay at home.

Specific: I don't want to get hurt again. If I stay at home, I'm safe.  
If I go back to work, it will be hard to catch up.

### Actions

Vague: Staying at home.

Specific: Avoiding work. Avoiding friends. Avoiding cars.

### Feelings

Vague: Nervous.

Specific: Scared of getting in a car again. Afraid I'll be in another wreck.  
Afraid of the work I've missed.

### Focal Dimension

If asked, the client reports that he or she would like to focus on ACTIONS.

### Deeper Pattern

When I feel scared I want to check out and withdraw. When I stay home and withdraw, I feel relieved that I don't have to face my fears. As I repeat this pattern, it feels better to withdraw and increasingly harder to leave the safety of my house. But I also feel guilty for withdrawing and scared that I am falling apart.

### **Role Play Scenario 3. Substance Abuse**

#### Background to be read to Counselor

During the first half of the first session, the client reports he or she has been worried about his or her drinking since becoming unemployed a few months ago. Here of some of the things the client reported to the therapist:

- I used to drink mostly on the weekend but now I'm drinking every night
- I tell myself I'm only going to drink one or two beers but then I usually drink six or more
- I'm trying to find a new job but I haven't found anything in my field of graphic design

#### Instructions for the Role-Play Client

When the counselor asks questions about your thoughts, actions, and feelings, you should respond at first with something a bit vague but if the counselor asks more questions, you can give them more details. As you talk with your counselor, please feel free to embellish this basic outline and fill in ideas about this character and his or her background.

#### Thoughts

Vague: I can't get a job.

Specific: I don't think I'm a very good graphic designer and I don't think anyone will hire me again.

#### Actions

Vague: Drinking too much.

Specific: I used to hang out with friends from work and play on a softball team from work but now I'm pretty isolated. Because I don't have anything to do and feel discouraged, I often drink at home to distract myself from my troubles.

#### Feelings

Vague: Crappy.

Specific: Lonely – I miss my friends from my old job.

Hopeless – I don't think I'm employable anymore.

Helpless – I hate just sitting at home but I also hate getting rejected when I apply for jobs.

#### Focal Dimension

If asked, the client reports that he or she would like to focus on FEELINGS.

#### Deeper Pattern

At the deepest level, I feel ashamed because I messed up at my old job and I'm afraid I'll never get a new one. I did well at my job for the first year and a half and then got a new supervisor. For the last six months, the new boss did not like my work. So, alongside the shame there is also some resentment and anger at my boss who gave me a hard project that I didn't do well at. I think he set me up to fail.

APPENDIX E  
Institutional Review Board Approval Letter



**Institutional Review Board**  
Office of Research and Sponsored Programs  
P.O. Box 425619, Denton, TX 76204-5619  
940-898-3378  
email: IRB@twu.edu  
<http://www.twu.edu/irb.html>

DATE: July 3, 2014

TO: Mr. Leslie J. Kelley  
Psychology & Philosophy

FROM: Institutional Review Board - Denton

Re: *Exemption for A Study Exploring the Feasibility and Integrity of Key Strategies Training (Protocol #: 17753)*

The above referenced study has been reviewed by the TWU Institutional Review Board (IRB) and was determined to be exempt from further review.

If applicable, agency approval letters must be submitted to the IRB upon receipt PRIOR to any data collection at that agency. Because a signed consent form is not required for exempt studies, the filing of signatures of participants with the TWU IRB is not necessary.

Although your protocol has been exempted from further IRB review and your protocol file has been closed, any modifications to this study must be submitted for review to the IRB using the Modification Request Form. Additionally, the IRB must be notified immediately of any adverse events or unanticipated problems. All forms are located on the IRB website. If you have any questions, please contact the TWU IRB.

cc. Dr. Shannon Rich Scott, Psychology & Philosophy  
Dr. Jeff E. Harris, Psychology & Philosophy  
Graduate School

APPENDIX F  
Demographic Information Sheet

## Demographic Questionnaire

Plant/Animal name: \_\_\_\_\_ Date: \_\_\_\_\_

INSTRUCTIONS: Please answer the following questions to the best of your ability.			
Age: _____	Zip Code: _____		
Ethnicity (check one):	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Black/African American <input type="checkbox"/> East Asian/ Asian American <input type="checkbox"/> Latino/Hispanic <input type="checkbox"/> Middle Eastern/West Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> South Asian/Asian Indian <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Biracial/Multiracial/Multiethnic Other (Please specify):	Sexual Orientation (check one):	<input type="checkbox"/> Bisexual <input type="checkbox"/> Gay <input type="checkbox"/> Heterosexual <input type="checkbox"/> Lesbian
Gender (check one):	<input type="checkbox"/> I am a man <input type="checkbox"/> I am a woman <input type="checkbox"/> I am trans	Sex (check one):	<input type="checkbox"/> I am female <input type="checkbox"/> I am male <input type="checkbox"/> I am intersex
	In what field is the degree you are currently pursuing? (please circle one letter): <ol style="list-style-type: none"> <li>a. Counseling Psychology</li> <li>b. Clinical Psychology</li> <li>c. School Psychology</li> <li>d. Counseling</li> <li>e. Marriage and Family Therapy</li> <li>f. Social Work</li> </ol> Other (Please specify):		

APPENDIX G  
Key Strategies Training Rating Manual

## **Key Strategies Training Rating Manual**

Leslie J. Kelley, M.A.

Jeff. E. Harris, Ph.D.

Texas Woman's University  
Department of Psychology & Philosophy  
Denton, TX

## General Instructions for Raters

This manual has been designed to assist raters in the assessment of psychotherapy trainees' knowledge and demonstration of Key Strategies Training by providing important guidelines and definitions of terms considered essential for the proper rating of trainee development in this system of training. The Key Strategies Rating Scales have been developed to rate trainees' progress on transcripts derived from essays or from role-play videos. Researchers who have conducted psychotherapy studies relying on the rating of therapeutic performance have pointed out a number of potential weaknesses, including 'halo' ratings and raters personal determination of the meaning of points on a Likert-type scale.

Young and Beck (1980), who developed the *Cognitive Therapy Scale Rating Manual*, pointed out that 'halo effects' can occur when raters think a therapist is good, and therefore rate the therapist higher on all categories, or vice versa, thinking a therapist is bad, and rating them lower. Madson et al. (2005), who developed the *Motivational Interviewing Supervision & Training Scale: Guidelines for Rating Audiotape Sessions*, pointed out that 'halo' ratings can also occur when raters begin to consider what OUGHT to have happened in a session, rather than ONLY WHAT ACTUALLY DID OCCUR. In order to avoid potential 'halo effects' raters should rely heavily upon and closely utilize the guidelines for rating transcripts listed as follows in this manual.

Young and Beck (1980) also pointed out the problem of raters relying "solely on their own notions of what a particular scale point means (e.g., 4 is average) and to disregard the descriptions provided on the form" (p.2). Descriptions listed below are intended to help raters assess trainees' performance in a more uniform manner. Basing your ratings on the guidelines listed below, will further insure that your ratings will be accurate and consistent with other raters. If a trainee appears to do well overall, in your opinion, please do not be concerned if you must rate the trainee lower on a given item, particularly as that item may, or may not be the target item for a given transcript.

Please use the guidelines below on each rating, and avoid basing your ratings on previous ratings on other items or previous ratings given to other trainees' transcripts. Also, please be sure to rate every item on each scale by circling one whole number, rather than leaving a question blank, circling two numbers, or circling the space between two numbers. While this manual attempts to provide clear definitions and guidelines for each phase and modality of treatment, some strategies may appear to overlap when described by trainees in essays or demonstrated in role-play scenarios. Raters are expected to use their best judgment when strategies appear to overlap or represent more than one category, keeping in mind that the 7-point Likert-type scale should provide raters with the opportunity to rate transcripts in more subtle manner.

## Key Strategies Training

Key Strategies Training (KST) (Harris, Kelley, Campbell, & Hammond, in press) is a new method of training psychotherapists based on a model of multitheoretical psychotherapy integration developed by Brooks-Harris (2008). The key strategies method retains the core principles of multitheoretical integration and facilitates therapists' development in three evidence based psychotherapy modalities (Harris et al., in press):

- Cognitive Therapy
- Emotion-Focused Therapy
- Behavioral Activation

KST trains psychotherapy students to gain introductory skills related to exploring and transforming cognitions, affect, and behavior, and was designed to aid new therapists in building upon a microskills foundation. Key Strategies Training has been divided into two **phases** of therapy:

- The *exploration* phase helps clients achieve a **deeper awareness** of cognitive, affective, or behavioral processes
- The *transformation* phase helps clients **progress toward changes** deemed important earlier in treatment.

Each of these phases of KST have been specified into four intervention processes considered similar across the three treatment modalities taught by the key strategies method (cognitive, emotion-focused, and behavioral). The exploration phase consists of: (a) Focusing on a specific dimension of functioning, (b) Exploring context, function, and impact, (c) Analyzing adaptive value, and (d) Discovering patterns outside of awareness. The transformation phase consists of: (a) Experimenting, (b) Modifying, (c) Generalizing and consolidating, and (d) Assessing change and impact (Harris et al., in press).

### Transcript Rating Process

As a rater, your task will be to rate essay and video transcripts based on how well each transcript represented the key strategies belonging to each treatment phase and modality on a 7-point Likert-type scale. This scale will range as follows:

- (1) “not at all representative”
- (4) “somewhat representative.”
- (7) “extremely representative,”

You will be presented one transcript at a time, and transcripts will be presented in a random order, such that the order will not in any way determine a specific treatment phase (exploration or transformation), modality (cognitive, emotion-focused, or behavioral), or timeframe (essays completed pre-training versus post-training). Generally on the 7-point Likert-type scale, “not at all representative” will indicate that a trainee did not identify or use any strategies from the target phase and modality of treatment; “somewhat representative” will indicate that a trainee attempted to describe or utilize strategies from the target phase and modality of treatment; and “extremely representative” will indicate that a trainee described or used strategies from the target phase and modality of treatment very consistently. Please use the guidelines below as a basis for rating transcripts belonging to specific phases and modalities of treatment. However, the examples below should be regarded only as guidelines and not as absolute rating criteria. Additionally, please note that the length of an essay or transcript should not be the basis for your judgment, but rather the degree to which essay and video transcripts represent strategies from the target phase and modality of treatment. Responses that give examples of therapeutic techniques or comments to be made to clients should likewise be rated based on whether the techniques or comments represent the key strategies belonging to the target phase and modality of treatment.

## Key Strategies Rating Scale: Guidelines for Raters

### (A) Exploring Thoughts: Guidelines

*Cognitive Therapy (CT)* was first developed in the 1960’s and applied to depression in the 1970’s by Aaron Beck (A. T. Beck, Rush, Shaw, & Emory, 1979). CT focuses on identifying and modifying dysfunctional thoughts and beliefs that often are associated with psychological problems like depression and anxiety (A. T. Beck, 1976; A. T. Beck & Weishaar, 2014). CT is a time-limited, present-focused approach in which psychotherapists identify and evaluate clients’ automatic thoughts as well as modify intermediate and core beliefs in order to relieve psychological symptoms (J. S. Beck, 1995). Research on CT has used clinical trials to demonstrate its effectiveness in treating depression, anxiety, eating disorders, and substance abuse (Hollon & Beck, 2004). CT operates from the supposition that “realistic evaluation and modification of thinking produce an improvement in mood and behavior. Enduring improvement results from modification of the patient’s underlying dysfunctional core beliefs” (J. S. Beck, 1995, p. 1). The first four cognitive strategies described by KST focus on exploring clients’ thoughts and understanding the way thinking may contribute to psychological problems.

### COG Exploration Strategies: Key Strategies Rating Scale – A Question

<p><u>Exploring Thoughts</u></p> <p>COG-1. Focusing on thoughts related to clients’ presenting concerns</p> <p>COG-2. Exploring the origins of thoughts, how they mediate experiences, and their impact on feelings and actions</p> <p>COG-3. Analyzing thoughts to evaluate their functional value</p> <p>COG-4. Discovering underlying core beliefs or schemas that influence conscious thought</p>	<p>Does this essay represent the key strategies belonging to this treatment phase and modality (see list in left column)?</p> <p style="text-align: center;">1    2    3    4    5    6    7</p> <p>Not at all                      Somewhat                      Extremely</p>
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### Exploring Thoughts: Essay Rating Guidelines

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An essay which is *Extremely Representative* of the Exploring Thoughts phase/modality will contain written information describing all four of the following strategies.

An essay which is *Somewhat Representative* of the Exploring Thoughts phase/modality will contain written information describing 2-3 of the following strategies.

An essay which is *Not At All Representative* of the Exploring Thoughts phase/modality will contain written information describing none of the following strategies.

COG-1. Focusing on thoughts related to clients' presenting concerns

- Alternatives verbs to Focusing: attending to, listening/actively listening, concentrating on, considering, exploring, observing
  - Related to thoughts about presenting concern

COG-2. Exploring the origins of thoughts, how they mediate experiences, and their impact on feelings and actions

- Alternative verbs to Exploring: searching for, looking for, focusing on, surveying, concentrating on, observing, noticing, investigating
  - Related to origin, context, and impact of thoughts

COG-3. Analyzing thoughts to evaluate their functional value

- Alternative verbs to Analyzing: examining, evaluating, considering, questioning, investigating, probing, assessing, appraising, discerning
  - Related to the functionality of cognitions

COG-4. Discovering underlying core beliefs or schemas that influence conscious thought

- Alternative verbs to Discovering: establishing, finding, learning, determining, realizing, ascertaining, discerning, concluding, verifying
  - Related to underlying core beliefs and cognitive schemas

COG Explorations Strategies: Key Strategies Rating Scale – B Question

<p><u>Exploring Thoughts</u>          COG-1. Focusing on thoughts related to clients' presenting concerns          COG-2. Exploring the origins of thoughts, how they mediate experiences, and their impact on feelings and actions          COG-3. Analyzing thoughts to evaluate their functional value          COG-4. Discovering underlying core beliefs or schemas that influence conscious thought</p>	<p>Does this transcript represent the key strategies belonging to this treatment phase and modality (see list in left column)?</p> <p style="text-align: center;">1    2    3    4    5    6    7</p> <p style="text-align: center;">Not at all                      Somewhat                      Extremely</p>
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### Exploring Thoughts: Extremely Representative Video Transcript Example

#### COG-1. Focusing on Thoughts Example (Scale Score: 7):

- **Client:** *I get so nervous being around groups of people that most of the time I just avoid any kind of social situation. I feel like I'm missing out on so much, but I just don't know how to deal with my nerves.*
- **Counselor:** *Sounds like your anxiety really gets in the way of being able to interact with people, especially socially. What goes through your mind when you think about being around a group of people?*

#### COG-2. Understanding the Impact of Thoughts Example (Scale Score: 7):

- **Client:** *I guess I start worrying that people won't like me and they'll make fun of me.*
- **Counselor:** *So when you think about this, how do you feel and what do you do?*
- **Client:** *I feel nervous and I want to avoid the whole situation. So usually I just stay home so I don't have to deal with it.*

#### COG-3. Analyzing the Functional Value of Thoughts Example (Scale Score: 7):

- **Counselor:** *So it seems that when you think about people not liking you, you then worry they'll make fun of you. This makes you feel anxious and leads you to avoid the whole situation.*
- **Client:** *Exactly. I just get so afraid that people will be mean to me that it paralyzes me. I can't go out with my friends no matter how much I want to, and I'm getting really isolated.*

#### COG-4. Discovering Underlying Core Beliefs and Schemas Example (Scale Score: 7):

- **Counselor:** *Sounds like this debilitating anxiety is linked to worry that people won't like you, which will lead them to bully or ridicule you. I wonder what leads you to worry that people won't like you and will try to embarrass you?*
- **Client:** *I think about how in high school, kids would always make fun of me and it was so embarrassing. They would say mean things about me being gay. I started thinking they didn't like me because I was gay and I worry other people will think that now.*

### Exploring Thoughts: Not At All Representative Video Transcript Example

#### COG-1. Focusing on Thoughts Example (Scale Score: 1):

- **Client:** *I get so nervous being around groups of people that most of the time I just avoid any kind of social situation. I feel like I'm missing out on so much, but I just don't know how to deal with my nerves.*
- **Counselor:** *That sounds tough. I'm glad I'm not in that situation. You should really try to stop that when you're around groups of people.*

#### COG-2. Understanding the Impact of Thoughts Example (Scale Score: 1):

- **Client:** *I guess I start worrying that people won't like me and they'll make fun of me.*
- **Counselor:** *No one likes getting made fun of, especially my little brother Johnny. He probably felt really bad as a kid because he was made fun of a lot.*

COG-3. Analyzing the Functional Value of Thoughts Example (Scale Score: 1):

- **Client:** *I feel nervous and I want to avoid the whole situation. So usually I just stay home so I don't have to deal with it.*
- **Counselor:** *Staying home can be fun and you could even make it a special time when you try out new recipes for dinner all by yourself. Then you won't have to worry about being anxious anymore. Unless, of course, you start worrying about how your recipe is going to turn out.*

COG-4. Discovering Underlying Core Beliefs and Schemas Example (Scale Score: 1):

- **Client:** *I just get so afraid that people will be mean to me that it paralyzes me. I can't go out with my friends no matter how much I want to, and I'm getting really isolated.*
- **Counselor:** *Did you try to do something new and fun around the house, like the new recipe we discussed last time? That could really take your mind off of your isolation.*
- **Client:** *Yeah. Um, well, I guess it helped a little, kind of, but I was still pretty isolated.*

(B) Transforming Thoughts: Guidelines

After a psychotherapist and client understand the way thoughts may contribute to psychological problems, it is often helpful to identify new ways of thinking that may be more adaptive and relieve distress. CT is designed to “challenge dysfunctional beliefs and to promote more realistic adaptive thinking” (A. T. Beck & Weishaar, 2011, p. 290). For example, a client who feels inadequate because he or she believes that, “I need to be perfect at everything to prove my worth” may need help to revise their thinking and come to the conclusion that, “I have strengths and weaknesses in different areas.” CT encourages psychotherapists to adopt an attitude of collaborative empiricism in which Socratic questioning and guided discovery are used to test the accuracy of thoughts, resulting in new, more functional beliefs. The next four cognitive strategies focus on transforming clients’ thoughts by embracing new ways of thinking that may relieve psychological distress.

COG Transformation Strategies: Key Strategies Rating Scale – A Question

<p><u>Transforming Thoughts</u>                  COG-5. Experimenting with thoughts to evaluate accuracy and generate alternatives                  COG-6. Modifying beliefs and identifying more functional thoughts                  COG-7. Reinforcing functional thoughts and putting these beliefs into practice                  COG-8. Assessing cognitive change and multidimensional impact</p>	<p>Does this essay represent the key strategies belonging to this treatment phase and modality (see list in left column)?</p> <p>1    2    3    4    5    6    7                  Not at all                      Somewhat                      Extremely</p>
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## Transforming Thoughts: Essay Rating Guidelines

Remember: The action words used to describe each strategy may be different from the one utilized in the strategy itself. As long as the essay response contains the basic idea or purpose of the strategy, credit should be given. Please note that the alternative action words listed below are not exhaustive and that raters are expected to use their best judgment in determining how representative an essay is of a particular phase/modality of KST. Likewise, the same action words may be used to designate different strategies, and raters should rely on context clues within the essay to determine which strategies are and are not represented.

An essay which is *Extremely Representative* of the Transforming Thoughts phase/modality will contain written information describing all four of the following strategies.

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An essay which is *Not At All Representative* of the Transforming Thoughts phase/modality will contain written information describing none of the following strategies.

COG-5. Experimenting with thoughts to evaluate accuracy and generate alternatives

- Alternative verbs to Experimenting: testing, trying out, conducting tests/experiments, investigating, researching, attempting
  - Related to the accuracy of thoughts and generating alternative thinking

COG-6. Modifying beliefs and identifying more functional thoughts

- Alternative verbs to Modifying: changing, adjusting, transforming, altering, amending, adapting, revising, reworking, correcting
  - Related to changing core beliefs and using more functional thinking

COG-7. Reinforcing functional thoughts and putting these beliefs into practice

- Alternative verbs to Reinforcing: strengthening, supporting, buttressing, highlighting, emphasizing, backing up, fortifying, corroborating, building up
  - Related to solidifying new thinking and generalizing changes

COG-8. Assessing cognitive change and multidimensional impact

- Alternative verbs to Assessing: evaluating, reviewing, appraising, judging, analyzing, examining, considering, determining, verifying
  - Related to exploring alternative dimensions for exploration and transformation

COG Transformation Strategies: Key Strategies Rating Scale – B Question

<p><u>Transforming Thoughts</u>                  COG-5. Experimenting with thoughts to evaluate accuracy and generate alternatives                  COG-6. Modifying beliefs and identifying more functional thoughts                  COG-7. Reinforcing functional thoughts and putting these beliefs into practice                  COG-8. Assessing cognitive change and multidimensional impact</p>	<p>Does this transcript represent the key strategies belonging to this treatment phase and modality (see list in left column)?</p> <p>1    2    3    4    5    6    7                  Not at all                      Somewhat                      Extremely</p>
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Transforming Thoughts: Extremely Representative Video Transcript Example

COG-5. Experimenting with Thoughts Example (Scale Score: 7):

- **Client:** *I think about how in high school, kids would always make fun of me and it was so embarrassing. They would say mean things about me being gay. I started thinking they didn't like me because I was gay and I worry other people will think that now.*
- **Counselor:** *So this fear is based on very real discrimination experiences, and now you understandably worry that everyone will feel the same way. This thought is strengthened when you find yourself so alone because you think it confirms that no one wants to be with you. Are there any other possible explanations for why you're alone all the time?*
- **Client:** *Well, I guess it could be because but I usually just don't even try to go out, because I'm too afraid.*

COG-6. Modifying Beliefs Example (Scale Score: 7):

- **Client:** *I just keep thinking "people won't like me because I'm gay, and there's nothing I can do about it." It makes me too afraid to try.*
- **Counselor:** *I wonder if you could change that thought to something like "some people will reject me because of my sexual orientation and some will not."*

COG-7. Reinforcing Functional Thoughts Example (Scale Score: 7):

- **Client:** *My friends asked me to go out last weekend and I practiced telling myself that it was okay to go out with them because they don't judge me. I repeated to myself that it doesn't matter what other people think. It helped! I wasn't as anxious and I had a good time!*
- **Counselor:** *That's great, so when you worked with your fearful thoughts and reminded yourself that you have friends who care about you and aren't judgmental, you became less paralyzed by anxiety. Now, the more you practice this, the easier it will become.*

COG-8. Assessing Cognitive Change and Impact Example (Scale Score: 7):

- **Client:** *I feel like working on changing my thoughts has really helped me be less anxious around people. But I know I'm still holding on to a lot of pain from being bullied in high school, that hasn't changed much.*
- **Counselor:** *I think it might be helpful for us to shift to focusing more intensely on the feelings associated with those times. That might be helpful in freeing you even more from the anxiety you still feel around people.*

Transforming Thoughts: Not At All Representative Video Transcript Example

COG-5. Experimenting with Thoughts Example (Scale Score: 1):

- **Client:** *I think about how in high school, kids would always make fun of me and it was so embarrassing. They would say mean things about me being gay. I started thinking they didn't like me because I was gay and I worry other people will think that now.*
- **Counselor:** *If you just disregard these comments then these memories probably won't bother you as much. Instead why don't you try to consider why no one wants to be with you. I'm sure there are good explanations for why you're alone all the time?*

COG-6. Modifying Beliefs Example (Scale Score: 1):

- **Client:** *I just keep thinking "people won't like me because I'm gay, and there's nothing I can do about it." It makes me too afraid to try.*
- **Counselor:** *I wonder if you could try to hold on to that feeling to help you remember times when people didn't like you. Maybe that will keep you from putting yourself in those situations again.*

COG-7. Reinforcing Functional Thoughts Example (Scale Score: 1):

- **Client:** *My friends asked me to go out last weekend and I practiced telling myself that it was okay to go out with them because they don't judge me. I repeated to myself that it doesn't matter what other people think. It helped! I wasn't as anxious and I had a good time!*
- **Counselor:** *That's great, so I guess you learned that when you just pull yourself up by your bootstraps and pretend not to be anxious, other people will like you more. You should keep disregarding your anxious feelings.*

COG-8. Assessing Cognitive Change and Impact Example (Scale Score: 1):

- **Client:** *I feel like working on changing my thoughts has really helped me be less anxious around people. But I know I'm still holding on to a lot of pain from being bullied in high school, that hasn't changed much.*
- **Counselor:** *I think it might be helpful for us to continue doing more cognitive work. If we keep doing the same thing over and over again, surely it will eventually work. That might be helpful in freeing you even more from the anxiety you still feel around people.*

(C) Exploring Feelings: Guidelines

*Emotion-Focused Therapy* (EFT) is a contemporary experiential approach to psychotherapy that integrates key aspects of Roger’s client-centered therapy and Perl’s gestalt therapy (Greenberg, 2002). EFT “can be seen as operating according to two overarching principles: facilitating a therapeutic relationship and promoting therapeutic work” (Greenberg & Watson, 2006, p. 93). EFT utilizes experiential interventions such as focusing on emotions, expanding and validating emotions, and building emotional awareness. EFT encourages psychotherapists to work with primary feelings and discover adaptive responses through active emotional experimentation. By exploring secondary emotions and defensive responses, emotional responses can be transformed and new meaning can be consolidated (Montagno, Svatovic, & Levenson, 2011; Denton, Johnson & Burlison, 2009; Greenberg & Watson, 2006). In EFT, “therapists work to enhance clients’ emotional intelligence, which involves the recognition and use of their own and others’ emotional states to solve problems and regulate behavior” (Greenberg & Watson, 2006, p. 9). Elliot, Greenberg, and Lietaer (2004) have summarized the research showing that experiential therapies are effective treatments for anxiety, trauma, depression, anger/aggression, schizophrenia, and health-related problems. As a specific example, EFT for depression has been tested using a randomized clinical trial and shown to be as effective as cognitive-behavioral treatment in relieving depression and related symptoms (Watson, Gordon, Stermac, Kalogerakos, & Steckly, 2003). More advanced EFT interventions include two-chair and empty-chair enactments (Greenberg & Watson, 2006) but these complex techniques are beyond the scope of this introduction. KST describes four EFT strategies that focus on exploring clients’ feelings and how they may contribute to psychological problems.

EFT Exploration Strategies: Key Strategies Rating Scale - A Question

<p><u>Exploring Feelings</u>  EFT-1. Focusing on feelings related to clients’ presenting concerns  EFT-2. Exploring the context and function of specific feelings and how they shape thinking and acting  EFT-3. Analyzing feelings to evaluate their adaptive value  EFT-4. Discovering unexplored emotional experiences outside of awareness</p>	<p>Does this essay represent the key strategies belonging to this treatment phase and modality (see list in left column)?</p> <p style="text-align: center;">1    2    3    4    5    6    7</p> <p style="text-align: center;">Not at all                      Somewhat                      Extremely</p>
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Exploring Feelings: Essay Rating Guidelines

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representative an essay is of a particular phase/modality of KST. Likewise, the same action words may be used to designate different strategies, and raters should rely on context clues within the essay to determine which strategies are and are not represented.

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EFT-1. Focusing on feelings related to clients' presenting concerns

- Alternative verbs to Focusing: attending to, listening/actively listening, concentrating on, considering, exploring, observing
  - Related to feelings about presenting concern

EFT-2. Exploring the context and function of specific feelings and how they shape thinking and acting

- Alternative verbs to Exploring: searching for, looking for, focusing on, surveying, concentrating on, observing, noticing, investigating
  - Related to context and function of feelings, and their relationship to thoughts and actions

EFT-3. Analyzing feelings to evaluate their adaptive value

- Alternative verbs to Analyzing: examining, evaluating, considering, questioning, investigating, probing, assessing, appraising, discerning
  - Related to the adaptive value of feelings

EFT-4. Discovering unexplored emotional experiences outside of awareness

- Alternative verbs to Discovering: establishing, finding, learning, determining, realizing, ascertaining, discerning, concluding, verifying
  - Related to unexplored emotional experiences

EFT Exploration Strategies: Key Strategies Rating Scale - B Question

<p><u>Exploring Feelings</u>  EFT-1. Focusing on feelings related to clients' presenting concerns  EFT-2. Exploring the context and function of specific feelings and how they shape thinking and acting  EFT-3. Analyzing feelings to evaluate their adaptive value  EFT-4. Discovering unexplored emotional experiences outside of awareness</p>	<p>Does this transcript represent the key strategies belonging to this treatment phase and modality (see list in left column)?</p> <p>1    2    3    4    5    6    7  Not at all                      Somewhat                      Extremely</p>
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Exploring Feelings: Extremely Representative Video Transcript Example

EFT-1. Focusing on Feelings Example (Scale Score: 7):

- **Counselor:** *How are you feeling right now as you're talking about your mother?*
- **Client:** *I feel angry and worried because she is never satisfied with me.*
- **Counselor:** *Tell me about being angry.*
- **Client:** *It eats away at me, like a constant pain. I'm always on edge. It's exhausting!*

EFT-2. Exploring the Context and Function of Feelings Example (Scale Score: 7):

- **Client:** *I feel hopeless, like things will never get better.*
- **Counselor:** *I wonder if there are certain times that these feelings impact you more strongly?*
- **Client:** *When I'm with my mother, and pretty much anytime I think about how she criticizes me.*

EFT-3. Analyzing the Adaptive Value of Feelings Example (Scale Score: 7):

- **Counselor:** *What about your relationship with your mother provokes anger?*
- **Client:** *She criticizes me so harshly.*
- **Counselor:** *It's natural to be angry about harsh criticism. Anger is an important emotion because it helps protect us.*

EFT-4. Discovering Unexplored Emotions Example (Scale Score: 7):

- **Client:** *My mother always tells me what to do. I'm not a child!*
- **Counselor:** *It's tough being treated like a child.*
- **Client:** *It feels like I'm going to get into trouble all the time and it scares me.*
- **Counselor:** *So, underneath your anger at your mother, you're experiencing fear.*

### Exploring Feelings: Not At All Representative Video Transcript Example

#### EFT-1. Focusing on Feelings Example (Scale Score: 1):

- **Counselor:** *So, what were we going to talk about again, what it your behaviors or your thoughts?*
- **Client:** *I feel angry and worried because my mother is never satisfied with me.*
- **Counselor:** *Oh yeah. That's right. What do you plan to do about that?*
- **Client:** *Uh, I guess I'll just be angry!*

#### EFT-2. Exploring the Context and Function of Feelings Example (Scale Score: 1):

- **Client:** *I feel hopeless, like things will never get better.*
- **Counselor:** *When you feel that way just consider how much worse it could be if you keep doing these things?*
- **Client:** *Wow. I'm not really sure how much worse it could get.*

#### EFT-3. Analyzing the Adaptive Value of Feelings Example (Scale Score: 1):

- **Counselor:** *So your relationship with your mom is pretty bad, huh?*
- **Client:** *She criticizes me so harshly.*
- **Counselor:** *Maybe you should try not to get so angry so that you don't upset her anymore than you already seem to be doing.*

#### EFT-4. Discovering Unexplored Emotions Example (Scale Score: 1):

- **Client:** *My mother always tells me what to do. I'm not a child!*
- **Counselor:** *Yeah, but you kind of act like it sometimes, and so does she, huh?*
- **Client:** *I guess. She makes me feel like I'm going to get into trouble all the time and it scares me.*
- **Counselor:** *So even though you're both acting like children, she's the bigger, meaner kid.*

### (D) Transforming Feelings: Guidelines

After psychotherapists and clients have had an opportunity to explore feelings and understand how they may be contributing to psychological distress, it may be helpful to experiment with new emotions in order to discover more adaptive emotional responses. EFT suggests that emotions can be used to change emotions (Greenberg, 2002). For example, a man raised by an abusive father may have learned to habitually respond to life with a feeling of shame, blaming himself for the problems he encounters in life. EFT might lead to the discovery of protective anger as an adaptive primary emotion that might emerge after exploring the secondary feeling of shame. Therefore, KST encourages psychotherapists to experiment with new feelings in order to modify emotional reactions that may be dysfunctional. KST describes four key strategies from EFT that focus on transforming feelings.

EFT Transformation Strategies: Key Strategies Rating Scale - A Question

<p><u>Transforming Feelings</u>  EFT-5. Experimenting with new feelings and overcoming emotional blocks  EFT-6. Generating adaptive feelings as an alternative to problematic emotional patterns  EFT-7. Generalizing adaptive feelings and reflecting on emotional responses  EFT-8. Assessing emotional change and multidimensional impact</p>	<p>Does this essay/transcript represent the key strategies belonging to this treatment phase and modality (see list in left column)?</p> <p>1    2    3    4    5    6    7  Not at all                      Somewhat                      Extremely</p>
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Transforming Feelings: Essay Rating Guidelines

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EFT-5. Experimenting with new feelings and overcoming emotional blocks

- Alternative verbs to Experimenting: testing, trying out, conducting tests/experiments, investigating, researching, attempting
  - Related to trying unexplored feelings and overcoming blocked emotions

EFT-6. Generating adaptive feelings as an alternative to problematic emotional patterns

- Alternative verbs to Generating: producing, engendering, changing, adjusting, transforming, revising, adapting, amending, altering, modifying, bringing about
  - Related to bringing about new feelings as alternatives to maladaptive emotions

- EFT-7. Generalizing and Consolidating adaptive feelings and reflecting on emotional responses
- Alternative verbs to Generalizing/Consolidating: broadening, supporting, strengthening, securing, merging, uniting, extending, backing up, expanding, proliferating, propagating, reproducing, flourishing, promulgating, disseminating, distributing
    - Related to finding the meaning of emotional change and generalizing changes
- EFT-8. Assessing emotional change and multidimensional impact
- Alternative verbs to Assessing: evaluating, reviewing, appraising, judging, analyzing, examining, considering, determining, verifying
    - Related to exploring alternative dimensions for exploration and transformation

EFT Transformation Strategies: Key Strategies Rating Scale - B Question

<p><u>Transforming Feelings</u>          EFT-5. Experimenting with new feelings and overcoming emotional blocks          EFT-6. Generating adaptive feelings as an alternative to problematic emotional patterns          EFT-7. Generalizing adaptive feelings and reflecting on emotional responses          EFT-8. Assessing emotional change and multidimensional impact</p>	<p>Does this essay/transcript represent the key strategies belonging to this treatment phase and modality (see list in left column)?</p> <p style="text-align: center;">1    2    3    4    5    6    7</p> <p>Not at all                      Somewhat                      Extremely</p>
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Transforming Feelings: Extremely Representative Video Transcript Example

EFT-5. Experimenting with Emotions Example (Scale Score: 7):

- **Client:** *I can't express these feelings of fear toward my mother or she'll just get angry.*
- **Counselor:** *Let's try an experiment. Imagine your mother being harsh and critical. Imagine how you feel. What would you like to say?*
- **Client:** *When you tell me I'm wrong all the time, I feel scared you won't love me anymore, like I'm 6 years old again.*

EFT-6. Generating Adaptive Feelings Example (Scale Score: 7):

- **Client:** *I can't hold this fear anymore, I'm going to be crushed.*
- **Counselor:** *It's too much. You just need...*
- **Client:** *I just need a break. I need to feel okay with me, to be good enough the way I am.*
- **Counselor:** *How does it feel to express your needs?*
- **Client:** *I feel a huge sense of relief. It's liberating.*

EFT-7. Generalizing Adaptive Feelings Example (Scale Score: 7):

- **Client:** *Learning to recognize and express my fear has made me feel better.*
- **Counselor:** *How has this change affected your life?*
- **Client:** *I feel like I'm learning how to care for myself and stand up for myself.*
- **Counselor:** *Is there someone else that you'd like to try sharing these feelings with?*

EFT-8. Assessing Emotional Change and Impact Example (Scale Score: 7):

- **Client:** *I've made progress being able to tolerate my fear and anger about my mother, but I still seem to have difficulty acting the same old ways.*
- **Counselor:** *Perhaps we should shift focus and look at specific actions you can use with your mom to enact your new feelings.*

#### Transforming Feelings: Not At All Representative Video Transcript Example

EFT-5. Experimenting with Emotions Example (Scale Score: 1):

- **Client:** *I can't express these feelings of fear toward my mother or she'll just get angry.*
- **Counselor:** *Why don't you just try to do it anyway and hope for the best. I mean, what's the worse that could happen? Do you think she'll just be harsh and critical like she usually is?*
- **Client:** *She'll tell me my feelings are wrong and it won't help at all, except that I'll feel scared, like I'm 6 years old again.*

EFT-6. Generating Adaptive Feelings Example (Scale Score: 1):

- **Client:** *I can't hold this fear anymore, I'm going to be crushed.*
- **Counselor:** *Too much, huh?. You probably will be crushed if you don't change your behavior.*
- **Client:** *I just need a break. I need to feel okay with me, to be good enough the way I am.*
- **Counselor:** *Well, too bad there aren't any breaks in life! Tough luck, huh?*

EFT-7. Generalizing Adaptive Feelings Example (Scale Score: 1):

- **Client:** *Learning to recognize and express my fear has made me feel better.*
- **Counselor:** *That's great. Now let's look at fear even more closely.*
- **Client:** *I feel like I'm learning how to care for myself and stand up for myself.*
- **Counselor:** *The fear really seems to be gone. You must be just about ready to stop therapy.*

EFT-8. Assessing Emotional Change and Impact Example (Scale Score: 1):

- **Client:** *I've made progress being able to tolerate my fear and anger about my mother, but I still seem to have difficulty acting the same old ways.*
- **Counselor:** *Perhaps we should work harder at understanding these emotional patterns so that you can eventually feel different about your mom and not need to talk to her about your feelings.*

(E) Exploring Actions: Guidelines

The history of behavior therapy began with the discovery of two basic learning paradigms: Pavlov's classical conditioning and Skinner's operant conditioning. Wolpe (1958, 1990) described behavioral techniques based on classical conditioning and have been referred to as stimulus-response interventions (Wilson, 2011). Operant conditioning (Skinner, 1953) was the basis for techniques related to behavior modification and applied behavioral analysis. Behavioral approaches have been tested by research and have shown to be effective for the treatment of a wide variety of anxiety disorders, depression, sexual dysfunctions, substance abuse, schizophrenia, and personality disorders (Emmelkamp, 2004).

It appears easier for students to learn about operant conditioning compared to classical conditioning (Lawson, 1994; Coleman, Faneli, & Gedeon, 2000). Beginning psychotherapists may find the idea of exposing clients to feared stimuli more daunting than reinforcing positive actions and shaping behavior toward desired goals. Therefore, this introduction to behavioral skills draws upon Martell's *Behavioral Activation* (BA) as a contemporary example of behavior therapy utilizing operant conditioning as a theoretical foundation (Martell et al., 2010). BA aims to activate "clients in specific ways that will increase rewarding experiences in their lives" (Martell, et al., 2010, p. 21). Research has shown that BA is as effective for treating depression as a more comprehensive cognitive-behavioral treatment (Jacobson et al., 1996; Gortner, Gollan, Dobson, & Jacobson, 1998; Dimidjian et al., 2006; and Dobson et al., 2008). BA psychotherapists are taught to focus on motivating clients to bring about change in their lives through action. KST draws four strategies from BA that allows psychotherapists to explore clients' actions.

BHV Exploration Strategies: Key Strategies Rating Scale – A Question

<p><u>Exploring Actions</u>                  BHV-1. Focusing on actions related to clients' presenting concerns                  BHV-2. Exploring the triggers and functions of specific actions and how they impact thoughts and feelings                  BHV-3. Analyzing actions to evaluate their effectiveness                  BHV-4. Discovering patterns of reinforcement that shape current actions</p>	<p>Does this transcript represent the key strategies belonging to this treatment phase and modality (see list in left column)?</p> <p style="text-align: center;">1    2    3    4    5    6    7</p> <p>Not at all                      Somewhat                      Extremely</p>
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## Exploring Actions: Essay Rating Guidelines

Remember: The action words used to describe each strategy may be different from the one utilized in the strategy itself. As long as the essay response contains the basic idea or purpose of the strategy, credit should be given. Please note that the alternative action words listed below are not exhaustive and that raters are expected to use their best judgment in determining how representative an essay is of a particular phase/modality of KST. Likewise, the same action words may be used to designate different strategies, and raters should rely on context clues within the essay to determine which strategies are and are not represented.

An essay which is Extremely Representative of the Exploring Actions phase/modality will contain written information describing all four of the following strategies.

An essay which is Somewhat Representative of the Exploring Actions phase/modality will contain written information describing 2-3 of the following strategies.

An essay which is Not At All Representative of the Exploring Actions phase/modality will contain written information describing none of the following strategies.

BHV-1. Focusing on actions related to clients' presenting concerns

- Alternatives verbs to Focusing: attending to, listening/actively listening, concentrating on, considering, exploring, observing
  - Related to problematic behaviors

BHV-2. Exploring the triggers and functions of specific actions and how they impact thoughts and feelings

- Alternative verbs to Exploring: searching for, looking for, focusing on, surveying, concentrating on, observing, noticing, investigating
  - Related to the function and triggers of specific behaviors, and their relationship to thoughts and feelings

BHV-3. Analyzing actions to evaluate their effectiveness

- Alternative verbs to Analyzing: examining, evaluating, considering, questioning, investigating, probing, assessing, appraising, discerning
  - Related to the effectiveness of specific behaviors

BHV-4. Discovering patterns of reinforcement that shape current actions

- Alternative verbs to Discovering: establishing, finding, learning, determining, realizing, ascertaining, discerning, concluding, verifying
  - Related to reinforced or rewarded behavioral patterns that may be outside awareness

BHV Exploration Strategies: Key Strategies Rating Scale – B Question

<p><u>Exploring Actions</u>                  BHV-1. Focusing on actions related to clients' presenting concerns                  BHV-2. Exploring the triggers and functions of specific actions and how they impact thoughts and feelings                  BHV-3. Analyzing actions to evaluate their effectiveness                  BHV-4. Discovering patterns of reinforcement that shape current actions</p>	<p>Does this transcript represent the key strategies belonging to this treatment phase and modality (see list in left column)?</p> <p>1    2    3    4    5    6    7                  Not at all                      Somewhat                      Extremely</p>
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Exploring Actions: Extremely Representative Video Transcript Example

BHV-1. Focusing on Actions Example (Scale Score: 7):

- **Client:** *Nothing is going right. I'm doing awful in school. I just want to lie in bed all the time and stay away from everybody. I miss my friends, but it's just too hard.*
- **Counselor:** *Sounds like you're feeling so bad that it's making it difficult to do your normal activities. So what do you do instead?*

BHV-2. Exploring Triggers and Functions of Actions Example (Scale Score: 7):

- **Client:** *Nights are the worst for me. I usually feel awful at night.*
- **Counselor:** *What happens for you at night that makes you feel worse? Can you give me an example?*

BHV-3. Analyzing the Effectiveness of Actions Example (Scale Score: 7):

- **Client:** *I got ready to go to the party, but then I just felt too depressed. I felt relieved at first when I decided not to go to the party, but later I felt guilty.*
- **Counselor:** *Sometimes we get stuck in the habit of doing things that make us feel better in the moment but end up making us feel worse later, like avoiding friends. We're going to try to break those habits by replacing activities that keep you stuck with activities that help you. What are things you already do that that help you to feel better?*

BHV-4: Discovering Patterns of Behavioral Reinforcement Example (Scale Score: 7):

- **Counselor:** *When you call in sick to work, how do you feel?*
- **Client:** *I feel relieved at first, but later I feel guilty and depressed.*
- **Counselor:** *So initially it feels pretty good. That would help to explain why you call in sick, even when it causes problems later.*

### Exploring Actions: Not At All Representative Video Transcript Example

BHV-1. Focusing on Actions Example (Scale Score: 1):

- **Client:** *Nothing is going right. I'm doing awful in school. I just want to lie in bed all the time and stay away from everybody. I miss my friends, but it's just too hard.*
- **Counselor:** *Sounds like you're feeling so bad that there's really nothing that you're going to be able to do about it. When times get tough, you got to get tougher!*

BHV-2. Exploring Triggers and Functions of Actions Example (Scale Score: 1):

- **Client:** *Nights are the worst for me. I usually feel awful at night.*
- **Counselor:** *Have you tried to take a hot bath before bedtime. Sometimes that can really help you feel more sleepy so that you can go to sleep fast and not have such a horrible night.*

BHV-3. Analyzing the Effectiveness of Actions Example (Scale Score: 1):

- **Client:** *I got ready to go to the party, but then I just felt too depressed. I felt relieved at first when I decided not to go to the party, but later I felt guilty.*
- **Counselor:** *Tell me all about this guilt. This sounds really interesting to me. I mean, maybe if you hadn't chickened out, then you wouldn't have felt so guilty. It only sounds normal to me.*

BHV-4: Discovering Patterns of Behavioral Reinforcement Example (Scale Score: 1):

- **Counselor:** *So you called in sick to work again. That's crazy! You're going to get fired!*
- **Client:** *I felt relieved at first, but later I feel guilty and depressed.*
- **Counselor:** *Yep. Seems pretty normal to feel guilty and depressed when you blow off your responsibilities. I'm kind of surprised you're even showing up to counseling.*

### (F) Transforming Actions: Guidelines

After psychotherapists and clients have a clear understanding of the way actions may contribute to psychological problems, it may be helpful to identify and enact more effective behaviors that may relieve distress. BA uses operant principles to encourage change based on Lewinsohn's (1975) observation that depression can be relieved through homework assignments that result in more positive reinforcement in the environment (Martell et al, 2010). For example, a socially isolated client experiencing depression may need help identifying social environments they enjoy that will result in positive experiences, social support, and enhanced mood. Therefore, KST encourages psychotherapists to promote behavioral change by identifying actions that will result in reinforcement. To meet this goal, it is often necessary to experiment within psychotherapy sessions and improve skills before generalizing these new actions to natural environments. KST describes four behavioral strategies designed to help clients transform their actions.

BHV Transformation Strategies: Key Strategies Rating Scale – A Question

<p><u>Transforming Actions</u>                  BHV-5. Experimenting with new actions and observing results                  BHV-6. Improving skills through training and behavioral rehearsal                  BHV-7. Generalizing effective actions to new environments outside of psychotherapy                  BHV-8. Assessing behavioral change and multidimensional impact</p>	<p>Does this essay/transcript represent the key strategies belonging to this treatment phase and modality (see list in left column)?</p> <p style="text-align: center;">1      2      3      4      5      6      7</p> <p>Not at all                      Somewhat                      Extremely</p>
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Transforming Actions: Essay Rating Guidelines

Remember: The action words used to describe each strategy may be different from the one utilized in the strategy itself. As long as the essay response contains the basic idea or purpose of the strategy, credit should be given. Please note that the alternative action words listed below are not exhaustive and that raters are expected to use their best judgment in determining how representative an essay is of a particular phase/modality of KST. Likewise, the same action words may be used to designate different strategies, and raters should rely on context clues within the essay to determine which strategies are and are not represented.

An essay which is *Extremely Representative* of the Transforming Actions phase/modality will contain written information describing all four of the following strategies.

An essay which is *Somewhat Representative* of the Transforming Actions phase/modality will contain written information describing 2-3 of the following strategies.

An essay which is *Not At All Representative* of the Transforming Actions phase/modality will contain written information describing none of the following strategies.

BHV-5. Experimenting with new actions and observing results

- Alternative verbs to Experimenting: testing, trying out, conducting tests/experiments, investigating, researching, attempting
  - Related to trying new behaviors and discovering how they work

BHV-6. Improving skills through training and behavioral rehearsal

- Alternative verbs to Improving: reinforcing, strengthening, supporting, adapting, adjusting, engendering, modifying, generating, getting better, advancing, progressing, fortifying
  - Related to strengthening new, effective actions

- BHV-7. Generalizing effective actions to new environments outside of psychotherapy
- Alternative verbs to Generalizing: broadening, supporting, strengthening, securing, merging, uniting, extending, backing up, expanding, proliferating, propagating, reproducing, flourishing, promulgating, disseminating, distributing
    - Related to habituating new actions and generalizing behavioral change

- BHV-8. Assessing behavioral change and multidimensional impact
- Alternative verbs to Assessing: evaluating, reviewing, appraising, judging, analyzing, examining, considering, determining, verifying
    - Related to exploring alternative dimensions for exploration and transformation

BHV Transformation Strategies: Key Strategies Rating Scale – B Question

<p><u>Transforming Actions</u>          BHV-5. Experimenting with new actions and observing results          BHV-6. Improving skills through training and behavioral rehearsal          BHV-7. Generalizing effective actions to new environments outside of psychotherapy          BHV-8. Assessing behavioral change and multidimensional impact</p>	<p>Does this essay/transcript represent the key strategies belonging to this treatment phase and modality (see list in left column)?</p> <p>1    2    3    4    5    6    7          Not at all                      Somewhat                      Extremely</p>
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Transforming Actions: Extremely Representative Video Transcript Example

BHV-5. Experimenting with New Actions Example (Scale Score: 7):

- **Client:** *I'm tired of feeling down. I just want to be happier and feel better.*
- **Counselor:** *And if you were feeling better, what might you be doing differently? These may be important behaviors for us to target.*

BHV-6. Improving Skills Through Rehearsal Example (Scale Score: 7):

- **Client:** *I felt better at first when I went for a walk. Later that day I felt very lonely. I'd like to invite a friend to walk with me but I'm afraid I might sound needy.*
- **Counselor:** *Let's talk about some different ways to ask a friend to walk with you and then practice an invitation that doesn't sound needy.*

BHV-7. Generalizing Effective Actions Example (Scale Score: 7):

- **Client:** *I've made some important changes in my life recently. Things were bad for awhile, but I got myself moving and I'm starting to feel better.*
- **Counselor:** *Good! One of the ways we can learn from your experience is to identify specific ways that your mood might be vulnerable in the future and what you can do about it. Do you want to make a list of these? Maybe you can write them down.*

BHV-8. Assessing Behavioral Change and Impact Example (Scale Score: 7):

- **Client:** *Therapy has been helpful. I am more active, but I still think people don't like me.*
- **Counselor:** *Now that you've made some changes in your actions, it may be helpful to switch our focus to thoughts.*

Transforming Actions: Not At All Representative Video Transcript Example

BHV-5. Experimenting with New Actions Example (Scale Score: 1):

- **Client:** *I'm tired of feeling down. I just want to be happier and feel better.*
- **Counselor:** *You were telling me last session about a good conversation you had with your previous therapist about your mother. Would you like to talk about that now? That way you don't have to focus on feeling down.*

BHV-6. Improving Skills Through Rehearsal Example (Scale Score: 1):

- **Client:** *I felt better at first when I went for a walk. Later that day I felt very lonely. I'd like to invite a friend to walk with me but I'm afraid I might sound needy.*
- **Counselor:** *Let's talk about some different ways to walk so that it helps keep your mind off of your friends. You could jog, or run, or walk, or speed walk. If you do ask a friend to go for a walk with you, you really need to practice not sounding so needy.*

BHV-7. Generalizing Effective Actions Example (Scale Score: 1):

- **Client:** *I've made some important changes in my life recently. Things were bad for awhile, but I got myself moving and I'm starting to feel better.*
- **Counselor:** *Good! One of the ways we can learn from these changes is to take some time to focus on the bad times and continue doing so. Maybe you can write about these difficulties.*

BHV-8. Assessing Behavioral Change and Impact Example (Scale Score: 1):

- **Client:** *Therapy has been helpful. I am more active, but I still think people don't like me.*
- **Counselor:** *Now that you've made some changes in your actions, it may be helpful to continue focusing on the same behaviors in order to improve them even more.*

(G) Key Strategies Rating Scale – B: Competence Rating

How competently did the therapist demonstrate this treatment phase and modality?

1	2	3	4	5	6	7
Not at all competent			Minimal competence			Extremely
competent						

Rating Guidelines

- (1) Not at all competent:
  - Trainee failed to adequately perform strategies related to the target phase and modality of treatment.
  - Trainee failed to make a connection with the client appropriate for supporting an adequate therapeutic relationship.
  - Trainee failed to understand or consistently utilize strategies from the target phase and modality of treatment and or utilized strategies in a manner inappropriate to the therapeutic context.
- (4) Minimal competence:
  - Trainee performed strategies related to the target phase and modality of treatment at a level competence such that basic corresponding goals and outcomes of treatment could be expected.
  - Trainee appeared to build a connection with the client sufficient for continuing psychotherapeutic exploration.
  - Trainee appeared to understand and consistently utilize strategies from the target phase and modality of treatment in a context appropriate manner.
- (7) Extremely Competent:
  - Trainee performed strategies related to the target phase and modality of treatment at a level comparable to a professional psychotherapist, such that the best possible goals and outcomes of treatment could be expected.
  - Trainee appeared to build a strong connection with the client, comparable to a professional psychotherapist, likely to aid in significant psychotherapeutic exploration and change.
  - Trainee appeared to identify and consistently utilize strategies from the target phase and modality of treatment in a context appropriate manner comparable to a professional psychotherapist.

#### (H) Multidimensional Survey Adherence and Competence Scale (MSACS)

In addition to learning emotion-focused, cognitive, and behavioral strategies, it is important for trainees to learn when to use each approach. Brooks-Harris (2008) described a process of integrative treatment planning that involves conducting a multidimensional survey and choosing one or more focal dimensions. KST teaches trainees to listen carefully to clients' presenting concerns and then to conduct a survey of specific feelings, thoughts, and actions. After each of these three dimensions of functioning have been explored with the client, the counselor can track the *firing order*, the way each of these modes of functioning may influence one another (Lazarus, 1997). Based on this exploration, the counselor can ask the client which dimension might be the most helpful place to begin the process of exploration and transformation. It is important to stress the idea that choosing an initial focal dimension should be based on collaborative dialogue with clients, rather than an *a priori* decision based on counselor preference. Once clients have chosen to focus on one dimension, exploration can begin. After a clear understanding of the role of this dimension has been established, transformation strategies can be introduced. In some cases, change in one area may generalize to other dimensions of functioning. At other times, it may be helpful for psychotherapists to shift the focus of treatment over time and combine skills from more than one theoretical approach.

#### MSACS Rating Guidelines

- (1) Strongly Disagree: Trainee entirely fails to assess this area
  - Example: So, what's going on with you and your depression?
  
- (4) Agree: Trainee assesses this area in a vague or confusing manner
  - Example: So, what kind of things happen in your mind about being depressed?
  
- (7) Strongly Agree: Trainee assesses this area in a clear and coherent manner
  - Example: What (thoughts/feelings) are you experiencing related to your depression?



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