DEVELOPMENT AND EVALUATION OF THE KEY STRATEGIES RATING QUESTIONNAIRE

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To the Dean of the Graduate School:

I am submitting herewith a thesis written by Leslie J. Kelley entitled "Development and Evaluation of the Key Strategies Rating Questionnaire." I have examined this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Arts with a major in Counseling Psychology.

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ABSTRACT

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One major challenge in training counselors is evaluating the effectiveness of training and the assessment of progress. The Key Strategy Rating Questionnaire (KSRQ) assesses counselors' knowledge, confidence, and intended use of interventions from three empirically-supported treatments (Cognitive Therapy, Behavioral Activation, and Emotion-Focused Therapy). This study describes the development and psychometric evaluation of the KSRQ to provide confirmation of internal consistency reliability by means of Cronbach's α, as well as convergent and divergent validity. The KSRQ will be used to provide data regarding the effectiveness of Key Strategies Training (KST), an integrative approach to psychotherapy training.

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CHAPTER I

INTRODUCTION

The effectiveness of counselor training has been a concern for instructors and researchers for several decades. Ivey, Normington, Miller, Morrill, and Haase (1968) conducted research on microcounseling, a structured form of training the most basic components of psychotherapy. This original 1968 microcounseling study measured 3 skills: attending behavior, reflection of feeling, and summarization of feeling. Microcounseling, later called microskills, continued to evolve and by 1978 was conceptualized as "a systematic format for teaching single helping skills" and as "a conceptual framework and theory concerning the basic skills of the helping process" (Ivey & Authier, 1978, p. 8-9). A plethora of research has given evidence that through the microskills training method, counselors are capable of learning the most basic units of therapeutic behavior. These units of behavior, broken down to the smallest and most discrete level, are taught through description, demonstration, practice, and feedback. Microskills training also places emphasis on the intentional use of basic skills. Not only must counselors learn each skill, they must also learn when to utilize each skill and the purpose behind utilization (Ivey & Authier). Microskills can also be conceptualized as a foundation for more complex interventions found in empirically-supported treatments (EST), although the microskills training method itself fails to reach this complexity.

Focusing on small units of behavior, the complexity of interventions found in ESTs is lost in the microskills approach. It has widely been recognized that counselors need training beyond the scope of microskills (Kuntze, van der Molen, & Born, 2009). The microskills method simply does "not cover the full range of behaviors counselors need to practice competently" (Ridley, Kelly, & Mollen, in press). While once hailed as a complete system of training, current research has illustrated numerous gaps. This change in opinion regarding the microskills approach can be understood by considering microskills as operationalizing a Rogerian or common factors approach which many counselors were using in the 1970's. Though the approach matched the climate of the 70's, it fails to account for counselor behavior in the 21st century.

While Ivey began from the basic elements of therapy and worked upward toward the theoretical, specific ESTs (e.g. Cognitive Therapy, Emotion-Focused Therapy) seem to be doing the opposite. Specific theories conceive of psychopathology as primarily due to some construct and then proceed to develop and test complex therapeutic strategies to combat the pathology. Cognitive Therapy, for example, is based on "a cognitive formulation of a specific disorder and its application to the conceptualization or understanding of the individual patient" (J. S. Beck, 1995, p. 2). Cognitive Therapy understands irrational beliefs and dysfunctional thoughts as the primary cause of depression and therefore attempts to intervene by utilizing interventions such as reality testing and by identifying and modifying underlying assumptions (Beck & Weishaar, 2000; Young & Beck, 1980). Behavioral Activation emphasizes psychopathology as rooted in clients being stuck in patterns of behavior that decrease positive reinforcement

and/or increase punishment (Martell, Dimidjian & Herman-Dunn, 2010). Gestalt Therapy conceives of psychopathology as caused by clients' lack of homeostasis or adaptation to their surroundings resulting in unfulfilled emotional needs (Perls, 1973). More recent derivatives of Gestalt Therapy, such as Emotion-Focused Therapy (EFT), emphasize intervening on the level of affect to express and clarify emotions and modify maladaptive emotional responses (Greenberg, 2002). Motivational Interviewing conceptualizes sustained substance abuse in terms of clients' ambivalence to change and emphasizes interventions such as rolling with resistance and supporting client self-efficacy (Miller, Rollnick & Conforti, 2002).

As the field of psychotherapy gravitates toward the use of empirically supported treatments (EST), questions arise regarding the effectiveness of training in ESTs as well as integrative derivatives (Lutz et al., 2006). Researchers have placed emphasis on establishing the efficacy of treatments resulting in a multitude of ESTs for a number of different psychopathologies. Further, ESTs have typically been manualized, utilizing highly developed protocols to help counselors determine how to intervene appropriately. Another key benefit to ESTs lies in the fact that interventions are often used sequentially allowing new therapists to easily determine the appropriate order for utilizing interventions.

In studies concerning effectiveness, the developers of ESTs generally presume that the interventions of the counselor are primarily responsible for affecting therapeutic change (McCarthy & Barber, 2009). Recent studies have emphasized the difference between knowing that a treatment works as a whole and knowing which parts of the

treatment work, operating under the assumption that not all interventions within an ESTs may be necessary (Busch et al., 2009). Another problem of EST training lies in the lack of clarity found in training protocols. While therapy protocols are highly developed, training protocols seem to be underdeveloped (Rakovshik & McManus, 2010). Manualized treatments, operating from a one-size-fits-all assumption, fail to offer counselors in-session flexibility as one must follow protocol or suffer from lack of adherence. This rigidity also leads to a lack of training in the intentional use of interventions in exchange for orderliness.

Decades of training from these two perspectives (microskills versus ESTs) seem to have produced a gap in the field, which has had repercussions specifically for new counselors. Training programs have generally taught basic helping skills, complex theoretical frameworks, or both. However, learning to tie basic helping skills to the larger framework seems to have been left in the hands of the counselor-in-training. Brooks-Harris (2008) developed Mutltitheoretical Psychotherapy (MTP) to fill this gap in training. MTP is an integrative approach to training and clinical practice which synthesizes the interventions of several foundational theories into seven theoretical domains and describes a method for deciding which interventions might be most beneficial to any given client in a particular setting (Brooks-Harris). MTP also advocates intentionality by suggesting that counselors should purposefully use interventions as well as collaborate with clients to choose two or three focal dimensions (e.g., thoughts, actions, feelings, interpersonal patterns, etc.), further indicating which interventions might be most beneficial to the client. MTP also emphasizes the interactive use of

interventions. Counselors are trained to use key strategies focusing on different dimensions interactively to produce a variety of possible therapeutic outcomes.

MTP, however, suffers from two weaknesses. First, MTP is too complex to learn in a short period of time. Rooted in a plethora of theories separated into seven theoretical domains, MTP incorporates 98 key strategies. While counselors would do well to become familiar with a wide range of key strategies over the course of their graduate education, MTP offers too many strategies to learn in a single class or practicum. Further, some of these individual strategies are too complex to be learned by beginning counselors (Harris, 2010). Second, MTP was based in theory and not research. While MTP is built upon a foundation in several theories, some of these theories and the accompanying interventions have not received empirical validation, leading to concern regarding the incorporation of these interventions into an integrated framework.

Key Strategies Training (KST), as a clarification and simplification of MTP, is a new method of counselor training being introduced here for the first time. KST attempts to fill the gaps in training by teaching counselors-in-training a small set of strategies from three ESTs (Cognitive Therapy, Behavioral Activation, and Emotion-Focused Therapy) as constructed from the most basic elements of therapeutic interventions. Beginning counselors will learn basic helping skills before being introduced to more complex strategies drawn from ESTs. KST, like MTP, uses key strategies to train students to use advanced interventions from well-established theories in the field of psychotherapy (Brooks-Harris, 2008). Education in a variety of interventions is considered central to

KST as "no one intervention has the sole propriety on therapeutic change" (Ridley, Mollen, & Kelly, in press).

KST interventions are divided into two therapeutic phases, exploration and change, consisting of seven intervention processes. KST recognizes that parallel ways of intervening therapeutically exist between Cognitive Therapy, Behavioral Activation, and Emotion-Focused Therapy. These parallels are represented here as seven intervention processes. The exploration phase is comprised of three types of strategies: (1) Focusing on a specific dimension of functioning, (2) Understanding context and function, and (3) Analyzing adaptive value (Harris & Kelley, 2010). The change phase is comprised of the remaining four types of strategies: (4) Discovering patterns outside of awareness, (5) Experimenting, (6) Modifying, and (7) Generalizing and Consolidating (Harris & Kelley).

Cognitive Therapy (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). KST utilizes seven interventions drawn from CT (see table 1 for references supporting each intervention). COG-1: Focusing on thoughts related to clients' presenting concerns. COG-2: Understanding the way automatic thoughts mediate clients' experiences and impact mood. COG-3: Analyzing thoughts in order to determine if they are functional or dysfunctional. COG-4: Discovering underlying core beliefs and assumptions that shape current thinking. COG-5: Experimenting with thoughts and beliefs to evaluate accuracy and test alternatives.

COG-6: Modifying beliefs and identifying more functional thoughts. COG-7: Reinforcing functional thoughts and putting these beliefs into practice.

Table 1.
Key Strategies Training – Cognitive Therapy References

Intervention Processes	Cognitive Strategies	References
- EXPLORATION PHASE -		
Focusing on a specific dimension	COG-1. Focusing on thoughts related to clients' presenting concerns	"The usual course of treatment in cognitive therapy involves an initial emphasis on automatic thoughts, those cognitions closest to conscious awareness" (J. S. Beck, 1995, p. 16).
Understanding context and function	COG-2. Understanding the way automatic thoughts mediate clients' experiences and impact mood	"The cognitive model states that the interpretation of a situation (rather than the situation itself), often expressed in automatic thoughts, influences one's subsequent emotion, behavior, and physiological response" (J. S. Beck, p. 75).
Analyzing adaptive value	COG-3. Analyzing thoughts in order to determine if they are functional or dysfunctional	"The cognitive therapist is concerned with identifying those thoughts that are dysfunctional, that is, those that distort reality, that are emotionally distressing and/or interfere with the patient's ability to reach her goals" (J. S. Beck, p.76).
- CHANGE PHASE -		
Discovering patterns outside of awareness	COG-4. Discovering underlying core beliefs and assumptions that shape current thinking	The cognitive therapist "looks for *central themes in the patient's automatic thoughts*, watches for *core beliefs expressed as automatic thoughts*, and *directly elicits* the core belief" (J. S. Beck, p. 170).
Experimenting	COG-5. Experimenting with thoughts to evaluate accuracy and test alternatives	"Automatic thoughts can be evaluated according to their *validity* and their *utility*. The most common type of automatic thought is distorted in some way and occurs despite evidence to the contrary" (J. S. Beck, p. 77).
Modifying	COG-6. Modifying beliefs and identifying more functional thoughts	"What is of particular significance to the cognitive therapist is that beliefs that are dysfunctional can be unlearned and new beliefs that are more reality based and functional can be developed and learned through therapy" (J. S. Beck, p. 16).
Generalizing and Consolidating	COG-7. Reinforcing functional thoughts and putting these beliefs into practice	"The goal in cognitive therapy is to facilitate the remission of the patient's disorder and to teach the patient to be her own therapist…She can resolve difficulties before they become major problems, she reduces the possibility of relapse; and she can use her skills to enrich her life in a variety of contexts" (J. S. Beck, p. 269; 278).

Behavioral Activation (BA) "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). KST utilizes seven interventions drawn from BA (see table 2 for references supporting each intervention). Behavioral Strategy 1 (BHV-1): Focusing on actions related to clients' presenting concerns. BHV-2: Understanding the triggers, functions, and impact of specific actions. BHV-3: Analyzing actions to determine if they are effective or ineffective. BHV-4: Discovering patterns of reinforcement that shape current actions. 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.

Table 2.
Key Strategies Training – Behavioral Activation References

Intervention Processes	Behavioral Strategies	References
- EXPLORATION PHASE -		
Focusing on a specific dimension	BHV-1. Focusing on actions related to clients' presenting concerns	"The job of the BA therapist is to engage the client in a careful and detailed examination of…behaviors" (Martell et al., 2010, p. 25).
Understanding context and function	BHV-2. Understanding the triggers, functions, and impact of specific actions	The psychotherapist notices "what precedes and what follows important behavior. People are generally unaware of the connections interlocking various situations, activities, and feelings…Detecting such relationships helps guide the identification of the behavioral target of treatment" (Martell et al., p. 64)
Analyzing adaptive value	BHV-3. Analyzing actions to determine if they are effective or ineffective	"Behaviors to increase include those that are likely to bring the client into contact with positive reinforcement in the environment…Behaviors to decrease are those that make the client's life more difficult or interfere with managing one's needs; typically these are avoidance patterns" (Martell et al., p. 65).
- CHANGE PHASE -		
Discovering patterns outside of awareness	BHV-4. Discovering patterns of reinforcement that shape current actions	"Therapists can identify avoidance by being on alert for behavior that helps a client keep something aversive from happening…To the extent that the behavior is likely to recur as a result of escape and avoidance, we can then say that it has been negatively reinforced" (Martell et al., p. 116).
Experimenting	BHV-5. Experimenting with new actions and observing results	"We encourage an experimental approach that focuses on trying a behavior and observing the outcome. In BA, the experiments are based on functional analyses of past behavior and hypotheses regarding potentially reinforcing activities for each client" (Martell et al., p. 31).
Modifying	BHV-6. Improving skills through training and behavioral rehearsal	"Clients also should not be expected to simply rely on willpower to engage in an agreed-upon assignment. The therapist should take time to discuss a plan of implementation with the client. The more specific and detailed the plan, the better!"(Martell et al., p. 33).
Generalizing and Consolidating	BHV-7. Generalizing effective actions to new environments outside of psychotherapy	"Instilling the ability to transfer what's been learned in one context to another is a critical component…It enables clients to respond effectively when presented with new situations" (Martell et al., p. 21).

In Emotion-Focused Therapy (EFT), "the lives of human beings are viewed as profoundly shaped and organized by emotional experiences, and emotion itself is considered the creative and organizing force in people's lives. Therapists work to enhance clients' emotional intelligence, which involves the recognition and use of their own and others' emotional states to solve problems" (Greenberg & Watson, 2006, p. 9). KST utilizes seven interventions drawn from EFT (see table 2 for references supporting each intervention). Emotion-Focused Strategy 1 (EFT-1): Focusing on feelings related to clients' presenting concerns. EFT-2: Understanding the context and function of specific feelings. EFT-3: Analyzing feelings to determine if they are adaptive or maladaptive. EFT-4: Discovering unexplored emotional experiences that may be outside of awareness. EFT-5: Experimenting with new feelings and helping clients overcome emotional blocks. EFT-6: Generating adaptive feelings as an alternative to problematic emotional patterns. EFT-7: Reflecting on emotional responses to consolidate meaning.

Table 3.

Key Strategies Training – Emotion-Focused Therapy References

Intervention Processes	Emotion-Focused Strategies	References
- EXPLORATION PHASE -		
Focusing on a specific dimension	EFT-1. Focusing on feelings related to clients' presenting concerns	"The first and most general goal in EFT…is to promote emotional awareness. Client's ability to articulate what they are experiencing in their inner world is a central focus" (Greenberg & Watson, 2006, p. 75).
Understanding context and function	EFT-2. Understanding the context and function of specific feelings	"Therapists can help clients become aware of and understand their feelings by attending to the triggers, or situational stimuli, that spark the feelings. Identifying the triggers helps clients and therapists begin to understand how clients construe the events in their lives" (Greenberg & Watson, p. 175-176).
Analyzing adaptive value	EFT-3. Analyzing feelings to determine if they are adaptive or maladaptive	A "crucial distinction to be made is between primary emotions that are adaptive, which are accessed for their useful information, and primary emotions that are maladaptive, which need to be transformed" (Greenberg & Watson, p. 69).
- CHANGE PHASE -		
Discovering patterns outside of awareness	EFT-4. Discovering unexplored emotional experiences that may be outside of awareness	"Primary and core emotions are often accessed through differentiation and exploration of the secondary emotion, and accessing…the primary emotions is the fundamental aim" (Greenberg & Watson, p. 208).
Experimenting	EFT-5. Experimenting with new feelings and helping clients overcome emotional blocks	"As blocks to experience and expression emerge, therapists need to focus on them and help clients become aware of and experience how they interrupt their feelings or needs…Focusing clients' attention on possibilities…is one important general principle of accessing new feelings" (Greenberg & Watson, p. 241; 251).
Modifying	EFT-6. Generating adaptive feelings as an alternative to problematic emotional patterns	"Once clients have accessed core dysfunctional emotion schemes…such as feeling shamefully worthless or helplessly insecure, the scene is set for mobilizing alternative emotional responses based on adaptive needs and goals to…transform the maladaptive state." (Greenberg & Watson, p. 281).
Generalizing and Consolidating	EFT-7. Reflecting on emotional responses to consolidate meaning	"When clients reflect on their experiences, they make connections between different elements of their lives, begin to posit alternative explanations for their experiences, revise their views of themselves or their history, and develop new narratives. This process is often accompanied by a sense of greater connectedness and mastery" (Greenberg & Watson, p. 303).

Parallels, between the interventions of these ESTs, point toward a similarity between the therapeutic processes underlying the interventions. This discovery allows for the organization of interventions into a systematic format (see table 4 – Parallel Structure of KST). The parallel structure of KST is an improvement over MTP as it allows beginning counselors to more easily learn and recall the interventions, as well as to more clearly utilize the interventions in session with clients.

In the Exploration Phase, KST recognizes a parallel between CT, BA, and EFT involving understanding of the context and function of thoughts, actions, and feelings, respectively. CT emphasizes helping clients understand the way automatic thoughts impact their "subsequent emotion, behavior, and physiological response" (J. S. Beck, 1995, p. 75). In contrast, BA focuses helping clients understand the antecedents and consequences of behavior as "people generally are unaware of the connections interlocking various situations, activities…feelings, thoughts, and actions [which] occur under certain conditions in certain environments" (Martell et al., 2010, p. 64; 67). Comparatively, EFT values helping clients to understand emotional triggers as they impact "how clients construe the events in their lives and react to those events" (Greenberg & Watson, 2006, p. 176).

In the Change Phase, KST recognizes a similar parallel involving modification of thoughts, actions, or feelings. CT emphasizes 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). In contrast, BA modifies behavior through training and rehearsal. "The therapist should take time to discuss a plan of implementation with the client. The

more specific and detailed the plan, the better!" (Martell et al., 2010, p. 33). Comparatively, EFT modifies emotions by accessing "core dysfunctional emotion schemes" and generating "alternative emotional responses based on adaptive needs and goals" (Greenberg & Watson, 2006, p. 281).

KST combines many of the advantages and eliminates many of the disadvantages of training in microskills, ESTs, and MTP. KST recognizes basic helping skills, the most basic elements of counselor behavior, as a foundation for more complex interventions, but also trains counselors how to combine these microskills into complex interventions drawn from ESTs. Further, KST trains counselors to use individual strategies, which allows for future investigation into mechanisms of change in order to determine which interventions work for which clients and why. KST further represents a clear and concise method of training which allows counselors to learn intentionality and flexibility regarding the use of interventions, while simultaneously providing guidelines for the sequencing of interventions. Similar to MTP, KST utilizes the interventions of multiple sources, teaching counselors to intentionally use and integrate strategies. KST, however, is simplified so as to be taught in a single semester and is based directly on interventions drawn from ESTs.

KST conceptualizes these ESTs as combining several of the basic components of effective therapy into complex variations and trains counselors to bring about client change through an array of methods. Counselors are trained to collaborate with clients in order to decide upon one or two focal dimensions (i.e., thoughts, actions, or feelings), considered most salient for bringing about client change. After receiving KST, counselors

will have established a repertoire of cognitive, behavioral, and emotion-focused strategies to explore possibilities for client change within each focal dimension, as well as methods for combining strategies in situations in which they may be most beneficial.

Table 4.
Parallel Structure Utilized in Key Strategies Training

Intervention Processes	Cognitive Strategies	Behavioral Strategies	Emotion-Focused Strategies
	- EXPLORATION PHASE -		
Focusing on a specific dimension	COG-1. Focusing on thoughts related to clients' presenting concerns	BHV-1. Focusing on actions related to clients' presenting concerns	EFT-1. Focusing on feelings related to clients' presenting concerns
Understanding context and function	COG-2. Understanding the way automatic thoughts mediate clients' experiences and impact mood	BHV-2. Understanding the triggers, functions, and impact of specific actions	EFT-2. Understanding the context and function of specific feelings
Analyzing adaptive value	COG-3. Analyzing thoughts in order to determine if they are functional or dysfunctional	BHV-3. Analyzing actions to determine if they are effective or ineffective	EFT-3. Analyzing feelings to determine if they are adaptive or maladaptive
	- CHANGE PHASE -		
Discovering patterns outside of awareness	COG-4. Discovering underlying core beliefs and assumptions that shape current thinking	BHV-4. Discovering patterns of reinforcement that shape current actions	EFT-4. Discovering unexplored emotional experiences that may be outside of awareness
Experimenting	COG-5. Experimenting with thoughts to evaluate accuracy and test alternatives	BHV-5. Experimenting with new actions and observing results	EFT-5. Experimenting with new feelings and helping clients overcome emotional blocks
Modifying	COG-6. Modifying beliefs and identifying more functional thoughts	BHV-6. Improving skills through training and behavioral rehearsal	EFT-6. Generating adaptive feelings as an alternative to problematic emotional patterns
Generalizing and Consolidating	COG-7. Reinforcing functional thoughts and putting these beliefs into practice	BHV-7. Generalizing effective actions to new environments outside of psychotherapy	EFT-7. Reflecting on emotional responses to consolidate meaning

The Key Strategy Rating Questionnaire (KSRQ) is designed to assess a trainee's acquisition of skills, a crucial component of counselor competence. Skills acquisition is defined here as the combination of knowledge, confidence, and intended use of interventions. As KST trains counselors to utilize the interventions of three ESTs (Cognitive Therapy, Behavioral Activation, and Emotion-Focused Therapy), the KSRQ is constructed to measure each of these subscales. Historically, measuring the effectiveness of psychotherapy training has been undertaken in several ways. Training measures generally assess progress by means of observer ratings, client ratings/outcomes, and/or supervisor, peer, and self-reports (Ford, 1979). As studies concerning the effectiveness of KST are soon to be underway, establishing a reliable self-report questionnaire to measure the acquisition of Key Strategies is a crucial first step.

The KSRQ and three accompanying scales were administered to a group of graduate students having completed at least one semester of practicum or internship in order to ascertain reliability and validity by measuring the relationship of specific items to intended theoretical subscales from similar scales. Utilizing Cronbach's α coefficients, each of the KSRQ subscales was expected to display adequate internal consistency of $\alpha > .80$ (Lounsbury, Gibson, & Saudargas, 2006). The coefficient α primarily allows researchers to know how items in a measure are correlating with each other and which items are reducing correlation coefficients (Ponterotto & Furlong, 1985). Differences in counselors, including demographic information and interpersonal skills, as well as exposure to different forms of therapeutic training, were not expected to have an impact on α coefficients, as the test measures the strength of relationships between the test

variables for each participant. Confirmation of sufficient alpha coefficient levels signified evidence of internal consistency reliability for the KSRQ indicating that participants who were measured as having acquired a skill on any half of the items in a subscale were shown to be competent with other items within the same theoretical subscale. These results suggest that the KSRQ may consistently measure self-reported acquisition of skills for trainees.

Convergent and discriminant validity were also be established by comparison of participant results on the KSRQ with results on the Multitheoretical List of Therapeutic Interventions (MULTI) developed by McCarthy and Barber (2009), the student self-rating form (SSRF) developed by Barnfield, Mathieson, and Beaumont (2007), and the Marlowe-Crowne Social Desirability Scale – Form C (SDS-C) developed by Reynolds (1982). Results indicated moderate to strong convergent validity ($r > .47$) on all the related subscales that were investigated suggesting evidence that the KSRQ may be accurately assessing the acquisition of skills in cognitive, behavioral, and emotion-focused therapies. Results also indicated adequate discriminant validity ($-.08 < r < .03$) suggesting that the KSRQ may be sufficiently different from unrelated scales.

CHAPTER II

LITERATURE REVIEW

Counselor Training

The training of counselors has undergone many changes over the past five decades. Increased emphasis on empirical validation of treatments has led to the increased need to measure the effectiveness of counselor training as treatments must both be effective and capable of being taught to new counselors (Milne, Baker, Blackburn, James & Reichelt, 1999). Many elements have been enumerated over time as the central focus of training and while many training programs emphasize intervening effectively with the client as the most foundational element of therapy, disagreement still remains about what constitutes effective interaction. Training in basic helping skills places importance on effectively using basic interventions intentionally. Cognitive Therapy, on the other hand, emphasizes training individuals to begin with a theoretical approach and to conceptualize clients in terms of dysfunctional thoughts (Ivey & Ivey, 2003; Beck, 1995). Training in behavioral therapies, such as Behavioral Activation, emphasizes recognition of ineffective actions; Emotion-Focused Therapy training emphasizes counselor awareness of maladaptive emotional responses (Martell et al., 2010; Greenberg & Watson, 2006).

Basic Helping Skills

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). 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. 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). While the microskills approach has continued to develop, several similar models have extended basic helping skills training in a variety of directions. This diversity can be seen in the work of Egan's (1998) *The Skilled Helper* and Hill's (2009) *Helping Skills.*

Egan (1998) proposed that counselors be trained to integrate basic helping skills into three stages in order to understand the client's current scenario, to explore possibilities of a preferred scenario, and to create action strategies to bring about change. The first stage involves exploring clients' stories, confrontation, and focusing on the problem. The second stage involves focusing on clients' possibilities for change, interpreting and reflecting meaning, and goal setting. The third stage involves influencing and strategies for change, determining client's course of action, and planning steps for action and change. Egan established two principle goals of this process: (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 training model suggesting that counselors integrate helping skills into three theoretically-based stages involving exploration, insight, and action. Respectively, these stages are conceptualized using client-centered, psychoanalytic, and cognitive-behavioral theories. Hill's exploration stage is aimed at building rapport and utilizes the basic helping skills of attending, listening skills, establishing the client's story, and goals. The insight stage is aimed at fostering awareness and utilizes the skills of confrontation, interpretation, and reflection of meaning (Hill, 2009). The action stage is aimed at skill development and creating new possibilities and utilizes influencing skills focusing on change (Hill). Counselors are also encouraged to learn awareness of the intentions behind their interventions as well as the basic helping skills prior to more advanced skills. Hill's *Helping Skills* is an example of a complex integrated model that combines specific helping skills with more developed theoretical underpinnings.

Specific Theories

Foundational theories of psychotherapy generally utilize a variety of different approaches to training generally focusing on accomplishing tasks rather than basic interventions. Beck (1995) described Cognitive Therapy as a time-limited, present-focused approach emphasizing that trainees learn to identify and evaluate automatic thoughts as well as to identify and modify intermediate beliefs leading to integration with underlying core beliefs. Young and Beck (1980) developed the Cognitive Therapy Scale

(CTS) as a method by which observers could rate trainees according to 10 broad categories divided into two subscales (general skills & cognitive therapy skills) and utilized a multitude of strategies. These categories include setting an agenda, working with automatic thoughts and beliefs, and incorporate some behavioral techniques as well. Counselors would also be trained in more complex strategies such as using imagery, cognitive rehearsal, and exposure techniques (Young & Beck).

Behavioral Activation (BA) is a brief structured treatment based on 10 core principles that aims at activating "clients in specific ways that will increase rewarding experiences in their lives" (Martell et al., 2010, p. 21). Training literature for BA is continuing to develop, however, BA counselors are taught 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 client's behaviors as a means to changing their thoughts and feelings, confronting the problem and avoiding coping strategies, drawing attention to behavioral antecedents and consequences as important clues for behavior activation, creating plans that start small, emphasizing behavioral reinforcement, acting as a coach, using a problem-solving empirical approach, assigning activities, and troubleshooting barriers (Martell et al.).

Emotion-Focused Therapy "can be seen as operating according to two overarching principles: facilitating a therapeutic relationship and promoting therapeutic work" (Greenberg & Watson, 2006). 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, therapeutic enactments, managing secondary emotions and defensive responses, transforming emotional responses, and consolidating work into new meaning (Montagno, Svatovic, and Levenson, in press; Denton, Johnson & Burleson, 2009; Greenberg & Watson). Counselors 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).

Motivational Interviewing (MI), a more recently developed theory, is a brief intervention which was first applied to problem drinking in 1983 and has since become the subject of extensive amounts of research on a variety of psychological problems (Arkowitz, Westra, Miller, and Rollnick, 2008). Building client's confidence and preparing for change is an underlying theme connecting MI interventions and counselors are taught to regard client's difficulties in changing as ambivalence rather than resistance. Training therefore focuses on building client awareness of discrepancies between their actions and values without confronting clients thereby supporting self-efficacy and increasing the desire to change (Arkowitz et al.). MI training begins with learning how to utilize several basic helping skills such as open-ended questions, affirmations, reflective listening, and summarizing (OARS) according to a MI protocol and develops through learning to work with ambivalence through expression of concern and enhancing client's confidence (Rosengren, 2009; Miller et al., 2002). The Motivational Interviewing Supervision and Training Scale (MISTS) was developed for observers or supervisors to rate trainees according to 16 items divided into three categories including listening skills, spirit of MI skills, and overall ratings. Interventions grouped as the spirit of MI are

considered keys to client change and includes eliciting/reinforcing change talk, addressing ambivalence, rolling with resistance, collaborating with the client, and supporting self-efficacy (Madson, Campbell, Barrett, Brondino, & Melchert, 2005). MI shares some similar qualities and techniques with BA, and while both emphasize motivation and behavior change, BA places greater emphasis on behaviors as the key to change whereas MI emphasizes motivation.

Measuring Skills Acquisition

Skills acquisition 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 counselors being rated are unknown to the observers, have been deemed by many as the most scientifically rigorous approach (Barber, Sharpless, Klostermann & McCarthy, 2007; James, Blackburn, Milne & Reichfelt, 2001; Chevron & Rounsaville, 1983). Rating systems suffer from a few risks, however, 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, et al., 2005). Raters may also have previously constructed ideas or confusion regarding particular scale point systems (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).

While rated training sessions are considered by many to be the standard for measuring training effectiveness, other researchers consider client reports and/or client

outcome measures to be vital. Some researchers argue that clients' perspectives on therapy have been overlooked (McCarthy & Barber, 2009) or that clients' evaluation of the therapeutic work has a direct impact on the effect 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. However, as variables other than therapy interventions may be responsible for improvement, many researchers have expressed the need for further research more clearly connecting intervention to outcome. (Barnfield et al., 2007; Barber et al., 2007; Milne et al., 1999).

Self-report forms completed by counselors-in-training offer additional means of providing rich data on the acquisition of therapeutic skills. However, self-reports have several limitations since they are subject to biases and at times have been found to vary significantly between supervisors, peers, and counselors-in training (Ford, 1979). In order to account for these limitations, researchers have combined multiple self-report measures as well as used self-report forms to collect preliminary data justifying the need for further research in specific areas. Self-report forms have also been utilized for supervisors and trainees to evaluate the supervision process (Zarbock, Drew, Bodansky and Dahme, 2009), for discovery of counselors' primary theoretical orientation (Coleman, 2004), and to measure the knowledge, attitudes, and interventions used by counselors in training (Freiheit & Overholser, 1997; Barnfield et al. 2007).

Many of these methods for measuring training effectiveness have been combined in order to obtain a more holistic view of the training process. Clemence, Hilsenroth, Ackerman, Strassle & 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. 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.

Helping Skills Research

Research in helping skills training is extensive and began with Ivey et al. (1968) who concluded that trainees could learn three basic microskills including attending behavior, reflection of feeling, and summarization of feeling. Other studies followed this initial investigation and began adding more interventions including open-ended questions, paraphrasing, and activity skills, as well as re-testing the strategies of the initial study (Ivey & Authier, 1978). Studies have continued to reiterate that the microskills approach was an effective means of training basic helping skills to new counselors.

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 (refection of feeling & 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. Overall results indicated that it is possible to teach new counselors to "discriminate between effective and ineffective helping responses" as significant differences were found between trained and untrained groups. (Lee et al., 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.

Baker and Daniels (1989) conducted a meta-analysis of microskills research which identified 146 studies, 81 of which were considered sufficiently constructed to accurately yield an effect size. Results indicated that microskills "is an effective educational program" as indicated by mean effect size differences in comparison to other forms of training (e.g. Interpersonal Process Recall, empathy training, sensitivity training) ranging from $d = .11$ to $d = .60$ as well as an overall effect size for all studies of $d = .83$, at a $p < .05$ significance level.

Larson et al. (1992) conducted research in the development and validation of the Counseling Self-Estimate (COSE) inventory. COSE is a self-report measure designed to measure new counselors' confidence regarding 37 items and rated on a 6-point Likert scale, indicating strongly disagree (1) and strongly agree (6); examples of items include confidence in being clear and concise when goal setting, confronting, using reflection of feelings, active listening and other microskills, e.g. "I am certain that my interpretation and confrontation will be concise and to the point" (Larson et al.; Lent, Hill & Hoffman, 2003, p. 99). Factor analysis yielded five factors that were minimally correlated ($r < .30$)

identified as microskills, process, difficult client behaviors, cultural competence, and awareness of values. Internal consistency was calculated at $\alpha = .88$, $\alpha = .87$, $\alpha = .80$, $\alpha = .78$, and $\alpha = .62$, respectively, with total $\alpha = .93$ (Larson, et al.). Another study was undertaken "to show that COSE scores would increase over the course of a semester of master's practicum because of exposure to performance accomplishments, vicarious learning, and verbal persuasion", which resulted in a mean increase of 29 and 30 points, or 1.3 and 1.4 standard deviations (Larson et al., p. 114).

Russell-Chapin and Sherman (2000) developed the Counseling Interview Rating Form (CIRF) 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 CIRF 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 (see counselor training section) and one category was added for rating the counselor's level of professionalism. Five counselor educators were asked to determine the validity of the scale and content validity index (V) coefficients were calculated for each section of the CIRF 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 (Russell-Chapin & Sherman). All sections except professionalism were found significant at the $p < .007$ level, with V-scores ranging from $V = .90$ to $V = 1.00$ (Russell-Chapin & Sherman).

Reliability was tested by five counselors in training rating four videotapes of microskills counseling session with agreement coefficients ranging from $A = .50$ to $A = 1.00$ (Russell-Chapin & Sherman). The researchers concluded that the preliminary validation data suggest that the CIRF is adequate for measuring microskills used by new counselors (Russell-Chapin & Sherman).

Lent et al. (2003) conducted a study to develop and validate the Counselor Activity Self-Efficacy scales (CASES), a 41-item self-report measure designed to assess trainee's confidence as rated on a 10-point Likert scale with higher scores indicating more confidence in one's therapeutic abilities. CASES is divided into three subsections as follows: helping skills (further divided into insight, exploration, and action skills – see skills listed earlier in counselor training section), session management, and client challenges (further divided into relationship conflict and client distress). Lent et al. conducted coefficient alpha analyses resulting in high internal consistency reliability scores for all subscales and for the total scale; Exploration skills ($\alpha = .79$), Insight skills ($\alpha = .85$), Action skills ($\alpha = .83$), Session management ($\alpha = .94$), Client distress ($\alpha = .94$), Relationship conflict ($\alpha = .92$), and Total score ($\alpha = .97$). Convergent and discriminant validity analyses were also conducted by comparing the CASES with the COSE and Crowne-Marlowe social desirability scale (SDS), respectively, finding a high total-score correlations ($r > .61$) with the COSE and non-significant correlations ($-.02 < r < .22$) with the SDS (Lent et al.).

Specific Theories Training Research

In 1980, Young and Beck developed the Cognitive Therapy Scale in order to ascertain counselors' strengths and weaknesses related to specific therapeutic interventions (see above in counselor training section) 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 counselor 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 also correlated highly, $r(88) = .85$, $p < .001$ (Vallis et al., 1986). Interrater reliability of five raters was calculated using intraclass correlation coefficients (ICC) and one-way ANOVA leading to mixed results as only one rater produced significant reliability (.59), $F(9, 40) = 8.23$, $p < .01$, and correlations for individual items remained low to moderate, ranging from .27 to .59, leading to questioning of subscales (Vallis et al.).

Blackburn et al. (2001) developed the Revised Cognitive Therapy Scale (CTS-R) stating that the original CTS was in need of revision since the most recently validated version was from 1980. The aim of this study was to make the CTS more useful for measuring skill acquisition, include an emphasis on therapeutic alliance, and to assess the psychometric properties of the scale. Observers viewed taped sessions and rated trainees on up to 14 items using a 7-point Likert scale. Blackburn et al. utilized the same protocol

as Vallis et al. (1986). The CTS-R 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 14th item, use of non-verbal behaviors (Blackburn et al.). Reliability and validity was satisfactorily established using a variety of methods. 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), ranging on the 13-item version from $\alpha = .92$ to $\alpha = .95$ (Blackburn et al.). Interrater reliability of 4 raters was calculated using intraclass correlation coefficients (ICC) averaging across raters at .63 (13-items) and .57 (14-items), both significant at $p < .01$, and Pearson correlations averaged for four raters at .66 (13-items) and .63 (14-items), significant at $p < .001$ (Blackburn et al.).

Freiheit and Overholser (1997) researched the effects of pre-existing biases toward CBT on trainee's ability to learn CBT. They concluding that trainees' prior theoretical orientation did not significantly impact their ability to learn CBT interventions in a practicum setting. Trainees were administered the Behavior Therapy Scale (BTS), a self-report scale measuring knowledge, attitude, and interventions used in previous sessions. Knowledge scores were measured using 20 multiple choice questions (e.g. "The behavioral approach to depression (e.g. Lewinsohn) focuses on correcting which of the following: (a) social skills deficits, (b) cognitive distortions, (c) excessive punishment, (d) maladaptive learning history, (e) none of the above") which assessed knowledge of

therapeutic interventions such as flooding, exposure, reinforcement, relaxation, and systematic desensitization (Freiheit and Overholser). Attitude scores were measured based on responses to 25 statements (e.g. "Behavioral approaches ignore the unique essence of human existence" or "The subject matter of human psychology is the BEHAVIOR of the human being. Consciousness is neither a definite nor a usable concept") measured on a continuous scale ranging from *strongly agree* (57) to *strongly disagree* (1) which included statements in favor and opposed to behavioral techniques, and in favor of traditional behavioral ideology, cognitive ideology, humanistic ideology or psychodynamic ideology (Freiheit and Overholser). Behavior scores were based on a 4 point frequency scale from (0) no use to (3) almost always indicating how often 18 specific CBT interventions (e.g. systematic desensitization, exposure, parent training) had been utilized in each of the previous 12 sessions (Freiheit & Overholser). Psychometrics demonstrated that the knowledge, attitude, and behavior scales were distinct and that the constructed attitude subscales showed moderate to high correlations (ranging from r = -.33 to r = .97). No validity coefficients were reported. The researchers concluded that the overall results of the study indicated that students can learn CBT techniques regardless of their theoretical biases prior to training (Freiheit & Overholser).

Barnfield, et al. (2007) investigated the development of competence in postgraduate mental health professions using a revised version of the BTS, CTS-R, and two self-report forms, the Supervisor Rating Form (SRF), and the Student Self-Rating Form (SSRF), parallel self-report forms which can be used to compare the perspectives of counselors-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., p. 141). In order to research competence from a variety of these common factors, Barnfield et al. developed the SRF and SSRF to assess the development of 24 therapeutic skills (14 CTS-R items and 10 additional items) as measured by 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 CBT 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).

Rakovshik and McManus (2010) conducted a review of the empirical research and theoretical underpinnings of CBT training, in order to demonstrate the relationship between training and client outcome. This review included 41 studies from 35 clinical trials from the previous 10 year period utilizing a variety of different measures to assess competence in CBT including the CTS, CTS-R, and related scales. 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. Hours of training decreased with client outcome category as follows: (1) $M = 199$ (SD = 104); (2) $M = 93$ (SD = 59), (3) $M = 33$ (SD = 32) (Rakovshik & McManus). Limitations

recognized in this review related to clarifying definitions and methods, utilizing a more scientific approach to researching CBT training (as done in treatment studies), and using the evidence collected regarding mechanisms of change to inform dissemination practices (Rakovshik & McManus).

Busch, et al. (2009) investigated the micro-process of Functional Analytic Psychotherapy (FAP), a derivative of Behavioral Analysis, and developed 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 are utilized due to the claim of FAP that "client problem behaviors will be displayed in the therapeutic relationship" (Busch et al., 2010, p. 11). Reliability was established using kappa scores with counselors codes ranging from $\kappa = .62$ to $\kappa = .75$, indicating acceptable levels of agreement between coders (Busch et al., 2009, 2010). Busch et al. (2010) replicated and extended the previous study on FAPRS, for the purpose of drawing particular emphasis to FAP'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.

Paivio and Nieuwenhuis (2001) investigated the effectiveness of Emotion Focused Therapy (EFT) for child abuse survivors, developing the EFT-checklist to measure adherence based on general EFT interventions. The checklist 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). These interventions are based on general EFT interventions previously established by Greenberg and Paivio (1997). Interrater reliability of two coders independently rating 37 sessions was indicated using kappa coefficients achieving an agreement of 79% ($\kappa = .73$) (Paivio & Nieuwenhuis).

Denton, et al. (2009) developed and validated the Emotion-Focused Therapy-Therapist Fidelity Scale (EFT-TFS) to measure the adherence and competence of EFT couples (EFT-C) counselors and for use "in training settings to assess therapist development and provide feedback to therapists" in training (p. 227). Each of 13 items of the EFT-TFS are rated on a 5-point Likert scale and each item represents an EFT-C 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 EFT and consolidating change and new narratives (Denton et al.). Copies of the EFT-TFS were distributed to EFT trained counselors ($n = 97$) who were asked to rate how essential, important, and necessary they considered items of the scale using a 7-point Likert scale

(ranging from (1) Low to (7) High), and results were calculated utilizing Cronbach's α (average α = .978), indicating that the three questions were understood in "a very similar fashion" (Denton et al., p. 229) These scores were then averaged and overall mean scores for the 13 items of the EFT-TFS ranged from 6.2 to 6.7 (on a 7-point scale) indicating that all items were regarded by participants as significantly important (Denton et al.).

Levenson and Svatovic (2009) developed the EFT Knowledge and Competency Scale (EFT-KACS), a 12-item self-report scale based on the 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 (consolidating change and new alternatives was removed), each to be rated by the counselor on a 7-point Likert scale from (1) not at all to (7) quite a bit and rated twice, once for knowledge and once for competence (Montagno et al., in press). Montagno (2009) conducted a principle 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 called Alliance. Internal consistency was also calculated using Cronbach's α and results ranged from α = .92 to α = .96 (Montagno et al., in press). Data were collected from clinicians who attended a 4-day externship training in EFT-C pre-test, post-test (N = 76), and 8 months post training (N = 29). 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 (17% to 54% - knowledge & 3% to 15% - competence) and retention of knowledge and competence scores at 8 months post-training (Montagno et al., in press).

Barsky and Coleman (2001) developed a measure to evaluate skill acquisition of trainees in Motivational Interviewing (MI), which they defined as "a directive, client-centered counseling style for eliciting behavior change by helping clients to explore and resolve ambivalence" (p. 71). The Motivational Interviewing Process Code (MIPC) was developed by means of collecting data from MI experts and focus group discussions. The completed measure consisted of a list of 13 functional skills (e.g. expresses faith that client will make the right decisions, helps client with goals & helps client identify barriers to change) and a list of 12 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 higher avoidance of dysfunctional skills, respectively (Barsky & Coleman).

Moyers, Martin, Manuel, Hendrickson, and Miller (2005) developed and evaluated the Motivational Interviewing Treatment Integrity (MITI) scale, a simplification of the original Motivational Interviewing Skills Code (MISC) which assesses MI competence by rating counselors' actions. Exploratory factor analysis was used to divide MI interventions from the MISC into 10 global dimensions such as the spirit of MI, empathy/understanding and complex reflections (Moyers et al.). Inter-rater reliability was analyzed by means of ICC resulting in moderate to excellent levels of reliability across all domains, ranging from .52 (empathy/understanding scale) to .97 (closed questions) (Moyers et al.).

The behavioral change counseling index (BECCI), was developed and evaluated to measure counselor competence in behavior change counseling (BCC), a modified

version of MI for use in healthcare settings (Lane et al., 2005). BECCI was developed for use in training and research and adapted the essential MI skills to brief consultation settings. Three raters used a 5-point Likert scale to measure items such as inviting patient to talk about behavior change and actively conveying respect for patient choices. Reliability of the index was measured by Cronbach's α (ranging from $\alpha = .71$ to $\alpha = .63$) and inter-rater reliability (ranging from $R = .79$ to $R = .93$), concluding that the BECCI could be reliably used to assess competence in trainees (Lane et al.).

Madson, Campbell, Barrett, Brondino, and Melchert (2005) developed and evaluated the Motivation Interviewing Supervision and Training Scale (MISTS), another clarification of the MISC, which "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, MI fidelity, and effectiveness of therapist interventions" (Madson, Campbell, Barrett, Brondino, et al., p. 305). Scores from three raters were calculated from a 7-point Likert scale, with higher scores indicating higher levels of adherence or competence. Items included general MI interventions (see counselor training section above) and two items were added for effectiveness of the counselor and response of the client. Interrater reliability of MISTS was satisfactorily established using generalizability coefficients ($p^2 = .79$), a form of Intraclass Correlation Coefficients (ICC) developed by Cronbach which estimates the correlation between an individual rater's ratings and the average ratings of all possible raters (Madson, Campbell, Barrett, Brondino, et al.). In conjunction with the scale, Madson, Campbell, Barrett, Rugg, and Stoffell (2005) developed rating guidelines for the MISTS to assist researchers in gaining greater uniformity of ratings when utilizing

the scale. These ratings give definitions of the global ratings and rating anchors for deciding how to code therapy sessions (e.g. Item 8 Addressing Clients Ambivalence – Rating Anchors: 1. Consistently misses ambivalence; 4. Recognizes ambivalence but does not fully explore or address in session; 7. Recognizes ambivalence and consistently addresses it) (Madson, Campbell, Barrett, Rugg, et al., 2005).

Martino, Haeseler, Belitsky, Pantalon, and Fortin (2007) developed a curriculum to teach medical students Brief Motivational Interviewing (BMI), which is designed to promote change in patient behaviors in the context of a fast-paced medical practice. Training was delivered in a 2-hour session and students learned the CHANGE acronym which encourages **C**hecking client perspectives using open questions, **H**earing the patient with listening skills, **A**voiding advice-giving or confrontation, **N**oting change priorities, **G**iving feedback when solicited by the patient, and **E**nding with a summary of plans for change (Martino et al.). Pretest, post-test, and 4-week follow-up data were collected by means of trainee self-report utilizing the Helpful Response Questionnaire, a 16-question survey to assess intervention knowledge, and additional questions for overall interest, confidence, and commitment levels as rated on an 11-point Likert scale from (0) *not at all* to (10) *extremely* (Martino, 2010). Results indicated significant increases in knowledge ($F = 27.65$, $P < .001$), interest ($F = 8.11$, $P < .01$), confidence ($F = 15.84$, $P < .001$), and commitment ($F = 9.28$, $P < .001$), maintaining similar results after a 4-week follow-up.

More recently, MI training has undergone a systematic review conducted by Madson, Loignon, and Lane (2009), which included 28 studies from the previous 10 year

period utilizing a variety of different measures to assess competence in MI including the MISC, MITI, and BECCI. 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 MI skills, the need for further research concerning MI training in practicum settings, and the need for psychometrically evaluated measures of MI knowledge, attitude, self-confidence, and self-efficacy as it relates to application of MI interventions into practice (Madson, Loignon, et al., 2009).

Other Relevant Training Research

Coleman (2004) developed the theoretical evaluation self-test (TEST), a measure which indicates a counselors theoretical orientation based on 36 items (therapeutic interventions) from eight domains (theoretical orientations) rated on a 7-point Likert scale from *strongly disagree* (1) to *strongly agree* (7), and including strategies from the following theories: psychodynamic, cognitive, humanistic, family, pragmatic, biological, casework, and cultural competence. Cronbach's α confirmed internal consistency reliability as high on 7 domains and moderate on 1 domain (humanistic) with overall α = .65 (Coleman). Convergent validity was confirmed by comparing 5 subscales with previously established scales with average correlation at $p < .01$ being $r = .45$ (Coleman).

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" (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). Reliability of the scale was assessed using Cronbach's α and confirmatory factor analysis showing results ranging from $\alpha = .66$ to $\alpha = .91$ and adequate fit for all factors (McCarthy & Barber). 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).

Zarbock, et al., (2009) constructed and evaluated the questionnaire to evaluate supervision (SSB), which included two parallel 12-item self-report questionnaires for supervisors and supervisees measuring supervisee progress according to the domains of relationship, problem coping, and clarifying. These domains were established by means of factor analysis. Reliability was established utilizing Cronbach's α (combined supervisee report at $\alpha = .86$ and combined supervisor report at $\alpha = .83$) and inter-item correlations (ranging from $r = .38$ to $r = .71$) suggesting SSB as a suitable means of measuring trainee progress.

Literature and Current Project

The current project bears many similarities and differences with previous studies. The KSRQ is unique in that it attempts to measure self-rated scores for knowledge, confidence, and intended use for individual Key Strategies. KST offers a conceptual framework through which a new counselor can intervene from more than one theoretical perspective and using practical strategies. The KSRQ aims at measuring trainees' acquisition of each of these strategies one-by-one.

Support from the Literature

Studies from the past few decades have emphasized the need to investigate the details of treatment and training in order to discover not only *if* something works, but *how* it works. Many studies have begun to investigate specific mechanisms of change under the assumption that general studies of effectiveness often leave many questions unanswered, such as which interventions are capable of being taught, or which interventions are more efficacious in bringing about client change (Busch, et al., 2009). Some researchers advocate evidence-based training, calling for "a shift toward describing dissemination trails by their discrete and specific training interventions and propose implementation of research methodologies that allow more accurate analysis and comparison of training interventions." (Ravovshik & McManus, 2010, p. 514).

While studies in basic helping skills have attempted to dissect the pieces of effective therapy for several decades, these studies have not dissected the interventions of widely used empirically-supported treatments. Studies have established the effectiveness of training in separate microskills, however "students perform better on the basic skills

than on the advanced skills", which seem to require more training in order to achieve comparable levels of competency (Kuntze, et al., 2009).

KST is a new, systematic alternative to counselor training that bridges the gap between basic helping skills and intervention strategies from three empirically-supported treatments. The KSRQ gathers self-report data regarding knowledge, confidence, and intended use for each intervention. Researchers have repeatedly stated the need to measure individual skills rather than overall efficacy in training and treatment, creating self-report and rater scales by which this can be accomplished (e.g. CIRF, COSE, CASES, CTS, BTS, SSRF, MISTS, FAPRS, EFT-TFS, EFT-KACS, MULTI). Some researchers have developed scales specifically to collect self-report data from trainees in order to better understand the first-hand experience of those in training programs (e.g. COSE, CASES, BTS, SSRF, EFT-KACS, MULTI). Emphasis has also been placed on collecting multiple aspects of trainee's experience and response to training such as knowledge, confidence, comfort, self-efficacy, intended use, and/or competence (e.g. COSE, CASES, BTS, SSRF, EFT-KACS). Scales have also been developed in order to investigate trainee's development in basic helping skills (e.g. MSDS, CIRF, COSE, CASES), as well as more complex strategy interventions based on specific psychotherapy theories (e.g. CTS, BTS, SSRF, MISTS, FAPRS, EFT-TFS, EFT-KACS, MULTI). Fewer scales have incorporated strategies from a variety of empirically-supported treatments (e.g. BTS, MULTI) and only the MULTI incorporates many interventions from each foundational theory.

Research Rationale for the Current Project

The KSRQ was developed to fill several gaps in research regarding collection of data from the perspective of counselors in training. Particularly, the KSRQ seeks to fill the needs for a psychometrically evaluated measure to assess knowledge, confidence, and intended use (Madson et al., 2009) for each individual intervention of multiple empirically-supported treatments (McCarthy & Barber, 2009; Busch et al., 2009), as opposed to utilizing general questions of competence, comfort, or commitment (Martino et al., 2005; Barnfield et al., 2007).

Lent et al. (2003) developed the CASES in order to measure counselor confidence in Hill's helping skills. The KSRQ extends the scope of the CASES by investigating knowledge and intended use as well. Further, although Hill's (2009) helping skills training divides basic skills into three stages (CASES measures these stages) based on three foundational theories, it fails to utilize the more complex interventions of those theories, to provide a transition from helping skills to the complex strategies, and is not tied directly to ESTs.

The BTS developed by Freiheit and Overholser (1997) and revised by Barnfield et al. (2007) measures general knowledge of CBT and previous usage of particular cognitive therapy skills. The KSRQ goes beyond the BTS by assessing confidence and knowledge for each particular skill. Barnfield et al. (2007) also developed the SSRF in order to measure a trainee's self-rating of skills and abilities in general and specific cognitive interventions (based on the CTS). The KSRQ similarly seeks to measure skills

acquisition but understands acquisition as encompassing the domains of knowledge, confidence, and intended use.

Levenson and Svatovic (2009) developed the EFT-KACS to assess knowledge and competence in particular interventions of EFT-C. The KSRQ similarly seeks to measure the knowledge and competence of trainees, but does not rely solely on general competence questions. Rather, competence is understood as encompassing several domains, one of which is acquisition of skills and the KSRQ aims at measuring this aspect of competence, particularly in terms of trainee's knowledge, confidence, and intended use of Key Strategies.

The purpose of the current project, therefore, is the development of a psychometrically valid and reliable instrument designed specifically to measure a counselor-in-training's self-reported acquisition of skills from three ESTs (Cognitive Therapy, Behavioral Activation, and Emotion-Focused Therapy). The development and evaluation of the KSRQ was undertaken as a necessary first step in measuring trainee progress thereby establishing the effectiveness of KST. Cronbach's α was used, rather than split-half reliability, as a more thorough and reliable manner of indicating internal consistency. Convergent validity was established by comparison with two existing scales, the SSRF (Barnfield et al, 2007) and the MULTI (McCarthy & Barber, 2009). Discriminant validity was established by comparison with a theoretically dissimilar scale, the Marlowe-Crowne SDS-C (Reynolds, 1982). The creation of the KSRQ will contribute to the literature by assessing skills acquisition in terms of knowledge, confidence, and intended use of each intervention individually, thereby providing a more thorough view

of skills acquisition and identifying specific areas of competence within each theoretical framework.

Hypothesis 1. Utilizing Cronbach's α, KSRQ subscales, consisting of seven items each and representing intervention strategies drawn from three different ESTs, will display an expected minimum internal consistency of $\alpha = .80$ (Lounsbury, Gibson, & Saudargas, 2006).

Hypothesis 2. KSRQ Cognitive Therapy, Behavioral Activation, and Emotion-Focused Therapy Subscales will display significant, moderate to strong convergent validity correlations ($r > .30$ to $r > .50$) with the Cognitive, Behavioral, and Process-Experiential subscales of the MULTI, respectively (Rosenthal & Rosnow, 2008).

Hypothesis 3. KSRQ Cognitive Therapy and Behavioral Activation Subscales will display significant, moderate to strong convergent validity correlations ($r > .30$ to $r > .50$) with the SSRF (Rosenthal & Rosnow, 2008).

Hypothesis 4. KSRQ Cognitive Therapy, Behavioral Activation, and Emotion-Focused Subscales will display discriminant validity correlations ($-.10 < r < .10$) with the SDS-C (Rosenthal & Rosnow, 2008).

CHAPTER III

METHOD

Initial Development of the KSRQ

A review of the related literature was undertaken in order to generate questions to assess trainee competence within the 21 intervention strategies of the KSRQ. For this scale, key strategies (and interventions) were defined as any intentional act taken by a mental health professional to "intervene therapeutically with their clients" (Brooks-Harris, 2008, p. 57). Psychometrically evaluated self-report assessments in which trainees measure their own ability level were identified as underrepresented in the literature. Madson et al. (2009) recognized this in their review of MI training literature, concluding that there was lack of psychometrically evaluated knowledge, attitude, and self-confidence measures, without which the results of the related studies come into question. The development of a reliable measure allowing counselors and trainees to rate their progress in a variety of strategies was therefore considered important.

Ford (1979) established criteria to determine the reliability and validity of training measures, 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). Ford suggested that reliability of scales be established by means of split-half or observer correlations and validity be established by sampling the representative population (e.g. trainees, counselors) or

correlating with a measure already validated, using precise operational definitions of the variables one is measuring which do not contain multiple, functionally different subcategories, and finding significantly different effects within each category.

James et al. (2001) pointed out that the "effectiveness of training is typically inferred from the results of psychological therapies, rather than demonstrated by the evaluation of the components of training; in short, there is a causal gap in our knowledge base...and two priority topics are: defining competence and analyzing its critical determinants" (p. 132). Competence has been defined and measured in a variety of ways. Definitions of competence were found to include features such as knowledge of treatment protocol, ability to consistently deliver treatment (congruence, timing, and suitability of interventions), willingness to adhere to treatment protocol, confidence, acquisition of skills, intended use of interventions, evaluation outcomes, interpersonal effectiveness, and client improvement (Barnfield et al., 2007; James et al., 2001; Madson et al., 2009; Miller et al., 2010; Moyers et al., 2005; Paivio et al., 2004). The aspect of confidence being measured was found to be related to the type of measure being created. For example, studies utilizing raters typically conceptualize competence in terms of observed delivery of treatment and/or the raters' impressions regarding other aspects of competence such as confidence, timing, congruence, and interpersonal effectiveness. Studies utilizing client reports conceptualize competence in terms of the client's improvement or the client's impressions of interventions that took place during therapy. Studies utilizing peer, supervisor, and/or counselor reports, on the other hand, generally measure skills acquisition, confidence, knowledge, and intended use.

The KSRQ was constructed as a measure to assess acquisition of skills. Knowledge, confidence, and intended use are important aspects of the acquisition process. First, knowledge of the theoretical purpose for interventions, which can be found in many training studies as an important aspect of skills acquisition, was identified and adopted. Adequate knowledge of the rationale for specific interventions is considered a fundamental part of effectively using those interventions (Barnfield et al., 2007; Madson et al., 2009; Montagno, Svatovic, & Levenson, in press). Knowledge is a cognitive construct and is assessed in the KSRQ by asking how clearly one understands the theoretical rational for each strategy.

Second, another important factor identified in the review was the degree to which a counselor felt confident or comfortable utilizing an intervention. Knowledge alone is not sufficient to produce competence in skills acquisition. Self-reported feelings of comfort utilizing interventions is measured and identified as confidence in the KSRQ. This component involves an affective dimension and is assessed by asking how confident the trainee feels utilizing each intervention. Many training measures have constructed similar ways of assessing an affective response to training by asking how confident/comfortable/competent one *feels* utilizing an intervention (Madson et al., 2009; Montagno, Svatovic, & Levenson, in press). A review of the relevant literature revealed that most of these studies only assess a trainee's overall feeling of comfort / competence / confidence after receiving training and not in regard to each particular intervention (Barnfield et al., 2007). The KSRQ was therefore constructed to measure one's confidence in relation to each strategy.

Third, counselors' intention to actually utilize an intervention strategy is also recognized as an important factor in skills acquisition. This is conceptualized as intended use in the KSRQ and is assessed by asking how likely one is to implement specific strategies with clients in the future. Intended use is a behavioral construct which predicts future behavior rather than reporting past behavior. A review of the relevant literature revealed that trainees' actual intended use of interventions was less frequently measured (Madson et al., 2009). The KSRQ was therefore constructed to measure intended use in order to assess beyond one's understanding and comfort and to determine how important the trainee actually considers each individual strategy. In this way, intended use is understood as a more accurate indicator that the strategy will be added to the counselor's repertoire of interventions and that the skill has in fact been acquired.

Together the constructs of knowledge, confidence, and intended use will be conceived as skills acquisition, a crucial component of competence. In this way, the KSRQ is therefore understood as measuring trainees' cognitive understanding, affective response, and intended behavior in regard to specific therapeutic interventions. By assessing specific strategies belonging to different theories, the KSRQ should provide a more accurate rating of counselor's skills acquisition than general questions related to confidence and intended use. Further, the development of the KSRQ is understood as the first step in developing a comprehensive system of measuring training in Key Strategies.

Participants

Participants in this study included 149 masters-level (M.A. & M.S.) and doctorate-level (Ph.D. & Psy.D.) students from various counseling, clinical psychology,

counseling psychology, and marriage and family therapy graduate programs. Selection criteria included completion of a graduate-level psychotherapy course incorporating theory and practical training, completion of one semester of practicum or internship, and English language fluency sufficient to complete the measure. Students having completed at least one semester of practicum or internship were sampled as this study aims at establishing the KSRQ's ability to consistently measure knowledge, confidence, and intended use of therapeutic interventions by experienced counselors. Participants varied in training experiences including exposure to different theories and interventions. Participants were also expected to differ in regards to their preferences in favor of and against particular treatment modalities. Graduate students participating in this study ranged in therapeutic experience from 1 semester to 41 years, with a median of 4 semesters of practicum, and a median of no additional practice in the field beyond practicum.

Instrumentation

KSRQ. The KSRQ was developed by consulting *Integrative Multitheoretical Psychotherapy* (MTP), which reviews a variety of psychotherapy theories and lays a foundation for integration (Brooks-Harris, 2008). MTP organizes a multiplicity of theories into seven conceptualized models including cognitive, behavioral, experiential, biopsychosocial, psychodymanic-interpersonal, systemic-constructivist, and multicultural-feminist (Brooks-Harris). The interventions of each theory are arranged as key strategies related to the appropriate conceptual model. Based on experience in training counselors, Harris (2010) concluded that it is difficult for new counselors to learn

a wide repertoire of therapeutic interventions in a short period of time and that counselors in training might be able master a small set of strategies drawn from each of three ESTs. This simplified and clarified version of MTP is being introduced here as Key Strategies Training (KST). Therefore, the KSRQ is being developed to measure the acquisition of these intervention strategies, which target cognition, behavior, and affect.

Literature related to therapeutic techniques, treatment manuals, and experts from a variety of fields were consulted in the construction of MTP key strategies and those utilized by the KSRQ, derived from ESTs, can be considered as core elements of therapeutic change by practitioners working within the relevant modalities. The KSRQ, based on seven key strategies from Cognitive Therapy, Behavioral Activation, and Emotion-Focused Therapy, will request trainees to rate their own knowledge, confidence, and intended use of all 21 key strategies. Each question will be rated on a 7-point Likert scale (0 – "not at all" and 6 – "very much"). Trainees will be able to produce total raw scores between 0 and 432.

Multitheoretical list of therapeutic interventions – therapist version. The therapist version of the multitheoretical list of therapeutic interventions (MULTI) was developed by McCarthy and Barber (2009) for counselors to rate the interventions actually used in therapy with clients after each session. The MULTI is based on interventions from eight foundational theories including Behavioral, Cognitive, Dialectical-Behavior, Interpersonal Psychotherapy, Person Centered, Psychodynamic, Process-Experiential, and Common Factors (McCarthy & Barber). The MULTI is comprised of 60 items (e.g. "I worked to give my client hope or encouragement.") 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, p. 111). Cronbach's α and confirmatory factor analysis were used to assess reliability showing results ranging from α = .66 to α = .91 and adequate fit for all factors (McCarthy & Barber). The validity of the MULTI to predict a counselor's theoretical orientation was also calculated using predictive discriminant analysis with an apparent error rate for classification ranging from 10% to 12% (McCarthy & Barber). This scale will be adapted to assess counselors' overall perceived use of interventions in general rather than their use of interventions during a particular session. McCarthy and Barber suggested as a future direction that convergent validity of the scale be established by comparison with other scales of therapeutic strategies.

Student self-rating form. Barnfield, Mathieson, and Beaumont (2007) developed the Student Self-Rating Form (SSRF) for students to rate their own use of Cognitive Behavioral Therapy (CBT) interventions based upon 24 therapeutic strategies. These interventions include the 14 strategies comprising the CTS-R, wherein raters identify cognitive and behavioral strategies used in session by therapists (Barnfield, 1999). An additional 10 items were also included to assess key behaviors, linking appropriate strategies to presenting problems, adhering to the agenda, assessment of patient's presenting problems, active listening, ability to explain the CBT 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 24

items of the SSRF are each rated on a 6-point Likert scale, with higher scores indicating more developed ability using clinical skills drawn from CBT (Barnfield, 1999).

Marlowe – Crowne social desirability scale: Form C. The Crowne & Marlowe (1960) Social Desirability Scale (SDS) was developed to measure whether participants' responses to questionnaires were based on the desire to present themselves in a favorable manner. The SDS was based on comparison with the MMPI and the Edwards Social Desirability Scale (E-SDS), and an attempt to purge the scale of all psychopathology-related terminology (Crowne & Marlowe). The SDS contains 33 items related to social desirability which are answered as either true or false (e.g., "I'm always willing to admit when I make a mistake"; Crowne & Marlow, p. 351). Internal consistency was measured with Kuder-Richardson formula 20 (KR20) resulting in strong findings ($R = .88$). Significant Pearson correlations, suggesting validity, were also found between the SDS and the E-SDS ($r = .35$, $p < .01$) and between the SDS and the MMPI *L* and *K* validity scales ($r = .54$, $p < .01$; $r = .40$, $p < .05$, respectively). Reynolds (1982) measured the reliability and validity of three shortened forms of the SDS, including the 13-item questionnaire (Form C – see appendix D for SDS-C) used in the present study. Internal consistency of the SDS-C was measured using KR20 finding acceptable reliability results ($R = .76$) (Reynolds). Significant Pearson correlations, suggesting validity, were also discovered between the SDS-C and the original 33-item SDS ($r = .933$, $p < .001$) and between the SDS-C and the E-SDS ($r = .41$, $p < .001$) (Reynolds).

Procedure

This study implemented a post-test only design measuring the internal consistency reliability, convergent validity, and discriminant validity of the KSRQ. Convenience sampling was used and participants completed the study online. The study was administered to graduate students at various APA accredited applied psychology programs. Written instructions for completion of the study were distributed by means of email listserv to students both locally and across the United States and Canada. Emails were forwarded to directors of academic and training programs in the appropriate mental health fields requesting that this study be placed on their listserv. Target programs required practicum or internship and training in psychotherapy theories. Online participants received an email containing a link to the study, which was electronically hosted on Psych-Data. The researchers' contact information and a link to the MTP website (www.multitheoretical.com) was included so participants could obtain further information about MTP and the KSRQ study should questions or concerns arise.

Before beginning this study, participants completed informed consent stating that responses were anonymous and explaining that the study concerns the development of trainees in selected mental health professions. Participants were informed that this survey will take approximately 30 minutes to complete and that they may stop at anytime during the study. Demographic information was collected, including participant age, race, gender, level of education, semesters of practicum/internship experience, and theoretical orientation. The three sections of the KSRQ form, administered online, were preceded by directions for completion. After being introduced to the study and giving consent, each

participant was administered the KSRQ, SSRF, MULTI and SDS-C. All participants received the same test items on the KSRQ forms, however, the three subscales of the KSRQ were administered in different orders. All participants received the KSRQ, SSRF, MULTI and SDS-C; however, the KSRQ was administered first so that an adequate sample size would be found for at least internal consistency results. The remaining three questionnaires were also administered in different orders.

After participants began the KSRQ, they read short descriptions of 21 key strategies (e.g. Strategy COG-3. Analyzing thoughts in order to determine if they are functional or dysfunctional). After each description, participants answered three questions rating their knowledge, confidence, and intended use, each rated on a 7-point Likert scale. The first question measured knowledge by asking, "How clearly do you understand the theoretical rationale for this strategy?" The second question measured confidence by asking, "How confident would you feel using this intervention with a client?" The third question measured intended use by asking, "How likely are you to implement this strategy with clients in the future?" (See Appendix A – KSRQ). The KSRQ thereby provides a holistic view of trainees' acquisition of skills by assessing knowledge, confidence, and intended use of the strategies from each of three ESTs based on the actual interventions used by each theory.

After participants began the SSRF, they proceeded to respond to questions regarding number of supervision sessions they have had completed and level of participation in those sessions. Next, participants rated their current skills and abilities in 24 strategies (e.g. (b) Assessment of key cognitions) according to a 6-point Likert scale

or indicated that they could not assess with an X (Barnfield et al., 1999) Last, participants were asked to indicate whether they were comfortable using CBT (either "yes" or "no").

After participants began the MULTI-R, they rated their typical use in counseling sessions of 60 therapeutic interventions (e.g., "I teach my clients specific new skills or behaviors") on a 5-point Likert scale ranging from 1 (Not at all typical) to 5 (Very typical) (McCarthy & Barber, p. 111).

After participants began the SDS-C, they answered true or false to 13 questions concerning their manner of interacting socially (e.g., "There have been occasions when I took advantage of someone") (Reynolds, 1982).

The Institutional Review Board (IRB) of Texas Woman's University approved this study prior to the collection of data. Participants were informed that all their responses would be confidential and that no record of personal information was connected with their responses. The consent form included an explanation about potential risks as well as contact information for the Texas Woman's University Institutional Review Board, the author, and the thesis advisor. Participants were informed that they could communicate any concerns regarding the study.

Statistical Analyses

Descriptive statistics were extracted from demographic information, including means and standard deviations. To account for order effects, the three sections of the KSRQ were administered in a variety of orders. Utilizing counterbalancing techniques, each of the three sections of the KSRQ form appeared in the 1st, 2nd, and 3rd positions at

approximately the same frequency. Measures used for convergent and divergent validity were also counterbalanced (SSRF, MULTI, & SDS-C).

Cronbach's α was used to examine internal consistency of each of the three KSRQ subscales separately. Ponterotto and Furlong (1985) critically reviewed six common counselor rating scales suggesting that reliability scores of many instruments had been over- or underestimated due to the use of split-half reliability instead of Cronbach's α coefficient and that the "generalizablity of counselor rating scales across settings and populations would be enhanced if all researchers reported α coefficients" (p. 612). Cronbach's α can be utilized to split items within a measure into all possible halves thereby finding the mean of all possible split-half coefficients (Ponterotto & Furlong). The benefit of using Cronbach's α lies in the capacity of ruling out error due to other possible ways of splitting data in half which could potentially result in inaccurate reliability coefficients (Ponterotto & Furlong). Further, Cronbach's α has become the standard in measuring reliability for test measures related to counselor competence and effectiveness of training procedures. Moderate internal consistency for a Cronbach's α coefficient is $\alpha > .70$, which is the expected minimum result for KSRQ reliability.

Convergent and divergent validity were assessed by comparing the KSRQ to the SSRF, MULTI, and SDS-C. Convergent validity, a form of construct validity, is generally established by correlating a measure with other measures and establishing patterns of correlations suggesting that the variables are associated in a manner that is predictable, while divergent validity is established by finding no correlation with a measure considered theoretically different (Westen & Rosenthal, 2003). Construct

validity is a crucial component in establishing the generalizability of research results because "if a psychological test...lacks construct validity, results obtained using this test will be difficult to interpret" (Weston & Rosenthal, p. 608). The importance of convergent validity lies in the establishment of a relationship between variables within a questionnaire to equivalent variables in other questionnaires which theoretically should be positively associated (Weston & Rosenthal). Moderate convergent validity correlations ($r > .30$) were the expected minimum results between the KSRQ and the SSRF, the KSRQ and the MULTI, and the KSRQ and the SDS-C. Divergent validity correlations between $r > -.10$ and $r < .10$ were expected between the KSRQ and SDS-C.

CHAPTER IV

RESULTS

Demographics

A total of 149 participants completed all sections of this study. Analysis of descriptive statistics revealed that the majority of respondents were female (80.5%), a much smaller percentage of respondents were male (18.8%), and one respondent (0.7%) identified as other, without reporting an identifying descriptive. The majority of participants identified as White (83.2%), with the remaining participants identifying as Black or African-American (6.0%), Asian (6.0%), Hispanic or Latina/Latino (2.0%), Middle-Eastern (2.0%), and Bi-racial or Multi-racial (0.7%). Table 5 further displays this demographic information. Ages of participants ranged from 22 years to 64 years, with the average age being approximately 30 years (M = 30.36, SD = 8.57). Median age was 27 years.

Table 5.
Gender and Race Frequencies and Percentages

Gender	*n*	%
Female	120	80.5
Male	28	18.8
Other	1	0.7
Race		
White	124	83.2
Black/African-American	9	6.0
Asian	9	6.0
Hispanic/Latina/Latino	3	2.0
Middle-Eastern	3	2.0
Bi-/Multi-racial	1	0.7

Participants indicated completion of an average of four to five semesters of practicum ($M = 4.51$, $SD = 3.35$), with a median of 4 semesters. Respondents indicated additional practice in the field of psychology ranging from 6 months to 41 years, with the majority reporting no additional practice in the field (63%). Most participants had additional practice of 3 years or less (89.9%). The majority of trainees responding to this study indicated their theoretical orientation to be Cognitive-Behavioral (32.9%) or Eclectic/Integrative (28.2%). Additional responses indicated theoretical orientations including Psychodynamic (9.4%), Experiential / Humanistic (6.7%), Interpersonal (4.0%), Family Systems (3.4%), Cognitive (2.7%), Behavioral (1.3%), Feminist / Multicultural (1.3%), and other (10.0%). Table 6 includes a display of these descriptive

statistics. Individuals who selected other indicated theoretical orientations including Transactional Analysis, REBT, Solution-Focused, Postmodern, Narrative, Developmental – Existential, Dynamical Systems – Psychodrama, Roger's Client Centered. Several individuals indicated combinations of therapies previously listed.

Table 6.
Theoretical Orientation Frequencies and Percentages

Theoretical Orientation	*n*	%
Cognitive-Behavioral	49	32.9
Eclectic / Integrative	42	28.2
Other	15	10.1
Psychodynamic	14	9.4
Experiential / Humanistic	10	6.7
Interpersonal	6	4.0
Family Systems	5	3.4
Cognitive	4	2.7
Behavioral	2	1.3
Feminist / Multicultural	2	1.3

Respondents also indicated highest degree previously completed including Psychology B.A. (19.9%), Psychology B.S. (10.3%), Counseling M.A. (7.1%), Counseling M.S. (1.9%), Counseling Ph.D. (1.9%), Counseling Ed.D. (0.6%), Counseling Psychology M.A. (6.4%), Counseling Psychology M.S. (3.2%), Counseling Psychology Ph.D. (1.9%), Clinical Psychology M.A. (22.4%), Clinical Psychology M.S. (5.8%), Clinical Psychology Ph.D. (1.3%), Clinical Psychology Psy.D. (0.6%), Marriage and Family Therapy M.A. (0.6%), Marriage and Family Therapy Psy.D. (0.6%), and other (15.4%), of which 54.2% (n = 13) completed a previous degree in psychology or a related field and 62.5% (n = 15) completed a previous graduate degree (Table 7 displays these descriptive statistics).

Table 7.
Completed Field of Study Frequencies and Percentages

Completed Degrees	*n*	%
Psych, B.A.	31	19.9
Psych, B.S.	16	10.3
Counseling, M.A.	11	7.1
Counseling, M.S.	3	1.9
Counseling, Ph.D.	3	1.9
Counseling, Ed.D.	1	0.6
Counseling Psych, M.A.	10	6.4
Counseling Psych, M.S.	5	3.2
Counseling Psych, Ph.D.	3	1.9
Clinical Psych, M.A.	35	22.4
Clinical Psych, M.S.	9	5.8
Clinical Psych, Ph.D.	2	1.3
Clinical Psych, Psy.D.	1	0.6
MFT, M.A.	1	0.6
MFT, Psy.D.	1	0.6
Other	24	15.4

Note. Frequencies add up to more than $n = 149$ as a result of multiple degrees earned.

Participants also indicated type of program in which they were currently enrolled including Counseling M.A. (4.7%), Counseling M.S. (2.7%), Counseling Ph.D. (8.7%), Counseling Psychology M.A. (2.0%), Counseling Psychology M.S. (1.3%), Counseling Psychology Ph.D. (20.8%), Counseling Psychology Psy.D. (1.3%), Clinical Psychology M.A. (3.4%), Clinical Psychology M.S. (0.7%), Clinical Psychology Ph.D. (28.9%), Clinical Psychology Psy.D. (16.1%), Marriage and Family Therapy M.A. (0.7%), Marriage and Family Therapy M.S. (0.7%), Psychology Ph.D. (0.7%), School Psychology Certificate of Advanced Graduate Study (1.3%), and Counselor Education and Supervision, Ph.D. (3.4%; Table 8 displays these descriptive statistics). There was a low occurrence of missing data regarding current program of study with approximately 2.0% of participants not indicating their current field of study.

Table 8.
Current Field of Study Frequencies and Percentages

Current Field of Study	*n*	%
Counseling, M.A.	7	4.7
Counseling, M.S.	4	2.7
Counseling, Ph.D.	13	8.7
Counseling Psych, M.A.	3	2.0
Counseling Psych, M.S.	2	1.3
Counseling Psych, Ph.D.	31	20.8
Counseling Psych, Psy.D.	2	1.3
Clinical Psych, M.A.	5	3.4
Clinical Psych, M.S.	1	0.7
Clinical Psych, Ph.D.	43	28.9
Clinical Psych, Psy.D.	24	16.1
MFT, M.A.	1	0.7
MFT, Psy.D.	1	0.7
Psychology, Ph.D.	1	0.7
School Psych, C.A.G.S.	2	1.3
Counselor Education & Supervision, Ph.D.	5	3.4

Note. Frequencies fail to add up to $n = 149$ as a result of missing data.

Internal Consistency

Analyses of internal reliability were conducted to assess the consistency of items within the three subscales of the KSRQ. Participants' individual scores on the 21 items of each KSRQ subscale were entered into SPSS. Scores were then analyzed by subscale and for the full-scale questionnaire. Table 9 displays mean, range, and variance of individual item means for each subscale and for the full-scale questionnaire.

Table 9.
KSRQ Summary Item Statistics

	n	*M*	Range	Variance
KSRQ Cognitive Subscale				
Item Means	21	5.906	.852	.057
KSRQ Behavioral Subscale				
Item Means	21	5.996	.658	.043
KSRQ EFT Subscale				
Item Means	21	5.017	1.114	.107
KSRQ Full Scale				
Item Means	63	5.640	1.839	.265

The 21 items of the cognitive therapy subscale displayed strong internal consistency reliability ($\alpha = 0.97$). Analysis for Cronbach's α if item deleted revealed that removing an item did not significantly increase the alpha coefficient. The 21 items of the behavioral therapy subscale also displayed strong internal consistency reliability ($\alpha = 0.96$). Analysis for item deletion did not significantly increase the alpha coefficient. The 21 items of the emotion-focused therapy subscale likewise displayed strong internal consistency reliability ($\alpha = 0.97$). Analysis for item deletion did not significantly increase the alpha coefficient. Tables 10 – 13 display further α coefficient data. Strong inter-item reliability coefficients were found signifying that items of each subscale are highly consistent. The overall alpha coefficient for the three subscales (63 items) combined also displayed strong internal consistency reliability ($\alpha = 0.97$) and item deletion did not result in an increase in alpha coefficients. These results, indicating alpha coefficients greater than .80, confirm the first hypothesis. This signifies strong internal consistency reliability and suggests that the KSRQ may consistently measure intervention processes across three empirically supported treatments comprising KST.

Table 10.
KSRQ Cognitive Subscale Cronbach's α Coefficient Results

	Corrected Item-Total Correlation	Cronbach's α if Item Deleted	Cronbach's α
KSRQ Cognitive Subscale			.968
COG 1 – Understanding	.721	.967	
COG 1 – Confidence	.728	.967	
COG 1 – Intention to Use	.666	.968	
COG 2 – Understanding	.768	.967	
COG 2 – Confidence	.846	.966	
COG 2 – Intention to Use	.798	.966	
COG 3 – Understanding	.728	.967	
COG 3 – Confidence	.864	.966	
COG 3 – Intention to Use	.805	.966	
COG 4 – Understanding	.676	.968	
COG 4 – Confidence	.707	.967	
COG 4 – Intention to Use	.732	.967	
COG 5 – Understanding	.763	.967	
COG 5 – Confidence	.801	.967	
COG 5 – Intention to Use	.802	.967	
COG 6 – Understanding	.793	.967	
COG 6 – Confidence	.804	.966	
COG 6 – Intention to Use	.808	.966	
COG 7 – Understanding	.725	.967	
COG 7 – Confidence	.773	.967	
COG 7 – Intention to Use	.723	.967	

Table 11.
KSRQ Behavioral Subscale Cronbach's α Coefficient Results

	Corrected Item-Total Correlation	Cronbach's α if Item Deleted	Cronbach's α
KSRQ Behavioral Subscale			.958
BHV 1 – Understanding	.735	.956	
BHV 1 – Confidence	.782	.955	
BHV 1 – Intention to Use	.708	.956	
BHV 2 – Understanding	.724	.956	
BHV 2 – Confidence	.771	.955	
BHV 2 – Intention to Use	.731	.956	
BHV 3 – Understanding	.722	.956	
BHV 3 – Confidence	.761	.955	
BHV 3 – Intention to Use	.712	.956	
BHV 4 – Understanding	.670	.956	
BHV 4 – Confidence	.718	.956	
BHV 4 – Intention to Use	.665	.957	
BHV 5 – Understanding	.712	.956	
BHV 5 – Confidence	.701	.956	
BHV 5 – Intention to Use	.702	.956	
BHV 6 – Understanding	.719	.956	
BHV 6 – Confidence	.737	.956	
BHV 6 – Intention to Use	.676	.957	
BHV 7 – Understanding	.651	.957	
BHV 7 – Confidence	.734	.956	
BHV 7 – Intention to Use	.659	.957	

Table 12.
KSRQ Emotion-Focused Subscale Cronbach's α Coefficient Results

	Corrected Item-Total Correlation	Cronbach's α if Item Deleted	Cronbach's α
KSRQ EFT Subscale			.970
EFT 1 – Understanding	.766	.969	
EFT 1 – Confidence	.768	.969	
EFT 1 – Intention to Use	.758	.969	
EFT 2 – Understanding	.788	.968	
EFT 2 – Confidence	.814	.968	
EFT 2 – Intention to Use	.778	.969	
EFT 3 – Understanding	.771	.969	
EFT 3 – Confidence	.737	.969	
EFT 3 – Intention to Use	.706	.969	
EFT 4 – Understanding	.792	.968	
EFT 4 – Confidence	.753	.969	
EFT 4 – Intention to Use	.728	.969	
EFT 5 – Understanding	.855	.968	
EFT 5 – Confidence	.841	.968	
EFT 5 – Intention to Use	.782	.968	
EFT 6 – Understanding	.755	.969	
EFT 6 – Confidence	.751	.969	
EFT 6 – Intention to Use	.741	.969	
EFT 7 – Understanding	.804	.968	
EFT 7 – Confidence	.760	.969	
EFT 7 – Intention to Use	.719	.969	

Convergent Validity

A test of convergent validity was computed to assess the correlation between KSRQ subscales and the MULTI subscales. Aggregate scores of the individual items comprising each subscale were calculated for each participant (n = 149) and analyzed by SPSS. Table 13 displays frequency, mean, and standard deviation of aggregate scores for each subscale. As expected, the cognitive therapy KSRQ subscale strongly correlated with the cognitive therapy MULTI subscale, $r(147) = .60$, $p < .01$, the behavioral therapy KSRQ subscale strongly correlated with the behavioral therapy MULTI subscale, $r(147) = .58$, $p < .01$, and the emotion-focused KSRQ subscale strongly correlated with the MULTI process-experiential subscale, $r(147) = .52$, $p < .01$. These results, indicating strong significant correlations on similar subscales, confirm the second hypothesis. This signifies validity by strong convergence of these subscales and suggests that the KSRQ may measure the intervention processes across three empirically supported treatments comprising KST.

As further expected, moderate to strong correlations were also observed between the cognitive therapy KSRQ subscale and the behavioral therapy MULTI subscale, $r(147) = .46$, $p < .01$ and between the behavioral therapy KSRQ subscale and the cognitive therapy MULTI subscale, $r(147) = .54$, $p < .01$. The cognitive therapy KSRQ subscale displayed a small correlation with the process-experiential MULTI subscale, $r(147) = .22$, $p < .01$, but a significant correlation was not found between the behavioral therapy KSRQ subscale and the process-experiential MULTI subscale, $p > .05$. As expected, significant

correlations were not found between the emotion-focused KSRQ subscale and the cognitive or behavioral MULTI subscales, $p > .05$ for both correlations.

Convergent validity was also assessed by comparison between the cognitive and behavioral KSRQ subscales and the SSRF. Aggregate scores of the individual items comprising each subscale were calculated for each participant ($n = 149$) and analyzed by SPSS. Table 13 displays frequency, mean, and standard deviation of aggregate scores for each subscale. As expected, the behavioral KSRQ subscale displayed a moderate to strong correlation with the SSRF, $r(147) = .47, p < .01$ and the cognitive therapy KSRQ subscale correlated strongly with the SSRF, $r(147) = .52, p < .01$. These results, indicating moderate to strong correlations on similar subscales, confirm the third hypothesis. This signifies validity by strong convergence of these subscales and suggests that the KSRQ may measure the intervention processes across three empirically supported treatments comprising KST. The emotion-focused KSRQ subscale also indicated a small correlation with the SSRF, $r(147) = .24, p < .01$.

KSRQ subscales were also found to correlate significantly. The cognitive and behavioral subscales of the KSRQ displayed a strong significant correlation, $r(147) = .65$, $p < .01$. This result was expected as a significant portion of the sample, much like the general population of psychotherapists, was comprised of counselors with a Cognitive-Behavioral theoretical orientation. The emotion-focused subscale correlated less strongly with the cognitive and behavioral subscales of the KSRQ, $r(147) = .27, p < .01$ and $r(147) = .20, p < .05$, respectively. Though these results were not expected, they may be due, in part, to the parallel processes inherent in KST, the similarity of questions

comprising the KSRQ (i.e., knowledge, confidence, and intended use for each intervention), or to the general similarity of the therapeutic interventions comprising cognitive, behavioral, and emotion-focused therapies.

Discriminant Validity

Analysis of discriminant validity was computed between the KSRQ subscales and the SDS-C. Aggregate scores of the individual items comprising each subscale and those comprising the SDS were calculated for each participant (n = 149) and analyzed by SPSS. Table 13 displays frequency, mean, and standard deviation of aggregate scores for each subscale and the SDS-C. As expected, analysis of the cognitive therapy KSRQ subscale indicated no significant correlation with the SDS-C, $r(147) = -0.03$, $p > .05$, the behavioral therapy KSRQ subscale indicated no significant correlation with the SDS-C, $r(147) = 0.03$, $p > .05$, and the emotion-focused KSRQ subscale indicated no significant correlation with the SDS-C, $r(147) = -0.08$, $p > .05$. KSRQ subscales were able to be discriminated from the SDS-C, a conceptually unrelated scale, thereby supporting overall validity of the KSRQ. These results, indicating discriminant correlations ($r < .10$ & $r > -.10$) on dissimilar subscales, confirm the fourth hypothesis. This signifies validity by lack of convergence between these scales and suggests that the KSRQ may be adequately constructed so as to measure the appropriate construct without measuring unrelated variables.

Table 13.
KSRQ Aggregate Subscale Statistics

	n	*M*	*SD*
KSRQ Cognitive Subscale	149	124.027	18.536
KSRQ Behavioral Subscale	149	125.920	16.785
KSRQ EFT Subscale	149	105.356	26.368
MULTI Cognitive Subscale	149	56.477	9.254
MULTI Behavioral Subscale	149	49.926	9.239
MULTI P-E Subscale	149	31.168	5.561
SSRF	149	131.940	20.148
SDS-C	149	19.832	1.757

Table 14.
KSRQ Convergent and Discriminant Validity Correlation Matrix

Correlations

		KSRQ_BHV	KSRQ_COG	KSRQ_EFT	SDS-C	MULTI_PE	MULTI_COG	MULTI_BHV	SSRF
KSRQ_BHV	Pearson Correlation								
	Sig. (2-tailed)								
KSRQ_COG	Pearson Correlation	.654**							
	Sig. (2-tailed)	.000							
KSRQ_EFT	Pearson Correlation	.202*	.269**						
	Sig. (2-tailed)	.014	.001						
SDS-C	Pearson Correlation	.030	-.027	-.082					
	Sig. (2-tailed)	.720	.740	.323					
MULTI_PE	Pearson Correlation	.049	.217**	.520**	-.016				
	Sig. (2-tailed)	.556	.008	.000	.849				
MULTI_COG	Pearson Correlation	.544**	.596**	.139	.060	.408**			
	Sig. (2-tailed)	.000	.000	.091	.469	.000			
MULTI_BHV	Pearson Correlation	.575**	.462**	.052	.130	.247**	.863**		
	Sig. (2-tailed)	.000	.000	.525	.114	.002	.000		
SSRF	Pearson Correlation	.473**	.520**	.241**	.045	.296**	.557**	.519**	
	Sig. (2-tailed)	.000	.000	.003	.585	.000	.000	.000	

Note. ** Correlation is significant at the 0.01 level (2-tailed). * Correlation is significant at the 0.05 level (2-tailed).

CHAPTER V

DISCUSSION

The current study aimed to establish the reliability and validity of the KSRQ, a new scale for measuring psychotherapy trainees' acquisition of skills and techniques drawn from Cognitive Therapy, Behavioral Activation, and Emotion-Focused Therapy. Similar studies have demonstrated the reliability and validity of instruments measuring related interventions (Barnfield et al, 2007; McCarthy and Barber, 2009). The purpose of the project, therefore, was to develop a psychometrically valid and reliable instrument for measuring a counselor-in-training's self-reported acquisition of the core interventions comprising Key Strategies Training (KST). To this end, the hypothesis that the KSRQ should maintain adequate internal consistency according to Cronbach's α was posited. Additionally posited were the hypotheses that convergent validity should be established by comparison with two existing scales, the SSRF (Barnfield et al, 2007) and the MULTI (McCarthy & Barber, 2009) and that discriminant validity should be established by comparison with a theoretically dissimilar scale, the Marlowe-Crowne SDS-C (Reynolds, 1982). Favorable results related to each of the hypotheses contributes to the research literature by establishing a reliable and valid tool for assessing skills acquisition in terms of knowledge, confidence, and intended use for individual interventions, as well as by offering a more thorough means of measuring skills acquisition and the ability to identify specific areas of competence within each theoretical subscale of KST.

Summary of Findings

The results of this study offer initial support for sufficient psychometric properties of the KSRQ, suggesting its usefulness as a tool to measure acquisition of skills. In a sample of psychotherapy trainees, Cronbach's α coefficients, measuring internal consistency, were high for all three KSRQ subscales. These findings confirm the first hypothesis, indicating that individuals score similarly on items within each theoretical domain. This suggests that the subscales may consistently measure interventions belonging to the appropriate theories from which they are derived.

Significant moderate to strong findings were also established for Pearson correlations between the KSRQ and theoretically similar scales (SSRF & MULTI-R). These findings confirm the second and third hypotheses, indicating that the subscales of the KSRQ are constructed and function much the same as analogous subscales on the related measures. This suggests that the subscales may be measuring the appropriate cognitive, behavioral, and emotion-focused interventions which they were constructed to assess.

The KSRQ subscales were also measured against the SDS-C, a theoretically dissimilar scale finding low Pearson correlations. These findings confirm the fourth hypothesis, indicating that the subscales of the KSRQ are not constructed in such a general manner as to correlate with a scale which has been validated as measuring a different construct than that intended. This suggests that the subscales of the KSRQ may be sufficiently specific to measure the intended domains, without measuring extraneous variables.

Several significant within-scale correlations were also discovered which were not hypothesized, though some were expected. For instance, a significant correlation, $r(147) = .65$, $p < .01$, was discovered between the cognitive and behavioral subscales of the KSRQ. This result was expected due to the fact that in the current field, cognitive and behavioral interventions are often integrated, but may point to an overlap of items on these subscales. Similarly, the cognitive and behavioral subscales of the MULTI-R also correlated strongly, $r(147) = .86$, $p < .01$. Other significant correlations were not expected. For instance, a small correlation was found between the KSRQ emotion-focused subscale and the KSRQ cognitive and behavioral subscales, $r(147) = .27$, $p < .01$ & $r(147) = .20$, $p < .05$, respectively. These correlations may be the result of the parallel structure of KST interventions. For example, there is an inherent similarity between COG-1: focusing on thoughts related to clients' presenting concerns, BHV-1: focusing on behaviors related to clients' presenting concerns, and EFT-1: focusing on feelings related to clients' presenting concerns. Similarly, all subscales of the MULTI-R correlated significantly, ranging from, $r(147) = .24$, $p < .01$ to $r(147) = .41$, $p < .01$ (not including the MULTI-R cognitive-behavioral correlation mentioned above).

Several significant between-scale correlations were also discovered. As expected, the KSRQ cognitive subscale correlated significantly with the MULTI-R behavioral subscale, $r(147) = .46$, $p < .01$, and the KSRQ behavioral subscale correlated significantly with the MULTI-R cognitive subscale, $r(147) = .54$, $p < .01$. A significant, small correlation was also found between the KSRQ cognitive subscale and the MULTI-R process-experiential subscale, $r(147) = .22$, $p < .01$, however a significant correlation

was not found between the KSRQ behavioral subscale and the MULTI-R process-experiential subscale, $r(147) = .05$. This may be due in part to the construction of the MULTI-R. That is, many of the interventions comprising the MULTI-R belong to multiple theoretical subscales. Another significant finding was a small, significant correlation between the KSRQ emotion-focused subscale and the SSRF, $r(147) = .24$, $p < .01$. Although, possibly more significant is the lack of significance between the KSRQ emotion-focused subscale and the MULT-R cognitive and behavioral subscales, $r(147) = .14$ & $r(147) = .05$, which may indicate that the KSRQ emotion-focused subscale, as intended, is accurately measuring EFT skills and not cognitive or behavioral strategies.

Implications for Research and Training

Though the current project bears similarities and differences with previous studies, the KSRQ is unique in its measurement of self-rated scores for knowledge, confidence, and intended use for individual strategies drawn from three treatments supported within the empirical literature. As a measure of skills acquisition, the KSRQ, unlike similar measures, focuses on the therapist's own domain of functioning (thoughts, feelings, and actions) by measuring knowledge, confidence, and intended use. Though further work with the KSRQ seems necessary, this study carries several important implications for the field by beginning to address the emphasis placed, in previous studies, on the need to investigate the details of treatment and training in order to discover not only whether something works, but how it works, particularly by exploring the different domains of functioning of the therapist. This study also begins to respond to questions regarding mechanisms of change, and which interventions are more efficacious.

The development of a psychometrically reliable and valid measure that can be used to differentiate between interventions and assess clinicians' perspectives on their own work will contribute to ongoing research about how to teach trainees to acquire clinical skills. Another important implication is the attempt made in the construction of the KSRQ to describe "discrete and specific training interventions" allowing for "more accurate analysis and comparison of training interventions" in future KST studies (Ravovshik & McManus, 2010, p. 514).

In addition, the current study has attempted to advance the field by drawing together the gap between basic helping skills training and the interventions of ESTs by creating a measure for assessing basic interventions, derived directly from ESTs, which typically require more training in order to achieve levels of competency comparable to the basic skills (Kuntze, et al., 2009). The KSRQ likewise meets the needs of researchers to measure individual skills rather than overall efficacy in training, and to create valid and reliable self-report scales to collect data from trainees. By collecting multiple aspects of trainee's experience of training (e.g., knowledge, confidence, intended use), this instrument will better measure the experience of those in training. This also suggests that clinical training programs should monitor knowledge, confidence, and the intended use of interventions as each is likely to impact skills acquisition as well as the effectiveness of training and practice.

Limitations and Future Research Directions

Several limitations of the current study should be discussed. First, the sample size of the current project was relatively small and homogeneous with over 80% of

participants identifying as female, over 83% of participants identifying as White, and with all participants being current graduate students studying in a mental health care field. Likewise, over 61% of participants indicated a theoretical orientation of CBT or Eclectic / Integrative. Further studies with the KSQR would do well to increase the size and diversity of the sample, possibly by including professional counselors who have been in the field for longer periods of time, by increasing the number of men and minority individuals in the sample, or by increasing the number of individuals with theoretical orientations other than CBT or Eclectic / Integrative. A related concern is the potential for a response bias, particularly since graduate students in the process of learning therapeutic techniques may be eager to demonstrate to themselves and others that they are competent utilizing a variety of interventions. No correlations between the KSRQ and the SDS were found, suggesting that individuals may not have simply answered in a manner they considered more favorable. However, the SDS has a high level of face validity and graduate students attempting to present themselves in a positive manner are likely to be capable of understanding the purpose of the SDS and responding differently on it.

A second limitation is that the scales to which the KSRQ was compared for convergent validity measured conceptually different areas of functioning than does the KSRQ. While the KSRQ aims at measuring skills acquisition operationalized in terms of self-reported knowledge, confidence, and intended use for cognitive, behavioral, and emotion-focused strategies, the SSRF measures self-reported skills and abilities of CBT interventions, without measuring knowledge, confidence, and intended use separately for

each intervention. In a similar manner, the MULTI (therapist version) was originally created to measure the self-reported behavior of therapists according to eight theoretical orientations, subsequent to a session with a client. In this study, it was modified (MULTI-R) to measure the self-reported behavior of typically-used interventions, rather than interventions immediately following a session. Further, the MULTI only measures use of interventions, without measuring knowledge and confidence. While the subscales of the KSRQ were compared primarily to the related subscales of the SSRF and the MULTI-R, future studies may want to explore the relationship of KSRQ subscales to more similar measures, e.g., measures of knowledge, confidence, and intended use, in order to establish more precisely that each subscale is measuring its intended domain.

An additional limitation of the current study relates to the creation of the KSRQ as a self-report questionnaire without the creation of parallel forms to be used by observers, supervisors, and clients. Skills acquisition has been traditionally measured by observer rating systems, client reports and/or client outcome measures, and self-report forms for the trainee and supervisors. Future KSRQ research may benefit from the validation of a combination of an observer rating system with clear and coherent rating guidelines, client report and outcome measures clearly connecting intervention to outcome, and rating forms for supervisors.

Another limitation, which may give rise to ample grounds for exploration, is that this study failed to investigate potential differences and similarities between knowledge, confidence, and intended use scores. These comparisons could likely shed light on questions such as which therapeutic perspectives are more and less difficult for trainees

to learn, whether individuals intend to use interventions in which they are more confident or have more knowledge, and whether trainees' knowledge or confidence affects their use of specific ESTs. Likewise, further analysis may discover a redundancy between questions of knowledge, confidence, and intended use, suggesting that the KSRQ may be consolidated so that a single question may elicit the same response. For example, simply asking, "How competent do you feel utilizing this intervention?" rather than three separate questions regarding knowledge, confidence, and intended use may be equally valid.

A related limitation is that the current study neglected to investigate potential differences and similarities between cognitive, behavioral, and emotion-focused subscales, and potential interaction effects between these variables. As KSRQ subscales were found to correlate significantly, particularly the cognitive and behavioral subscales which correlated strongly ($r(147) = .65$, $p < .01$), it may be that the KSRQ subscales are measuring a single construct, rather than the separate constructs for which they were constructed. It is expected that these correlations were a result of a significant portion of the sample being comprised of counselors with a Cognitive-Behavioral (32.9%) or an Eclectic / Integrative (28.2%) theoretical orientation. Further exploratory analyses are necessary to discover whether this is the case or whether there is an overlap between subscale domains.

Exploratory analyses may be conducted on the current data, which may illuminate the subscale correlations and the degree to which the cognitive, behavioral, and emotion-focused subscales may be able to be separated conceptually. Conducting a regression

analysis may be beneficial in order to determine the degree to which the different demographic factors are contributing to participants' scores. For instance, determining the correlation of participants' theoretical orientations with subscale scores when controlling for or removing participants with other theoretical orientations may display that no significant correlations are found between subscales when controlling for participants adhering to therapies comprised of interventions from multiple ESTs. For example, when controlling for participants espousing CBT, it is expected that the correlation between the KSRQ cognitive and behavioral subscales may cease to be significant. Likewise, when controlling for Eclectic / Integrative therapists, the small correlation observed between the KSRQ emotion-focused subscale and the KSRQ cognitive and behavioral subscales may also cease to be significant.

Conducting an analysis of variance may also be beneficial to determine the degree to which differences related to theoretical orientation, gender, amount of time in practicum, level of education (e.g., M.A. or Ph.D.), or current field of study (e.g., clinical psychology or counseling psychology) are effecting participants' results. The results of these analyses may display the effect that one or more of these factors are contributing to participants' scores. Further studies exploring the relationship within the KSRQ subscales and between the KSRQ and dissimilar subscales may also be beneficial in order to more precisely account for differences and potential overlap between each theoretical subscale.

A further means of exploring the potential separation of the subscale domains could be achieved by performing additional studies with the KSRQ, such as a study of construct validity, an experimental study with students utilizing scenarios, or a training

study scaffolding EST interventions and assessing progress before and after training in each new EST. Investigating construct validity may be done by eliciting the assistance of experts from Cognitive Therapy, Behavioral Activation, and Emotion-Focused Therapy in efforts to assure that the interventions measured by the KSRQ are representative of their respective EST and that they do not represent non-related ESTs. In this way, the cognitive and the behavioral subscales of the KSRQ could be further differentiated. Further studies would likely benefit from expert confirmation that the strategies comprising KSRQ reflect the necessary and sufficient interventions of their intended foundational theories.

Creating an experimental study may also help to further differentiate between the subscales. For example, further evidence of the conceptual difference of subscales could be displayed if students are able to discriminate scenarios in which cognitive, but not behavioral, techniques would be beneficial. Last of all, conceptual differences between the subscales may also be displayed if trainees are able to learn and apply the different EST interventions separately. For example, a pretest-posttest study could be conducted in which students are administered the KSRQ on four occasions, prior to any training, after receiving training in cognitive therapy, after receiving training in cognitive and behavioral training, and after receiving training in all three ESTs represented in the KSRQ. Conceptual differences would be displayed if trainees' scores on the KSRQ differed, as would be expected, at each administration, thereby demonstrating that at least during training cognitive, behavioral, and emotion-focused strategies can be learned separately, even though they may often be integrated at a later time.

The present study contains one further limitation, namely, a factor analysis was not conducted in the construction of the KSRQ. Future studies might benefit from running exploratory and/or confirmatory factor analyses in order to establish whether the interventions of each subscale conceptually belong to the appropriate subscale. Factor analysis for the KSRQ may be particularly difficult due to the manner in which the KSRQ was constructed and due to the parallel processes inherent in KST. In other words, since the interventions of all three subscales share similar processes, and since knowledge, confidence, and intended use are measured for each intervention, individual items of the KSRQ may factor together by theoretical subscale (cognitive, behavioral, emotion-focused), or by process (e.g., focusing on a dimension, understanding context and function, experimenting), or by one of the trainee domains (knowledge, confidence, intended use), or by some combination of the three.

Conclusion

The purpose of this study was the development and evaluation of a self-report questionnaire for measuring the basic intervention of three ESTs comprising KST. Results indicate significant Cronbach's α coefficients for each subscale of the KSRQ. Results also demonstrate a significant positive correlation between the KSRQ subscales and scales drawn from two theoretically similar measures (SSRF & MULTI-R), as well as the lack of any significant relationship between the KSRQ and a theoretically dissimilar measure. This study has shown significant evidence of validity and reliability for the KSRQ in measuring trainees' perception of their knowledge, confidence, and intended use of clinical strategies. Clearly, further exploration of the psychometric

properties and factor structure of the KSRQ would be helpful. However, sufficient reliability and validity coefficients from this study already suggest the appropriateness of utilizing the KSRQ in KST research to assess the self-reported skills acquisition of trainees.

The findings of this research contribute to the previous psychotherapy training literature by establishing the reliability and validity of a tool for assessing trainees' knowledge, confidence, and intended use for individual skills drawn from three ESTs. Further KST research using the KSRQ may make it possible for researchers to have a deeper understanding of therapeutic processes and mechanisms of change that comprise effective psychotherapy training and practice.

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APPENDIX A
Key Strategies Rating Questionnaire (KSRQ)

KSRQ (Key Strategy Rating Questionnaire)

Please rate your understanding, confidence, and intended use of each of the following key strategies. Circle the appropriate number indicating your level of understanding, confidence, and intention to use each skill.

Emotion-Focused Strategies

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

a. How clearly do you understand the theoretical rationale for this strategy?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

b. How confident would you feel using this intervention with a client?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

c. How likely are you to implement this strategy with clients in the future?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

EFT-2. Understanding the context and function of specific feelings

a. How clearly do you understand the theoretical rationale for this strategy?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

b. How confident would you feel using this intervention with a client?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

c. How likely are you to implement this strategy with clients in the future?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

EFT-3. Analyzing feelings to determine if they are adaptive or maladaptive

a. How clearly do you understand the theoretical rationale for this strategy?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

b. How confident would you feel using this intervention with a client?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

c. How likely are you to implement this strategy with clients in the future?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

EFT-4. Discovering unexplored emotional experiences that may be outside of awareness

a. How clearly do you understand the theoretical rationale for this strategy?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

b. How confident would you feel using this intervention with a client?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

c. How likely are you to implement this strategy with clients in the future?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

EFT-5. Experimenting with new feelings and helping clients overcome emotional blocks

a. How clearly do you understand the theoretical rationale for this strategy?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

b. How confident would you feel using this intervention with a client?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

c. How likely are you to implement this strategy with clients in the future?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

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

a. How clearly do you understand the theoretical rationale for this strategy?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

b. How confident would you feel using this intervention with a client?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

c. How likely are you to implement this strategy with clients in the future?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

EFT-7. Reflecting on emotional responses to consolidate meaning

a. How clearly do you understand the theoretical rationale for this strategy?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

b. How confident would you feel using this intervention with a client?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

c. How likely are you to implement this strategy with clients in the future?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

Cognitive Strategies

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

a. How clearly do you understand the theoretical rationale for this strategy?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

b. How confident would you feel using this intervention with a client?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

c. How likely are you to implement this strategy with clients in the future?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

COG-2. Understanding the way automatic thoughts mediate clients' experiences and impact mood

a. How clearly do you understand the theoretical rationale for this strategy?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

b. How confident would you feel using this intervention with a client?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

c. How likely are you to implement this strategy with clients in the future?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

COG-3. Analyzing thoughts in order to determine if they are functional or dysfunctional

a. How clearly do you understand the theoretical rationale for this strategy?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

b. How confident would you feel using this intervention with a client?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

c. How likely are you to implement this strategy with clients in the future?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

COG-4. Discovering underlying core beliefs and assumptions that shape current thinking

a. How clearly do you understand the theoretical rationale for this strategy?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

b. How confident would you feel using this intervention with a client?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

c. How likely are you to implement this strategy with clients in the future?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

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

a. How clearly do you understand the theoretical rationale for this strategy?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

b. How confident would you feel using this intervention with a client?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

c. How likely are you to implement this strategy with clients in the future?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

COG-6. Modifying beliefs and identifying more functional thoughts

a. How clearly do you understand the theoretical rationale for this strategy?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

b. How confident would you feel using this intervention with a client?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

c. How likely are you to implement this strategy with clients in the future?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

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

a. How clearly do you understand the theoretical rationale for this strategy?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

b. How confident would you feel using this intervention with a client?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

c. How likely are you to implement this strategy with clients in the future?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

Behavioral Strategies

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

a. How clearly do you understand the theoretical rationale for this strategy?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

b. How confident would you feel using this intervention with a client?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

c. How likely are you to implement this strategy with clients in the future?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

BHV-2. Understanding the triggers, functions and impact of specific actions

a. How clearly do you understand the theoretical rationale for this strategy?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

b. How confident would you feel using this intervention with a client?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

c. How likely are you to implement this strategy with clients in the future?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

BHV-3. Analyzing actions to determine if they are effective or ineffective

a. How clearly do you understand the theoretical rationale for this strategy?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

b. How confident would you feel using this intervention with a client?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

c. How likely are you to implement this strategy with clients in the future?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

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

a. How clearly do you understand the theoretical rationale for this strategy?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

b. How confident would you feel using this intervention with a client?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

c. How likely are you to implement this strategy with clients in the future?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

BHV-5. Experimenting with new actions and observing results

a. How clearly do you understand the theoretical rationale for this strategy?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

b. How confident would you feel using this intervention with a client?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

c. How likely are you to implement this strategy with clients in the future?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

BHV-6. Improving skills through training and behavioral rehearsal

a. How clearly do you understand the theoretical rationale for this strategy?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

b. How confident would you feel using this intervention with a client?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

c. How likely are you to implement this strategy with clients in the future?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

BHV-7. Generalizing effective actions to new environments outside of psychotherapy

a. How clearly do you understand the theoretical rationale for this strategy?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

b. How confident would you feel using this intervention with a client?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

c. How likely are you to implement this strategy with clients in the future?

0	1	2	3	4	5	6
Not at all			Somewhat			Very much

APPENDIX B
Student Self-Rating Form (SSRF)

SSRF (Student Self-Rating Form)

POSTGRADUATE CERTIFICATE IN HEALTH SCIENCES COGNITIVE-BEHAVIOUR THERAPY COURSE STUDENT SELF-RATING RATING FORM

Name: .....

Date of Rating: .....

This rating form asks you to rate your skills, knowledge and behaviour across a range of areas pertinent to Cognitive-Behaviour Therapy. You are asked to rate your skills currently.

How many supervision sessions have you had?

---

1. How would you rate your level of preparation for supervision sessions? ***(Please circle)***

X	0	1	2	3	4	5
CAN'T ASSESS	POOR	*MEDIOCRE*	SATISFACTORY	GOOD	VERY GOOD	EXCELLENT

2. Please rate your *current* skills and abilities in the following areas, using the scale below:

X	0	1	2	3	4	5
CAN'T ASSESS	POOR	*MEDIOCRE*	SATISFACTORY	GOOD	VERY GOOD	EXCELLENT

(a)	assessment of a patients presenting problems	☐
(b)	assessment of key cognitions	☐
(c)	assessment of key behaviours	☐
(d)	developing a Cognitive-Behaviour Therapy formulation/conceptualisation	☐
(e)	linking appropriate treatment strategies to presenting problems	☐
(f)	setting an agenda	☐
(g)	adhering to the agenda	☐
(h)	pacing and efficient use of therapy time	☐
(i)	interpersonal effectiveness (empathy, genuineness, warmth)	☐
(j)	eliciting feedback from patients	☐
(k)	developing a collaborative relationship with patients	☐
(l)	active listening	☐
(m)	ability to develop and convey empathy	☐
(n)	appropriate facilitation of emotional expression	☐
(o)	use of guided discovery/Socratic dialogue to explore problems	☐
(p)	ability to identify & focus on key cognitions & behaviours within sessions	☐

X	0	1	2	3	4	5
CAN'T ASSESS	POOR	*MEDIOCRE*	SATISFACTORY	GOOD	VERY GOOD	EXCELLENT

(q) application of behavioural techniques in general ☐

(r) application of cognitive techniques in general ☐

(s) ability to explain the Cognitive-Behaviour Therapy model to patients ☐

(t) ability to select appropriate treatment strategies within a session ☐

(u) ability to communicate rationales for particular treatment strategies to the patient in an appropriate manner ☐

(v) ability to employ treatment strategies within therapy sessions in an appropriate manner ☐

(w) ability to select useful and appropriate homework assignments ☐

(x) appropriate review of homework within sessions ☐

3. Please comment on your own strengths and weaknesses, in terms of practising Cognitive-Behaviour Therapy:

4. **Would you feel comfortable using Cognitive-Behaviour Therapy with selected patients?**
(Please circle)

YES ***NO***

APPENDIX C
Multitheoretical List of Therapeutic Interventions (MULTI)

MULTI – R (Multitheoretical List of Therapeutic Interventions – Revised)

Name:	Date Completed:

MULTITHEORETICAL LIST OF THERAPEUTIC INTERVENTIONS - Revised (MULTI-R)

Therapist Version

Instructions: The following items represent actions that you may or may not typically use with clients. Please rate each item using the scale provided. There are no right or wrong answers.

1	2	3	4	5
Not at All Typical of Sessions	Slightly Typical of Sessions	Somewhat Typical of Sessions	Typical of Sessions	Very Typical of Sessions

1. I set an agenda or establish specific goals for therapy sessions. 1 2 3 4 5

2. I make connections between my client's current situation and his/her past. 1 2 3 4 5

3. I focus on identifying parts of my clients' personality that are in conflict, like: 1 2 3 4 5
   - one part that wants to be close to others and another part that does not.

4. I ask my clients to visualize specific scenes or situations in detail. 1 2 3 4 5

5. I encourage my clients to identify specific situations or events that tended to precede their problematic behavior. 1 2 3 4 5

6. I often focus on my clients' recent experiences. 1 2 3 4 5

7. I work to give my clients hope or encouragement. 1 2 3 4 5

8. I convey my belief in the effectiveness of the methods I am using to help my clients. 1 2 3 4 5

9. My clients and I discuss a plan for them to try to control (increase or decrease) specific behaviors, like: 1 2 3 4 5
   - smoking;
   - eating;
   - exercising;
   - checking something repeatedly;
   - saying or thinking certain things;
   - hurting him/herself.

10. I repeat back to my clients (paraphrased) the meaning of what they say. 1 2 3 4 5

11. I encourage my clients to identify or label feelings that they have in or outside of the session. 1 2 3 4 5

12. I encourage my clients to talk about feelings they have previously avoided or never expressed.	1	2	3	4	5
13. I point out times when my clients' behavior seems inconsistent with what they were saying, like when they: • suddenly shift their moods or topics; • were silent a long time; • laugh, smile, look away, or are uncomfortable; • avoid talking about specific topics or people.	1	2	3	4	5
14. I encourage my clients to talk about whatever comes to their mind.	1	2	3	4	5
15. I teach my clients specific new skills or behaviors, like how to: • relax their muscles; • control their emotions; • be assertive with others; • act in social situations.	1	2	3	4	5
16. I encourage my clients to think about, view, or touch things that they are afraid of.	1	2	3	4	5
17. I review or assign homework exercises, like: • writing down certain thoughts or feelings outside the session, • practicing certain behaviors.	1	2	3	4	5
18. I am warm, sympathetic, and accepting.	1	2	3	4	5
19. I point out recurring themes or problems in my clients' relationships.	1	2	3	4	5
20. I talk about the function or purpose that my clients' problem might have, like how it: • lets them avoid responsibility • keeps others away from them.	1	2	3	4	5
21. I encourage my clients to explore explanations for events or behaviors other than those that first came to their mind.	1	2	3	4	5
22. I make connections between the way my clients act or feel toward me and the way that they act or feel in their other relationships.	1	2	3	4	5
23. I encourage my clients to see the choices they have in their lives.	1	2	3	4	5
24. My clients and I discuss their dreams, fantasies, or wishes.	1	2	3	4	5
25. I encourage my clients to consider the positive and negative consequences of acting in a new way.	1	2	3	4	5
26. I make sessions a place where my client could get better or solve their problems.	1	2	3	4	5
27. I try to help my clients identify the consequences (positive or negative) of their behavior.	1	2	3	4	5
28. My clients and I worked together as a team.	1	2	3	4	5

29. I give my clients advice or suggest practical solutions for their problems.	1	2	3	4	5
30. I share personal information with my clients.	1	2	3	4	5
31. I listen carefully to what my clients are saying.	1	2	3	4	5
32. I often explain what I am trying to do.	1	2	3	4	5
33. I led the discussion most of the time.	1	2	3	4	5
34. I focus on how disagreements between certain parts of my clients' personality have caused my clients' problems.	1	2	3	4	5
35. I encourage my clients to change specific behaviors.	1	2	3	4	5
36. I focus on the ways my clients cope with their problems.	1	2	3	4	5
37. I encourage my clients to look for evidence in support of or against one of their beliefs or assumptions.	1	2	3	4	5
38. I explore my clients' feelings about therapy.	1	2	3	4	5
39. I encourage my clients to view their problems from a different perspective.	1	2	3	4	5
40. I encourage my clients to explore the personal meaning of an event or a feeling.	1	2	3	4	5
41. I often focus on my clients' childhood experiences.	1	2	3	4	5
42. I focus on improving my clients' ability to solve their own problems.	1	2	3	4	5
43. I encourage my clients to list the advantages and disadvantages of a belief or general rule that they follow.	1	2	3	4	5
44. I have my client role-play (act out or rehearse) certain scenes or situations.	1	2	3	4	5
45. I try to help my clients better understand how they relate to others, how this style of relating developed, and how it causes their problems.	1	2	3	4	5
46. I convey my interest in trying to understand what my clients are experiencing.	1	2	3	4	5
47. I encourage my clients to focus on their moment-to-moment experience.	1	2	3	4	5
48. I try to help my clients better understand how their problems are due to certain beliefs or rules that they follow.	1	2	3	4	5
49. I encourage my clients to question their beliefs or to discover flaws in their reasoning.	1	2	3	4	5

50. I focus on a specific concern in my clients' relationships, like: • disagreements or conflicts • major changes; • loss of a loved one; • loneliness.	1	2	3	4	5
51. I encourage my clients to explore ways in which they could make changes in their relationships, like ways to: • resolve a conflict in a relationship; • fulfill a need; • establish new relationships or to contact old friends; • avoid problems they have experienced in previous relationships.	1	2	3	4	5
52. I review the gains my clients have made while in therapy.	1	2	3	4	5
53. I review the difficulties that my clients are currently experiencing.	1	2	3	4	5
54. I encourage my clients to examine their relationships with others, like: • positive and negative aspects of their relationships; • what they want and others want from them; • the way they act in relationships.	1	2	3	4	5
55. I encourage my clients to think about ways in which they might prepare for major upcoming changes in their relationships, like: • learning new skills; • finding new friends.	1	2	3	4	5
56. I both accept my clients for who they are and encourage them to change.	1	2	3	4	5
57. I encourage my clients to identify situations in which their feelings were invalidated • times when a significant other told my clients their feelings were incorrect; • situations in which my clients had strong feelings that seemed inappropriate.	1	2	3	4	5
58. I encourage my clients to think about or be aware of things in their life without judging them.	1	2	3	4	5
59. I make it clear that my clients' problem was a treatable medical condition.	1	2	3	4	5
60. I try to help my clients better understand how their problems were due to difficulties in their social relationships.	1	2	3	4	5

APPENDIX D
Marlowe-Crowne Social Desirability Scale: Form C (SDS-C)

SDS – C (Marlowe-Crowne Social Desirability Scale – Form C)

Marlowe – Crowne Form C (M-C Form C; Reynolds, 1982)

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is *true* (T) or *false* (F) as it pertains to you personally.

1. ____ It is sometimes hard for me to go on with my work if I am not encouraged.
2. ____ I sometimes feel resentful when I don't get my way.
3. ____ On a few occasions, I have given up doing something because I thought too little of my ability.
4. ____ There have been times when I felt like rebelling against people in authority even though I knew they were right.
5. ____ No matter who I'm talking to, I'm always a good listener.
6. ____ There have been occasions when I took advantage of someone.
7. ____ I'm always willing to admit it when I make a mistake.
8. ____ I sometimes try to get even rather than forgive and forget.
9. ____ I am always courteous, even to people who are disagreeable.
10. ____ I have never been irked when people expressed ideas very different from my own.
11. ____ There have been times when I was quite jealous of the good fortune of others.
12. ____ I am sometimes irritated by people who ask favors of me.
13. ____ I have never deliberately said something that hurt someone's feelings.