# A New Psychotherapy Training Program

## *Description and Preliminary Results*

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*Psychotherapy training programs require a uniform introduction to psychotherapy that presents the basic, generic concepts common to the major schools in a time-efficient manner. The program described in this article fits these criteria. The program has been initiated at seven residency training programs in the United States. The authors describe the six modules comprising the program—verbal response modes and intentions, working alliance, inducing patterns, change, resistance, and transference and countertransference. The authors also report preliminary results of the program evaluation (N=15) from the University of Missouri–Columbia. By using a well-researched measure of trainee self-confidence as psychotherapist (The Counselor Self-Estimate Inventory), the authors report a statistically significant increase in trainee self-confidence beginning and maintained after Module 4. The authors conclude that this training shows promise as a standard introduction to psychotherapy for psychiatric residents. (Academic Psychiatry 1999; 23:95–102)*

If psychiatric residencies are to maintain psychotherapy as core to their training programs, a uniform and consistent standard for psychotherapy education must be adopted. Without consistent standards used across training sites, some training programs will continue to emphasize psychotherapy, whereas others will gradually lose their psychotherapy content. Future generations of psychiatrists will no longer embrace psychotherapy as a core practice of the profession (1).

The designers of an effective training program must select a limited number of skills that, if effectively taught, will lead to effective psychotherapy. This objective requires the careful selection from a wide variety of potential alternatives, from both research and clinical experience (2). The selected alternatives should include what are generally considered to be the common factors or pantheoretical elements of the psychotherapies. It is toward this aim that this training program is developed. In addition, the program attempts to help trainees acquire a mastery of multiple treatment approaches and to adjust their therapeutic approaches to fit the needs of their patients. An additional goal is to educate trainees to think and perhaps to behave integratively, openly, and synthetically—but critically—in their clinical pursuits (3). Trainees are encouraged to examine their own thinking and to apply critical research attitudes to what they do and how they do it. They learn to measure their effectiveness and respond to these evaluations with a sharpening of behavior and thinking. Trainees should be informed consumers of research findings and should respect research evidence that can contribute to clinical effectiveness.

The characteristics of an ideal introduction to psychotherapy should include 1) time efficiency so that much can be taught in a short period of time, 2) a research base so that well-established ideas are easily communicated, and 3) an outcomes orientation with targeted results and the ability to measure them. This program contains these desirable qualities.

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The program described in the following section was initiated at the University of Missouri—Columbia in 1995, and beginning July and August 1998 in the following other departments of psychiatry: Stanford, University of Southern California, University of Missouri—Kansas City, University of Michigan, University of Connecticut, and George Washington University.

## PROGRAM DESCRIPTION

The training program uses a once-weekly seminar format that requires about 30—90 minutes of homework from each participant almost every week. The program is generally offered in the second year before residents enter their outpatient years. Supervisors are informed of the content of the modules and encouraged to organize their supervision around module-specific content. A fundamental aim is training in the activation and use of each trainee's observing self (4) under the assumption that greater access to self-awareness is a crucial variable in therapeutic effectiveness for both therapist and patient. The modules are intended to follow the general stages of the development of the psychotherapy relationship. In addition to pre- and postmodule activities, the following modules are presented 1) Module 1: Verbal Response Modes and Intentions, 2) Module 2: Working Alliance, 3) Module 3: Inductive Reasoning to Determine Patterns, 4) Module 4: Strategies of Change, 5) Module 5: Resistance, and 6) Module 6: Transference and Countertransference.

### *Premodule*

Fundamental to this training program is the development of a set of baseline measures from which to compare trainee change. The primary outcome measure is the Counseling Self-Estimate Inventory (5) to self-rate therapeutic competence over five subscales. The 37 items query trainees on items including "I am certain that my interpretation and confrontation responses will be concise and to the point," "I feel confident that I will appear confident and earn the respect of my patient," and "My assessment of patient problems may not be as accurate as I would like them to be."

Trainees are required to make audiotapes of two third-session psychotherapy relationships. Trainees rate their verbal response modes (6,7) and intentions (8) and complete a Working Alliance Inventory (WAI) (9). Their patients complete the WAI and the Session Evaluation Questionnaire (SEQ) (10), which measures general qualities of the session; the Patient Re-action System (11), which measures specific reactions to specific therapist interventions during the session; and a Treatment Outcome Profile (TOP) (12), which measures satisfaction with treatment, symptoms, quality of life and work, and social functioning. The TOP is also completed before the first session.

### *Module 1: Verbal Response Modes and Intentions*

The purpose of Module 1 is to teach them verbal response modes and intentions. Verbal response modes refer to the basic grammatical tools available to therapists. As defined by Hill and colleagues (6,7,11), these include minimal encouragement, silence, approval—reassurance, information, direct guidance, closed question, open question, restatement, reflection, interpretation, confrontation, nonverbal referent, self-disclosure, and other. Verbal response modes are correlated with patient-rated session outcomes (13).

If the verbal response modes help the trainees answer the question "What do I do in the session?", intentions can help them answer "What do I want to accomplish in the session?" Hill and O'Grady (8) defined an intention as a therapist's rationale for selecting a specific behavior, response mode, technique, or intervention to use with a patient at any given moment within the session. Hill and O'Grady originally described 19 therapist intention categories. Later, Hill et al. (13) suggested that only seven intentions occur frequently enough to be used in future research. The Therapist Intention List, with 19 intentions, includes the following: set limits, get information, give information, support, focus, clarify, hope, cathart, cognition, behaviors, self-control, feelings, insight, change, reinforce change, resistance, challenge, relationship, and therapist needs. Hill et al. (11) demonstrated that therapist intentions provide a more adequate description of therapist interventions than therapist response modes.

Trainees are asked to rate two standardized transcripts for both verbal response modes. They are also asked to rate the therapist's intentions in one of these.

They are then given one copy of the transcript of one of their third sessions from the premodule. They are asked to rate their intentions for each of their speaking turns on parts of one of these transcripts.

### *Module 2: Working Alliance*

Module 2 teaches trainees the components of the therapeutic relationship. The WAI (9) measures three components of the therapeutic relationship: bonds, tasks, and goals. Trainees are asked to rate two different therapeutic relationships by using the instrument and then by discussing their ratings in the group. One tape used in our program is Carl Rogers' "Gloria" (14). They then rate a third session from one of the authors (Beitman BD, videotape of Dr. Beitman's therapy session with MF, University of Missouri, 1995) under the assumption that trainees can learn more effectively by seeing local and national therapists in action. The trainees are shown the patient's rating of Dr. Beitman's session as well as how their ratings compare with the ratings of prior trainees and with a group of experienced therapists. Differences become subjects for discussion.

A volunteer also plays portions of his/her own tape to the group, which then rates its working alliance. These ratings are compared with the patient's and the therapist's own ratings to demonstrate the differences among the three perspectives.

### ***Module** 3: Defining Patterns*

The goal of pattern search is to define patterns of thought, feeling, and/or behavior that are within the patient's ability to influence and, that if changed, would lead toward a desirable outcome (15). Almost every therapeutic approach, no matter how it explores and explains human experience, identifies the patient's general dysfunctional patterns from limited samples of information that the patient presents through verbal and nonverbal information during the session. In addition, each school embraces a limited collection of general dysfunctional patterns into which to place each patient's problems. Inductive reasoning is a necessary process across psychotherapy schools because all therapists must take individual bits of data to define general patterns. Because psychotherapy helps patients change their dysfunctional patterns, inducing these patterns is a prerequisite to patients' change. Training in the use of inductive reasoning can help students develop efficient ways to think about the process of elucidating dysfunctional patterns. Trainees are shown various common inducing points, in addition to patients' verbal reports, including diaries, countertransference, and reports by significant others. An underlying theme of this presentation is that different labels may be used for similar patterns and could explain the relative equality of effectiveness of various schools. The terms of the label for the pattern(s) must first be compatible with the patient's self-understanding to be accepted. We compare this process with trying to sell hats or shoes in that the pattern must fit and be liked to be used. The trainees are presented a glossary of terms for the generic patterns associated with various schools.

The goals of Module 3 include 1) understanding the concept of inductive reasoning, 2) learning how to find the patient's patterns from inducing points, and 3) learning how to use the triple-column technique (16).

The triple-column technique is a structured homework exercise that promotes ongoing self-observation in patients who agree to do it. This exercise provides one of several ways by which patients can be taught how to self-observe. By studying their own inductive reasoning thought processes, trainees refine their abilities to monitor and direct their thinking.

At first they are presented brief case vignettes that require only modest inductive reasoning to achieve the definition of a dysfunctional pattern. The students are then presented a pair of transcripts from which inducing points must be gleaned from the more extraneous information. Finally, they are presented videotape vignettes that contain many levels of information from visual-postural data, to transference–countertransference, to voice tone and inflection, and verbal-inducing points. This gradient of increasing data complexity brings them gradually closer to the clinical reality.

### *Module 4: Strategies for Change*

This module introduces the complex concept of change. Trainees are asked to be humble in the face of the multiple factors contributing to change in addition to strategies and techniques, including the strength of the working alliance (17), the patient's

readiness to change (18), and the strength of the patient's social network (19). The students are introduced to the substages of change: relinquishing the old pattern, initiating and then maintaining the new one. Figure 1 describes the relationship between generic change strategies and the substages of change. Trainees are supplied a glossary defining each of the generic change strategies.

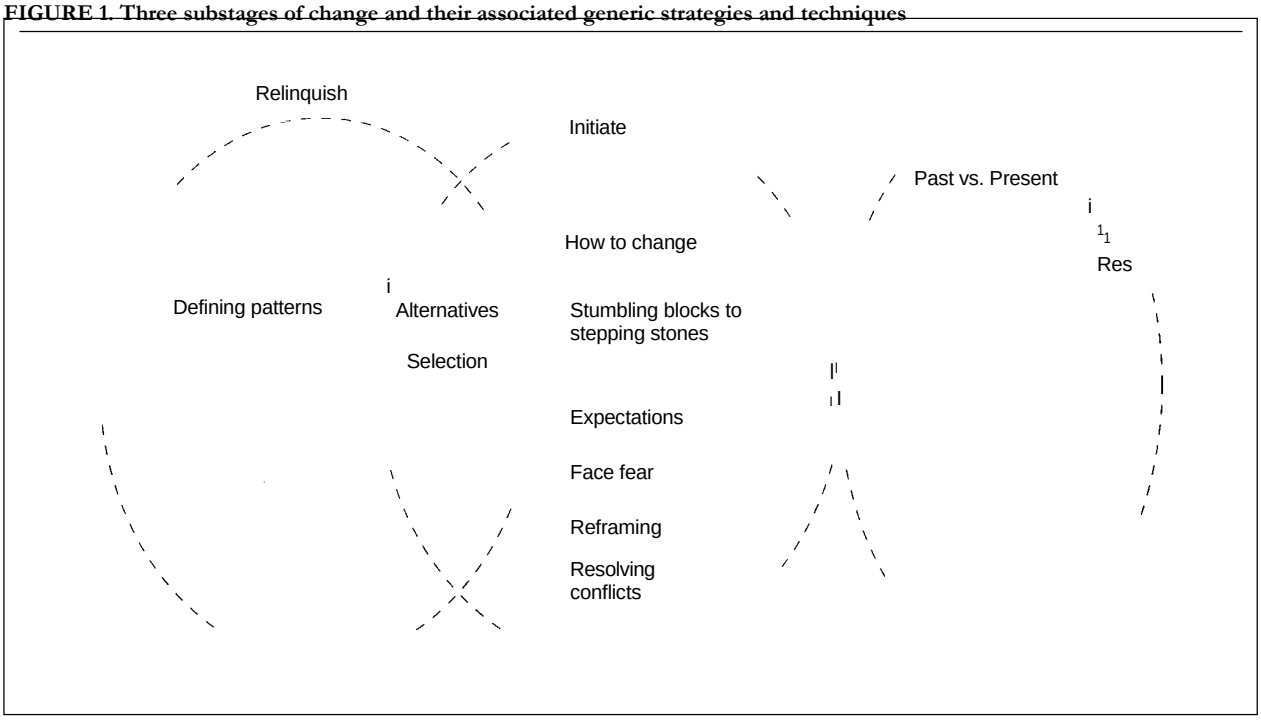
The trainees are then shown a lengthy table with glossary describing strategies and techniques associated with the various schools of therapy (Emotion-focused, Cognitive, Behavioral, Interpersonal—Psychodynamic, and Systems) or ECBIS. It is emphasized that each of these perspectives is part of the general whole, as suggested in Figure 2.

The goals of Module 4 include 1) understanding the substages of change, 2) understanding the various strategies for change, and 3) a beginning understanding of the principles for strategy selection. Trainees are given two sets of transcripts, each containing 10 different therapeutic interchanges. At the end of each interchange, they are posed two to three multiple-choice questions asking them to define the substages of change being passed through in this dialogue, the generic change strategies used, and the ECBIS strategies being used. They are asked to compare their answers with each other during the seminar and to explain their differences. Trainees often find this homework exercise very interesting, exciting, and satisfying because they are reading real dialogues and are becoming able to understand what the therapist is thinking. They are also given two sets of two short-paragraph vignettes. They are asked to describe what generic and ECBIS strategies they would use. In these ways, they become increasingly more familiar with how these strategies are used. They are also shown brief videotape vignettes from prominent therapists representing each of the ECBIS schools (20) as well as one from one of the authors (Beitman BD, videotape of Dr. Beitman's therapy session with MC, University of Missouri, 1996). To demonstrate that psychotherapy does not always work and that therapists are sometimes quite helpless, they are shown a videotape vignette of a frustrated therapist (Beitman BD, videotape of Dr. Beitman's therapy session with J, University of Missouri, 1990).

### *Module 5: Resistance*

Trainees are encouraged to activate their ability to self-observe when they detect a block in the progress of therapy. They are taught three general sources of resistance: 1) patient-originated (e.g., fear of change); 2) therapist-originated (e.g., unrealistic

**FIGURE 1. Three substages of change and their associated generic strategies and techniques**



ponsibility

Maintain

Challenge

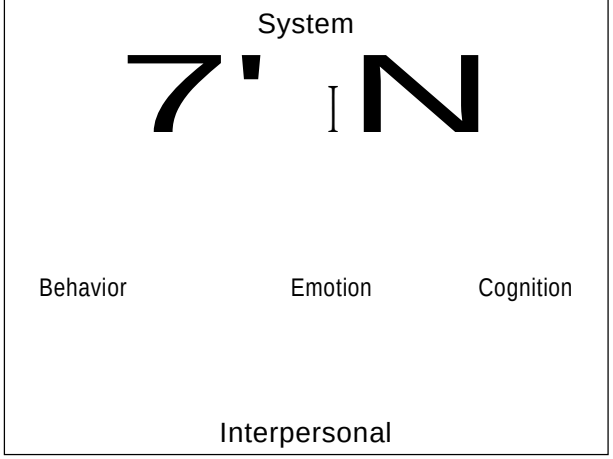
Operationalizing \

Positive reinforcement

Advantages of change

Practice

FIGURE 2. Interactions among E C B I S




expectations of patient change potential); and 3) social network-originated (e.g., change is disruptive to social system equilibrium).

They are shown standard expectations for patients, forms of resistance, and sources of resistance in each of the stages of psychotherapy. Then they are introduced to five general therapist responses to resistance, including 1) empathic encouragement to do what is needed; 2) explanation of the problems the resistance causes and how to get past it; 3) interpretation of the cause, reason, or pattern suggested by the resistance; 4) ignoring or accepting the resistance without comment; and 5) paradoxical cooperation with the resistance.

The goals of Module 5 include understanding the forms, sources, and management of resistance. After discussing these issues, they are given 15 case vignettes, after each of which they are asked to identify the source and potential management of resistance.

### ***Module 6:*** *Transference* ***and Countertransference***

After an introduction to the concepts of transference and countertransference, trainees are presented various signs of transference, as illustrated in Table 1. Then they are shown relationships among and between the working alliance, the real relationship, and transference—countertransference.

Finally, they are shown several methods of handling transference and countertransference responses. The goals of the module are to understand and use transference and countertransference, with particular emphasis on the therapist's and patient's observing self.

The trainees are shown a videotape of one of the authors (Beitman BD, videotape of Dr. Beitman's therapy session with W, University of Missouri, 1988) demonstrating clear countertransference reactions for discussion; they are taught the use of the Core Conflictual Relationship Theme (21), and then in several homework assignments they rate standardized transcripts according to this method. They are then asked to analyze their reactions to both patients and significant others in their lives (sometimes to find similar themes). The next homework assignment involves reading transcripts of borderline patients and then recording how they would feel if they were the therapist. They read a transcript and discussion of an intense erotic transference reaction, which they are asked to discuss. The trainees are then given 14 case vignettes containing transference—countertransference interactions, which they are asked to categorize as to source (patient or therapist). Then they are given transcripts containing transference responses and asked to write how they would respond to what the patient has just said.

### ***Postmodule***

Trainees repeat the acquisition of two third-session audiotape recordings, accompanied by measures of working alliance completed by both trainee and patient. In addition, they record their intentions at each therapist speaking turn and identify from a transcript their verbal response modes. The distribution of intentions and verbal response modes is to be compared with the premodule distribution as a measure of potentially increased range of responses and intentions as a result of their experience. The patient measures are also completed, including TOP, SEQ, and patient reaction system.

## METHODS

The primary outcome measure in this program evaluation is the Counselor Self-Estimate Inventory (COSE) (5). Developed by counseling psychologists to measure therapist confidence in using microskills (e.g., concise use of reflections and probes); attending to process (e.g., ability to handle personal anxiety

about performance); dealing with difficult client behaviors (e.g., sufficiently broad repertoire from which to draw); cultural competence (dealing with cultural differences); and values (being able to respond in a nonjudgmental way) . Each of the 37 items can be rated from 1–6 (from strongly disagree to strongly agree).

Data were gathered from two groups, totaling 15 residents (5 women and 10 men, mean age: 37.5 years), who rated themselves at premodule period competence and immediately following each of the 6 modules. The training program required 42 one-hour sessions. Pre- and post-COSE measures were analyzed by using the paired comparisons with PROC means (22).

## RESULTS

Table 2 displays the mean differences between premodule COSE and the COSE responses at the end of each of the modules. Their ratings actually decrease after the first module, compared with baseline. After Module 4, their self-reports are statistically significant, compared with baseline, and remain significant after each of the subsequent modules.

Table 3 displays COSE results for the subscales between premodule and the end of Module 6. Each of the five scales showed statistically significant increase except for the microskills scale, which was marginally significant (P = 0.08).

## DISCUSSION AND CONCLUSIONS

This group of residents reported a statistically significant increase in their self-confidence as therapists, suggesting that this training program may have played a part in this change. Interestingly, they reported a drop in self-confidence as therapists after the first module, which focused on verbal response modes and intentions, suggesting that at this point they began to discover what they did not know they did not know. The results reached and maintained statistical significance after Module 4, by which time they had learned the basics of the change process and related techniques. This latter finding suggests that their confidence can be greatly increased when they learn how to help patients change. The marginal significance on the microskills subscale is consistent with the objectives of the training, which do not include direct "hands-on" instructions in the specific practice of psychotherapeutic techniques. Further-

**TABLE 1. Signs of transference and countertransference**

| Signs | |
|---|---|
| **Transference** | **Countertransference** |
| Inappropriate or excessive:<br>Feelings such as anger, hostility, hurt, envy, distrustfulness, excessive appreciation, concern, and erotic attraction | Inappropriate or excessive:<br>Feelings such as anger, irritation, anxiety, guilt, fear, sexual stimulation, disappointment, shame, helplessness, envy, boredom, awe, excessive pride in the patient's accomplishment, high anticipation about seeing the patient, resentment at having to see a patient or, on the other hand, having to terminate therapy |
| Behaviors such as calling the therapist at home, calling the therapist by first name, asking to see the therapist outside the office, asking the therapist for personal information, writing a love letter to the therapist, or excessively criticizing the therapist | Behaviors such as arranging an opportunity to socialize with the patient, criticizing the patient, or excessively reassuring the patient; bragging to other therapists about a patient's success, making fun of patients, asking favors of the patient, trying to impress the patient, keeping excessively silent, reducing or not charging the fee, avoiding discussion of the patient's boundary violations |
| Thoughts and fantasies such as fantasy to have a family and children with the therapist, becoming a colleague of the therapist, dreaming about the therapist | Thoughts and fantasies such as fantasies of sexual involvement, of romance, of being best friends, of taking a trip together, dreaming about the patient |
| Resistance reactions (see Module 5): any resistance reactions may suggest transference | |

more, these are beginners who have had very little psychotherapy experience. When they are asked to rate the statement "I don't feel I possess a large enough repertoire of techniques to deal with different problems my patient may present," they are likely to express relatively less confidence, compared with "I feel confident that I have resolved conflicts in my personal life so that they will not interfere with my therapy abilities." This latter item is a major focus of the training program, which emphasizes the need to be self-aware during the therapeutic encounter.

This study lacks a control group to help explain the influence of the other factors in the psychiatric residency training program that may help to increase their self-confidence as therapists. However, this report falls more closely under program evaluation than formal research. Like clinical outcomes measurement, training program evaluation emphasizes service delivery (in this case adequacy of training) over controlled trials. The positive results reported here could be a product of the enthusiasm of the originators rather than the content and process of the pro-gram itself. To answer these problems, we have initiated a multisite evaluation of the program including using an additional site as a control group.

Another limitation of this study concerns the failure to report the degree to which the training pro-gram influences subsequent patient care. We are gathering and analyzing data on patients seen in the premodule, compared with those seen in the post-module, to gain objective information about it and how the trainees change their conduct of psycho-therapy. What we really want to see is whether this program influences trainee involvement in psycho-therapy as practitioners and the degree to which it influences clinical effectiveness after completing their residencies.

We have presented an outline of an innovative introduction to psychotherapy training program that has been started in seven residency training pro-grams. The program shows promise in the significant increase in therapist self-efficacy associated with the training experience. As training programs in psycho-pharmacology become increasingly more standardized in an effort to provide information in time-efficient ways, training in psychotherapy should also be considered for standardization for the same reasons. Psychotherapy is a crucial element of resident education; its generic components are well-established. This program offers a possible answer to the need for a time-efficient training program in the basics of psychotherapy.

**TABLE 2. Counselor self-estimate ratings: baseline vs. each postmodule**

| Comparison | *N* | Mean | Std Error | T pro | I TI |
|---|---|---|---|---|---|
| Postmodule 6 vs. Premodule | 14 | 29.07 | 9.0823 | 3.2008 | 0.0070' |
| Postmodule 5 vs. Premodule | 13 | 19.9230 | 7.9263 | 2.5135 | 0.0272[a] |
| Postmodule 4 vs. Premodule | 13 | 22.8461 | 8.2515 | 2.7687 | 0.0170' |
| Postmodule 3 vs. Premodule | 13 | 9.61538 | 7.0977 | 1.3547 | 0.2005 |
| Postmodule 2 vs. Premodule | 8 | 5.6250 | 8.8235 | 0.6374 | 0.5441 |
| Postmodule 1 vs. Premodule | 10 | - 5.8000 | 6.9806 | - 0.8308 | 0.4275 |

'Significant at P = 0.05.

**TABLE 3. COSE Subscales: Postmodule 6 vs. Premodule**

| Analysis **Variance:** Difference | *N* | Mean | Std Error | T pro | ITI |
|---|---|---|---|---|---|
| Microskills | 14 | 7.4285 | 3.9470 | 1.8820 | 0.0824 |
| Counseling process | 15 | 8.8666 | 2.5539 | 3.4717 | 0.0037' |
| Dealing with difficult client behaviors | 13 | 6.7692 | 2.0100 | 3.3676 | 0.0056' |
| Cultural competence | 15 | 2.9333 | 0.9074 | 3.2324 | 0.0060' |
| Values | 15 | 3.1333 | 0.8556 | 3.6621 | 0.0026' |

*Note:* COSE = Counselor Self-Estimate Inventory.
[a]Signficant at P = 0.05.

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