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PSYCHOTHERAPY TRAINING: SUGGESTIONS FOR CORE INGREDIENTS AND FUTURE RESEARCH

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Despite our considerable depth and breadth of empirical knowledge on psychotherapy process and outcome, research on psychotherapy training is somewhat lacking. We would argue, however, that the scientist–practitioner model should not only guide practice, but also the way our field approaches training. In this paper we outline our perspective on the crucial elements of psychotherapy training based on available evidence, theory, and clinical experience, focusing specifically on the structure, key components, and important skills to be learned in a successful training program. In addition, we derive specific research directions based on the crucial elements of our proposed training perspective, and offer general considerations for research on training, including method and measurement issues.

Keywords: psychotherapy, training, change principles

In recent years, a tremendous amount of attention has been paid to the relevance and importance of evidence-based practices. Although the focus has largely been on providing evidence to support particular treatment approaches for specific disorders (Chambless & Ollendick, 2001), research support has also been delineated for processes related to the therapeutic relationship (Norcross, 2002) and for principles of change (e.g., Castonguay & Beutler, 2006). In addition, there has been a push for psychotherapists to demonstrate the effectiveness of their practice, predominately from external sources (e.g., managed care companies). At the very least, these are important shifts in the way that we understand and approach the practice of psychotherapy.

The variety and sheer number of evidence-based guidelines that are now available to therapists reflects the vitality and, in many respects, the clinical relevance of more than 50 years of psychotherapy process and outcome research (see Lambert, 2007). In contrast with this wealth of information, there is an unfortunate paucity of empirical knowledge with regard to psychotherapy training. Although we agree that the practice of psychotherapy should be informed, at least in part, by empirically derived interventions and guidelines, we also believe that this should be the case for psychotherapy training. The scientist–practitioner model, in other words, should not only guide our practice—it should also be manifested in the way that we approach training. As such, we need to anchor, as much as it is possible, our training efforts on empirical evidence, and to conduct much needed research on the most effective ways to train therapists.

In the first section of this paper, we begin to address these questions by outlining what we consider to be an effective perspective on psychotherapy training. We believe that a successful training program should adhere to a coherent structure as well as emphasize specific components and foster certain skills. The perspective presented below is derived from the empirical literature as well as clinical and training experience. However, the actual impact of these elements on the competency of a psychotherapy trainee, and ultimately the individuals he or she treats, remains unclear. Consequently, our focus in the second section will shift toward delineating what we believe to be important directions for research on psychotherapy training.

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Structure of Training Programs

Phases of Training

We believe that optimally, psychotherapy training should be conducted within a systematic, organized, cohesive, and flexible program, which is most likely to involve a series of sequential stages or phases. An example of such a proposed developmental perspective (described in more detail in Castonguay, 2000), includes five phases of training: preparation, exploration, identification, consolidation, and integration.

Preparation. In this initial stage of training, students would begin to learn basic clinical and interpersonal skills in an effort to socialize them to the therapeutic encounter.

Exploration. In this second stage, trainees would be given the opportunity to apply treatment protocols associated with each of the major orientations; for example, the implementation of short-term dynamic therapy (e.g., Strupp & Binder, 1984) or cognitive–behavioral therapy (CBT) for posttraumatic stress disorder (e.g., Foa & Rothbaum, 1998).

Identification. After exploration, students would be encouraged to commit themselves, at least temporarily, to one particular orientation. Students would begin by fully immersing themselves in the theoretical assumptions of a particular model (e.g., emotion-focused psychotherapy or CBT), gaining intensive and systematic experience in the specific interventions prescribed by this approach, and seeking in-depth knowledge of the empirical literature supporting its process and outcome. The rationale for this is to allow students to develop extensive competencies in thinking about and conducting therapy within one cohesive framework. We believe that every major approach to psychotherapy is conceptually and clinically complex, and although it is important that students be exposed to a number of approaches, we are convinced that the optimal way to learn how to develop adequate case formulation and treatment planning skills (at least early in a career) is to know one system well, rather than knowing a little bit about a variety of orientations.

Consolidation. In this stage, trainees would expand the knowledge they have acquired during the *identification* stage to a variety of clinical roles and settings (e.g., couples or group therapy).

Integration. In this final stage, trainees would be encouraged to revise the constructs and treatment methods learned during previous phases by integrating contributions from other orientations. Because evidence has shown that one treatment model cannot claim superiority over another across a variety of clinical problems (Luborsky, Singer, & Luborsky, 1975; Wampold et al., 1997), the limitations of one's model of choice should be recognized and interventions that are specific to an alternative treatment model should be considered with particular clients to better facilitate change, that is, a trainee who previously identified him or herself as a CBT therapist would be encouraged to integrate within his or her technical repertoire humanistic techniques to repair alliance ruptures.

A Focus on Change Principles

We also argue that training programs are likely to be more cohesive and lead to broader clinical skills if their primary focus is on general principles or models of change (e.g., Castonguay & Beutler, 2006; Hill, 2004), as opposed to a list of variables or a series of empirically supported treatment (EST) manuals alone. A focus on principles of change, such as those described by Goldfried (1980; e.g., providing a new perspective of self, facilitating corrective experience, fostering continued reality testing), allows trainees to become aware, especially at an early phase of their training (i.e., exploration), that various types of technique associated with divergent theoretical approaches can serve similar therapeutic functions. Focusing on principles of change during the middle phase of their training (i.e., identification and consolidation) would help therapists to fully master a variety of interventions that have been developed within one particular orientation to foster these global therapeutic functions. Once identified as a CBT therapist, for example, a trainee's primary goal would be to achieve competence in the use of cognitive techniques to foster a new understanding of self, exposure interventions to facilitate corrective experiences, and relapse prevention procedures to foster continued reality testing.

At the integration phase, the focus on change principles would allow one to enhance his or her clinical repertoire by incorporating interventions from other theoretical orientations that serve the same therapeutic function. For example, a CBT

therapist might find it beneficial to incorporate a humanistic intervention such as empathic reflection to promote a new view of self when cognitive restructuring appears to be less helpful or contraindicated for a particular client (see Castonguay, 2000; Goldfried & Castonguay, 1993). As such, these general principles would actually guide the treatments and interventions one chooses to emphasize based on the stage and/or preference of the individual program or trainee. In other words, a focus on principles should always be contextualized within the trainee's needs and level of experience.

Supervision

Key in one's learning of therapeutic skills is the supervision he or she receives. Considering the complexity of psychotherapy, optimal training requires, in our opinion, a variety of supervisors who can provide multiple areas of expertise, a substantial level of experience, as well as a good dose of clinical insight and wisdom. To maximize the probability of covering such breadth and depth of competence, we believe that therapists' in-training should receive supervision from at least three sources:

Faculty members. In most clinical and counseling psychology programs, tenure-track faculty have up-to-date empirical and theoretical expertise in particular aspects of etiology, assessment, and/or the treatment of psychological disorders. Such expertise is likely to provide trainees with useful knowledge for case formulation and treatment planning. In addition, we would argue that the opportunity for psychotherapists in-training to be supervised by faculty members is likely to foster greater consistency across coursework, research and clinical training.

Full-time practice therapists. Although faculty members teach and often write about clinically relevant issues, they tend not to see a large number of clients—even when they keep a independent practice. Because full-time clinicians tend to work with a wide variety of clients and clinical problems in their day-to-day practice, involving them in graduate training is likely to provide trainees with rich information about "what to do," as well as "when and how to do it" in therapy.

Expert therapists. In addition, we suggest that it would be important, when possible, for trainees to be exposed (via videos and seminars) to specialized training from those individuals who have had a substantial impact on the field's clinical practice (e.g., Lorna Benjamin, Marvin Goldfried, Leslie Greenberg, Hanna Levenson, Marsha Linehan, and Jeremy Safran).

Important Components of a Training Program

In addition to the general structural points outlined above, we believe that a successful psychotherapy training program should include the following components: (a) exposure to classical works in psychotherapy and behavior change (e.g., Bandura, Freud, and Rogers), (b) exposure to both applied (i.e., process and outcome) and basic (e.g., social, developmental, cognitive psychology) research, (c) experiential forms of training such as self-exposure to feared objects or situations (Freeston, Cromarty, & Thwaites, 2006), rather than a purely didactic focus, (d) the systematic encouragement of self-reflection (Bennett-Levy, 2006), and (e) an emphasis on multicultural competence throughout (including both awareness and practice). The importance of experiential forms of training and an emphasis on multicultural competence are further addressed in the later section on future research.

Therapeutic Skills to Be Fostered in Training Programs

Along with the particular components proposed above, we argue that certain therapeutic skills should be fostered throughout the course of one's training. For example, in line with the epistemological assumptions underlying cognitive–behavioral therapy, we believe that therapists should be trained in mastering relationship and technical skills that have received empirical support (Castonguay & Beutler, 2006). Also consonant with the same epistemological assumptions, we think that therapists should be trained to approach clinical reality as a scientist where one is constantly generating and testing hypotheses about the causes of client difficulties as well as the processes likely to facilitate his or her change (i.e., Mahoney, 1976).

Further reflecting our own cognitive–behavioral leanings, we would argue that all therapists in-training, irrespective of their theoretical preferences, are likely to improve their case formulations and treatment plans by learning how to

implement a functional analysis of client behaviors (Goldfried & Davison, 1976). Furthermore, we believe that therapists' in-training should pay attention to two overarching goals of psychotherapy: (a) decreasing clients' level of distress and impairment and, (b) helping clients to develop coping skills that can be used to increase the efficiency of treatment and facilitate relapse prevention (i.e., skills that can help the client to become his or her own therapist). Although the focus on these specific dimensions of client functioning can be viewed as hallmarks of CBT (see Castonguay, 2005), the fostering of such processes of change is likely to require the use of procedures and interventions associated with divergent theoretical orientations (see Castonguay, 2000; Goldfried & Castonguay, 1993).

Future Directions for Research on Training

In the first section, we offered a brief description of what we believe to be the structure, training components, and skills to be emphasized in a successful psychotherapy training program. Although these suggestions are based, at least in part, on evidence taken from the literature, each of the proposed elements remains to be formally tested. In this section, we would like to offer some specific directions for future research on psychotherapy training. Some of these directions are derived directly from the specific components of training discussed above, and others focus on more general considerations related to effective and comprehensive training.

Specific Directions for Future Research on Training

Among the empirical questions that emerge from the training components highlighted above, is whether or not a formal training structure or framework can enhance the acquisition of therapeutic skills. It would be interesting to determine, for example, if a training model guided by developmental phases would produce better training outcomes than a "training as usual" model, where students typically choose to take a practicum course in a particular year based on personal preference and availability of supervisors. We would predict that the former would lead to a more comprehensive repertoire of skills, as it is more likely to provide a systematic exposure to many approaches to psychotherapy during the course of one's graduate training.

In addition, we assume that the focus of training should be on general principles or models of change (Castonguay & Beutler, 2006; Hill, 2004). One way of testing the validity of this assumption would be to assess whether a principle-based training would lead to more effective and comprehensive practice than a sole focus on EST manuals. In addition, we posit that trainees would optimally benefit by receiving supervision from multiple sources, or supervisors with different types of professional emphases (e.g., tenure track faculty, full-time practitioners, etc.); a key element of this assumption is that each source of supervision can provide a slightly different, yet complementary, perspective on clinical phenomena (e.g., case conceptualization, treatment planning, and psychotherapy process and outcome). An important question that emerges from this hypothesis is whether students actually experience these multiple sources of supervision (provided by individuals with different professional emphases) differently, and if so, does this multifaceted system relate to greater breadth and depth in the development of clinical knowledge and skills?

We also assume that it is important to include an experiential component throughout the course of one's training, rather than relying mostly on a didactic modality. It is our experience, for example, that many trainees perceive cognitive intervention strategies, such as cognitive restructuring, as relatively straightforward and simplistic when presented in a textbook or during a practicum lecture. However, it is also our experience that these same trainees quickly recognize the difficulty and complexity of utilizing these intervention strategies once in the therapy room with a client. Although we assume that an experiential component to training would be beneficial to one's training, regardless of the specific intervention or approach, it remains to be tested that trainees would become more efficient in practicing CBT if they learned how to apply cognitive restructuring techniques via self-exposure (e.g., role plays with peers and supervisors; see Freeston et al., 2006) to their own distorted thinking styles and core beliefs.

In addition, although the topic of multicultural competence continues to receive greater attention in the field of psychotherapy, there is very little evidence to inform us as to how training in mul-

ticultural competence can be conducted most effectively in graduate training. Given the variability in exposure to diverse populations, one important question that should be the focus of future research is whether a multicultural training emphasis that is mostly didactic leads to different outcomes than a training program that does have direct access to the treatment of diverse populations?

We would also like to suggest a number of research ideas that are less directly related to the components of training identified in the first section of this paper. For example, considering that the majority of clinicians end up defining themselves as integrative therapists (Orlinsky & Rønnestad, 2005), it seems important to determine whether it is best to train graduate student therapists within an integrative model(s) from the beginning of their training, or whether they should first be trained competently in one (or perhaps two) approach(es) and then be encouraged to master systematic ways to integrate different orientations later in their professional training and development (see Castonguay, 2005; Consoli & Jester, 2005).

Finally, evidence has emerged that strongly suggests that receiving direct and consistent feedback on client progress can enhance psychotherapy outcomes, at least for experienced therapists (Lambert, 2007). However, feedback during training is typically limited to what is provided by one's supervisor, and even when comprehensive, this information may not serve the same function as other sources of feedback (e.g., client self-report measures of process and outcome). As such, we are inclined to think that it would be important for trainees to receive feedback on client progress above and beyond what is typically provided in the context of supervision, and this additional feedback should result in improved outcomes.

General Issues for Consideration

A partial explanation for the paucity of existing research on training is the complexity involved in investigating the topic. Needles to say, this reality is not likely to be sidestepped. Consequently, we are perhaps better served if we recognize that research on training will require multiple levels of investigation in which each level of analysis can provide different, yet complementary, types of information. As an example of what is meant by multiple levels of investigation, one might study the training of specified treatments and/or techniques *within* a single training site, while another study might directly compare the same training strategies across or *between* training sites.

The research directions that have been proposed so far in this paper have mostly focused on the independent variables to be manipulated and investigated, such as the type of training framework, specific components of training (e.g., didactic vs. experiential), and the form of supervision one receives. However, as a field, it will be crucial to also direct our attention toward identifying the pertinent dependent variables in training research (e.g., skill acquisition, trainee self-confidence, client outcomes, etc.). In other words, we need to place more emphasis on what it is we want to change, and how we intend to measure change.

In addition to the delineation of important independent and dependent variables, it will also be important, as a field, to reach some agreement on the proper methods of investigation, including clinically reliable and valid measurement. As noted above, multiple levels of investigation are likely to also require multiple methods, such as the use of both qualitative and quantitative research designs within and between training sites, where each method can contribute to an accumulating body of knowledge. Although the call for investigations utilizing between-site randomization may at first appear daunting, particularly when the focus is on client outcomes, we believe that it can provide clinically relevant information.

In addition, we would like to recommend that research on training should be conducted in training clinics. Although analogue studies provide a great source of knowledge, training research in naturalistic settings is likely to lead to more externally valid findings. Similar to studies conducted with experienced therapists in their day-to-day practice, such "real world" studies do not have to sacrifice internal validity (Borkovec & Castonguay, 1998). By conducting research on training in the environment where students receive training, we will also go a long way toward fostering therapists' integration of the Boulder model (Raimy, 1950) at the early, and most formative, stage of their career.

This training philosophy was cogently articulated by Borkovec (2004) in a paper outlining his vision for psychotherapy training clinics func-

tioning as a series of practice research networks. Using Borkovec's proposed model, we can begin to envision how this type of research might be effectively conducted. For example, one crucial element for consideration is the assessment of client outcomes across training sites. This would be partially addressed through the establishment of an agreed on common core battery, such as the one we use in our clinic at Penn State University (i.e., Treatment Outcome Package; Behavioral Health Laboratories; see Kraus, Seligman, & Jordan, 2005).

Above and beyond the research directions previously suggested, we believe that people should do more research on training. In other words, we suggest that the Boulder model should not be restricted to the clinical practice of experienced therapists, but should also be a perspective that is intrinsic to training. Consequently, it is important for us to better understand what appears to work and not work in our training of psychotherapists, and improve on existing models based on evidence. Of course, it is an assumption that "better" training will result in "better" therapists with "better" outcomes. Fortunately, this is also a testable assumption.

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