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ABSTRACT

The training of psychotherapists has been an ongoing process in psychiatry and clinical psychology. Recently, however, a growing demand to operationalize competence criteria to enable independent evaluation of therapists' skills in specifically defined psychotherapies has occurred. To examine this phenomenon, evaluation procedures were developed and tested during a pilot training program in Interpersonal Psychotherapy (IPT). Several different instruments and procedures were used to monitor the therapist trainees' skills on a variety of dimensions. The Didactic Examination was designed to assess therapist trainees' cognitive understanding of the theoretical background, rationale, techniques and procedures of short-term IPT; other instruments were developed to assess the therapist trainees' practical IPT skills in therapy sessions. Results of analyses of the trainee outcome data confirmed the decision to rely on multiple information and derived composite scores. Although scores on Didactic Examinations showed significant improvement at post-testing, the written examination had little predictive validity for determining the competence of the therapist to perform IPT during practicum. Findings of a lack of agreement between supervisor and independent evaluator perceptions of the therapist underscore the importance of including videotape reviews of actual therapy sessions as part of therapist assessments. (Author/NRB)

EVALUATION PROCEDURES FOR TRAINING PSYCHOTHERAPISTS IN INTERPERSONAL PSYCHOTHERAPY (IPT)

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The training of psychotherapists has been an ongoing process in psychiatry and clinical psychology. However, recently there has been a growing demand to operationalize competence criteria to enable independent evaluation of therapists' skills in specifically defined psychotherapies. Despite the incorporation of sophisticated design features in many completed psychotherapy efficacy studies, there have been few systematic attempts to explicitly define the essential components of the psychotherapies offered in clinical trials. Specification of the treatments offered is important if different types of therapy are to be compared. Rigorous comparative efficacy studies cannot be undertaken without precise specification of treatment conditions and the development of training and monitoring procedures that are adequate to insure that the therapists are performing the treatment as described. In addition to specifying the characteristics of the therapy being tested, it is essential that procedures for evaluating psychotherapy sessions be developed to insure that the therapy being practiced is, in fact, the therapy being tested in the clinical trial.

This paper will describe the evaluation procedures that were developed and tested during a pilot training program in Interpersonal Psychotherapy and will examine and compare the utility of the various evaluation procedures. We present our experiences as a specialized "case report" of the development and evaluation of various procedures for assessing therapist competence to participate as IPT therapists

in controlled, comparative psychotherapy efficacy studies. Before describing the evaluation procedures used in the pilot training program in Short-Term Interpersonal Psychotherapy (IPT) for Depression, some of the defining characteristics of the therapy will be outlined.

IPT Interpersonal Psychotherapy (IPT) is a brief (12 to 16 weeks), weekly, individual therapy which focuses on current social and interpersonal difficulties in the ambulatory, non-bipolar, non-psychotic depressed patient. The therapy, developed and tested by the New Haven-Boston Collaborative Depression Project (Weissman, Prusoff, Dimascio, Neu, Goklaney, & Klerman, 1979; Klerman, DiMascio, Weissman, Prusoff, & Paykel, 1974) was designed to fill a gap in the field where the only therapies that had been sufficiently specified in procedural manuals in order to undertake serious replication trials had been those based on cognitive and/or behavioral approaches (Beck, Rush, Shaw, & Emery, 1980; Klerman, Rounsaville, Chevron, Neu, & Weissman, 1979; Luborsky, 1978; McLean, 1980; Rehm & Kornblith, 1978). Based on an interpersonal framework this approach utilizes techniques derived from psychodynamically-oriented psychotherapies, but treatment is focused on the patient's current life and interpersonal relationships.

When designing procedures for assessing the content and quality of the psychotherapy, we gave considerable thought to the following methodological issues: What should be assessed? How should it be assessed?

In terms of what we needed to assess, we recognized two essential types of knowledge that the therapists needed to acquire: (1) conceptual understanding of the treatment and techniques, and (2) the ability to put this understanding into practice with depressed patients.

The desired outcome of IPT training was to train therapists to understand and perform the therapy as described and avoid using techniques which are not a part of IPT. Thus, training goals and therefore assessment procedures involved evaluation of both conceptual skills and practical skills. Given the attempt to make IPT representative of treatments commonly offered for depression, many therapists accepted into the training needed to modify their style only slightly in order to become effective IPT therapists. Thus, the important assessments were not of the extent to which the therapist had changed in the course of training but of whether the therapist was utilizing IPT techniques at a level of competence sufficient to certify him/her for participation in a clinical trial. With this consideration in mind, change measures were not used to assess therapist practical skills.

In terms of the second question, how we assess competence, we felt it was important to utilize information from a variety of sources in order to provide a relatively complete picture of the change process and to control for systematic bias. Researchers typically have relied upon information obtained from the therapist, from the patient, and, in traditional training programs, from the supervisor's global evaluations. The exclusive reliance on these types of ratings is widespread despite the fact that several

studies have raised questions about the reliability of therapist and/or patient self-reports as indicators of what actually occurs in therapy.

Advances in video technology have made it possible to obtain objective recordings of entire therapy hours which provide a potentially valuable data source for monitoring the process of psychotherapy. The advantage of utilizing videotape recordings in psychotherapy studies is that they provide an accurate, more-or-less permanent record of the entire therapy which can greatly facilitate the reliable evaluation of the content and quality of therapeutic interactions. Thus, in addition to ratings obtained from the participants in the therapy process, i.e., the therapist, patient and supervisor, we obtained independent documentation of the therapeutic interactions in order to evaluate the reliability of various assessment procedures.

In conducting the pilot study to develop procedures for evaluating psychotherapist's competence to perform Interpersonal Psychotherapy (IPT), a number of different instruments and procedures were utilized to monitor the therapist trainees' skills on a variety of dimensions. By comparing ratings of the therapy process from the perspectives of the therapists, the supervisors, and an independent evaluator, we demonstrated the importance of obtaining independent documentation of the therapy process. The areas assessed, the evaluation instruments/procedures, the raters and timing of the assessments are presented in Table 1.

The didactic examination was designed to assess therapist trainees' cognitive understanding of the theoretical background, rationale, techniques and procedures of Short-Term Interpersonal Psychotherapy (IPT). The instrument consisted of 35 questions, in a multiple choice format, selected on the basis of their relevance to the material presented in the didactic seminars; i.e., questions that seemed to assess therapists' learning in areas that the trainers thought essential to a basic understanding of the IPT method. The intent of the trainers in designing the test was not so much to discriminate amongst therapists as to establish that each individual therapist had sufficient understanding of the IPT approach to prepare him/her to participate in the practicum portion of the training program. The Didactic Examination was administered to all therapists before and after their participation in the didactic phase of training.

The overall goal of a program to train psychotherapists for efficacy studies is to make sure that they are actually performing the therapy that is being tested in the clinical trial and that they are performing it well. Thus, in terms of evaluating the therapist trainees' practical IPT skills, the trainers in the pilot program had to determine what aspects of the therapists' behavior in treatment should be rated in order to assess whether or not the therapists were actually performing IPT as described in the procedural manual. The concepts of inclusive and exclusive boundaries were utilized in determining the areas to be rated. In order to be performing

IPT the therapist must give evidence of using techniques described in the practitioners manual and following the prescribed general strategies for approaching patients' problems. On the exclusive side, the therapist should not use techniques or strategies that are definitive of some other therapy.

The instruments used to assess the therapist trainee's practical IPT skills were the Process Rating Form and the Therapist Strategy Rating Form. The Process Rating Form was designed to assess therapists' use of the various IPT techniques in each therapy session. Ratings provided information on whether or not a particular technique was used, to what extent it was used, and on the quality of use.

The Therapist Strategy Rating Form was used to evaluate therapists' skill in the use of appropriate goal-directed activity in relation to the interpersonal problem area with which the patient presented. In addition to the qualitative rating of the individual therapist's use of IPT stragegies, rating were made in the following four areas:

1. Therapists' skill at helping patient with intimate self-disclosure.
2. Therapists' ability to tend to the therapeutic relationship.
3. Therapists' ability to focus session on appropriate topic.
4. Overall quality of the session.

These ratings attempt to evaluate the overall quality of the psychotherapy, i.e., is the therapist generally following good clinical practice? Although these evaluations assess aspects of

the treatment which are not specific to IPT, it was felt that if trainees were not performing well in these areas they were not performing IPT correctly even if all the appropriate techniques were being used.

Using these rating instruments, selected sessions from the beginning, middle, and termination phases of each therapy were rated, based on guidelines that were prepared to help standardize the qualitative ratings. Prior to the study we established inter-rater reliability among the two trainer/supervisors and the independent evaluator, on these rating forms.

Both of the rating forms were completed by the therapist, following each therapy hour, by the independent evaluator on the basis of observation of videotapes of entire sessions, and by the supervisor, on the basis of the material presented by the therapist trainee during weekly supervisory sessions.

Global Ratings (GR) of the individual therapists were completed by 3 judges (the supervisor, an IPT trainer, and an independent evaluator) on the following dimensions: (1) trainee's overall therapeutic skills (pre-existing qualities); (2) trainee's cognitive and practical IPT skills. These ratings were made following completion of the training program and reflect the degree to which the individual therapists were perceived as having demonstrated an understanding of IPT concepts and strategies, as reflected in the quality of their:

--participation in the didactic training seminars;

--discussion of case material in weekly supervision and/or at the weekly case conference; and

--behavior in therapy, based on the observation of randomly selected videotaped therapy segments.

Evaluations were completed by different raters on the basis of different data sources in order to examine and compare the utility of the various assessment procedures. In this study ratings by the therapist about his own behavior in the therapy hour were used primarily to facilitate learning. The ratings by the supervisor on the basis of supervisory sessions and the global ratings were used to tap the traditional means of determining therapist competence. Ratings by an independent evaluator on the basis of videotapes of therapy sessions were obtained in order to provide the most objective evaluation of the therapy process and to provide the standard by which to measure the other ratings.

Because therapist assessment procedures utilized multiple outcome measures, gleaned from different perspectives, a summary score was derived in order to reflect a composite estimate of each therapist's competence. The derived composite scores reflects the overall skill of the therapist trainee in terms of his/her use of IPT techniques and goal-directed activity. The therapist's self-ratings were not included in the computation of the final composite score. Although the therapist trainees self-ratings serve an important function in encouraging the therapists to think about and assess their work in terms of their use of IPT techniques

and strategies, we do not believe that these self-ratings should enter into the assessment of therapist competence. Therapist self-ratings often reflect therapist modesty more than they reflect an accurate assessment of therapists' skills.

What, then did we find?? How useful were the various assessment procedures?

Results of analyses of the therapist trainee outcome data confirmed our decision to rely on multiple informants and derived composite scores. The Didactic Examination score, the outcome measure for the didactic phase of training, was administered prior to the didactic phase of training as well as after the training was completed. The overall matched T-test for the total difference score (pre-post) showed significant improvement at post-testing ($p < .005$). However, the analysis of individual items indicated that the therapists were familiar with much of the material before training began; half of the items were scored correctly by all therapists at that time.

When the therapists' post-training scores on the written examination were correlated with ratings of therapists practical skills, there appeared to be a negative relationship, although correlations between performance on the didactic examination and the assessments of the therapists' practical IPT skills failed to reach significance. However, greater improvement on the didactic examination was shown to be associated with poorer evaluations on the global assessments made by the supervisor/trainers

($r = .68$, $p < .06$) and on the Overall Composite Score ($r = .65$, $p < .06$). These findings suggest that, at best, there is no relationship between cognitive grasp of IPT as assessed by the didactic examination and competence in the practical application of IPT and at worst that these skills are inversely related. Thus, the pilot findings have failed to support the value of using at least this particular written examination as an assessment of therapist outcome and may be indicative of the low general value of this kind of assessment in predicting therapists' competence to perform psychotherapy.

The inter-correlations among the various outcome measures used to assess therapist competence in the practicum phase of training were all in the predicted direction; however, many were of low magnitude. The strongest finding which emerged is that correlations are most significant when scores derive from the same informant. Thus, the strategy and process ratings completed by the independent evaluator were highly correlated. Similarly, the supervisor's Strategy Rating Form score correlated significantly with the global assessments, which were comprised, in part, of ratings made by the supervisor. That ratings of identical content areas were uncorrelated across different raters may be accounted for, in part, by the fact that ratings were made from different data sources, i.e., memory, observation of videotapes, and supervision. Careful initial screening of therapist trainee applicants, which tends to minimize variance, and the small size of the sample ($n = 9$) further reduces the likelihood of obtaining significant inter-correlations.

Although inter-rater reliability on the Therapist Strategy Rating Form and Process Rating Form was excellent when ratings were made on the basis of videotapes or therapy transcripts, there was virtually no agreement between therapist strategy ratings made by the supervisors and the strategy or process ratings made by the independent evaluator. One explanation of these findings is that observation of videotape allows the rater to view a therapy session in its entirety, whereas, information gained in supervision is dependent on a therapist's ability and/or willingness to present accurately the therapist/patient interaction in the therapy hour.

In summary, an examination of the utility of the various therapist evaluation instruments/procedures that were piloted in this study indicate that the written didactic examination had very little predictive validity for determining the competence of the therapist to actually perform IPT during the practicum phase of training. With respect to the practicum phase of training, the evaluation procedures utilized multiple outcome measures. In most clinical training prgrams, psychotherapists practical skills are evaluated solely on the basis of supervisor's global evaluation which are based on therapists' reporting of process notes and/or therapists' presentations at case conferences. Very few programs include detailed ratings of videotapes of psychotherapy sessions as part of the assessment procedure to determine therapists' competence. In the present study, assessments of the trainees were made by

several types of raters on the basis of several sources of information, including use of traditional supervisor ratings.

Although therapists' self-ratings serve an important function in encouraging the therapists to think about and assess their work in terms of their use of prescribed techniques and strategies, therapists' recollection of sessions and self-ratings can be biased by self interest. Supervisor's ratings, based on the therapists' presentation of process material, share the weaknesses of therapist self-ratings. Ratings of videotapes by an independent evaluator who did not have an investment in the process as either therapist or supervisor, and who had the most complete source of data, appear to be the most valid.

Our findings, which demonstrate a lack of agreement between the supervisor's perceptions of the therapist (based on material presented in supervision) and the independent evaluator's perceptions of the therapist (based on observation of the actual therapy hour), raise questions about the customary reliance on supervision as the sole basis on which to make valid and reliable judgements about the skill of therapists or the techniques and strategies employed in the therapy hour. This finding underscores the importance of including videotape review of actual therapy sessions as part of therapist assessment, and, if replicated in a larger sample, may have important implications for the selection of evaluation procedures to be utilized in future therapist training programs.

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TABLE 1

ASSESSMENT OF THERAPISTS

Outcome Measures

Area Assessed	Instrument/Procedure	Rater	PT*	PD**	1	6	11	12/16***
Conceptual Skills								
Understanding of theoretical framework & general principles of IPT	Didactic Examination	Scored exam	X	X				
	Ratings of therapist's participation/performance in didactic seminars	Trnr./ Eval.		X				
Practical Skills								
Skill in use of the various IPT techniques	Process Rating Form	Ind. Eval.			X	X	X	X
		Therapist			X	X	X	X
Ability to identify interpersonal problem area; follow through on goal-directed activity (focus); to help patient with intimate self-disclosure; to tend to therapeutic relationship.	Therapist Strategy Rating From	Supervisor			X	X	X	X
		Ind. Eval.			X	X	X	X
		Therapist			X	X	X	X
Overall therapeutic skill: skill in use of IPT	Global Ratings	Supervisor						X
		Trnr./Eval.						X
		Ind. Eval.						X
Overall Competence	Derived Composite Score							X

PT* = Pre-training
PD** = Post-didactic
*** = At last session or at termination