

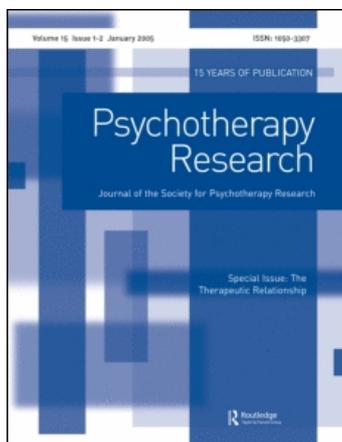
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### Effectiveness of a structured training program in psychotherapeutic skills used in clinical interviews for psychiatry and clinical psychology residents

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## Effectiveness of a structured training program in psychotherapeutic skills used in clinical interviews for psychiatry and clinical psychology residents

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### Abstract

The authors evaluated a training program based on a structured manual of psychotherapeutic skills, using a randomized controlled design. The experimental group consisted of 135 residents from 12 teaching units in Spain. To control the improvement in therapeutic skills that could be attributed to the training received during the residency, the authors compared the experimental group with a control group of 35 residents from three teaching units. Two types of assessment instruments were used: a paper-and-pencil questionnaire based on clinical cases and a videotape of a role-playing interview. Both were given before and after the experimental group attended the training program. The experimental group shows a statistically significant improvement compared with the control group in both measurements.

**Keywords:** psychotherapist training; supervision; development

Psychotherapy alone or combined with psychotropic drugs is, in most cases, effective in the treatment of most mental disorders (Lambert & Olges, 2004). Thus, psychotherapy training is a key factor in psychiatrists' and clinical psychologists' educational programs. Research has supported the importance of training in the so-called common factors (meaning those aspects of psychotherapeutic intervention that are present regardless of the therapist's theoretical approach, as with therapeutic alliance, empathy, goal consensus, and collaboration; Norcross, 2002). Nevertheless, it is striking that most of the training programs do not take this into consideration. There are, however, some programs that have already included training in common factors (Beitman & Yue, 1999; Fernández Liria & Rodríguez Vega, 2002b). There are two types of structured training programs designed to be evaluated with standardized tools (Beitman et al., 1999; Brooks-Harris, 2008; Fernández Liria et al., 2002b): (a) programs that are based on the selection of techniques used in

interventions that have proven to be effective in outcomes research and, as such, are considered to be empirically validated (Brooks-Harris, 2008), and (b) those, like the one tested in this study, that are based on a common factors approach (i.e., the selection of elements that have been shown to be effective in the interventions of different orientations in the process–outcome research; Beitman et al., 1999; Fernández Liria et al., 2002b). Trainees should be able, for instance, to create and sustain a relationship that is therapeutic for patients or to implement some psychotherapeutic skills in clinical interviews that could help patients to explore positive and negative feelings and also to work collaboratively (Rider & Keefer, 2006). This program specifically intends to meet the needs of the Spanish trainees in psychiatry and clinical psychology working in the National Health Service to comply with the guidelines of the World Federation for Medical Education (WFME; de V van Niekerk, Christensen, Karle, Lindgren, & Nystrup, 2003; WFME, 2003). These guidelines

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Table I. Summary of the Articles Published on Formative Programs Concerning Interviewing Abilities and Psychotherapy

Study	Sample	Sample size per group		Recorded interviews for training/evaluation	General skills or specific orientation training	Improvement in:	
		Study	Control			Interviewing skills	Specific orientation skills
Iwata & Wong (1982)	Psychology students	8	No	Yes	Behavioral therapy	Yes	Yes
Fairbairn, Maguire, & Chambers (1983)	Medical students	36	No	Yes	General interviewing	Yes	No
Goldberg, Hobson, & Maguire (1984)	Psychiatrists	5	5	Yes	Conversational model	No	No
Maguire et al. (1984)	Psychiatry residents	12	No	Yes	Conversational model	Yes	Yes
Miltenberger & Fuqua (1985)	Clinical psychologists	4	4	Yes	Behavioral therapy	Yes	Yes
Milne (1986)	Psychiatrists, nurses	71	18	No	Behavioral therapy	No	Yes
Weihls & Chapados (1986)	Medical students	16	16	Yes	Carkhuff model based in client-centered therapy	Yes	Yes
Girón & Sánchez-García (1988)	General practitioners	10	10	Yes	General interviewing skills	Yes	Yes
Lieberman, Cobb & Jackson (1989)	Psychiatry residents	26	27	Yes	General skills	Yes	Yes, but not
Wade, Prakash, & Leichner (1992)	Psychiatry residents	5	No	Yes	General interviewing skills	Yes	Yes (some)
Henry et al. (1993)	Psychotherapists: psychiatrists and psychologists	16	No	Yes	Brief dynamic therapy	Yes	Yes
Evans, Stanley, & Burrows (1993)	Medical students	28	27	No	Empathy training	No	No
Gagnon, Lefort, & Demers (1994)	Family medicine residents	38	16	No	Interviewing skills	Yes	No
Gagnon, Lefort, & Demers (1995)	Family medicine residents	90	No	No	Interviewing skills (validity of evaluation instruments)	Yes	No
Smit & Van der Molen (1995)	Psychology students	160	78	Yes	General interviewing skills	Yes	Yes
Evans, Coman, & Goss (1996)	Medicine students	30	30	Yes	Interviewing skills	Yes	No
Krasner, Howard, & Brown (1998)	Psychiatry and Psychology residents	65	No	Yes	Dynamic psychotherapy	Yes	Yes
Cegala & Lenzmeier (2002)	Meta-analysis <sup>a</sup>						
Chan et al. (2003)	Family doctors	79	No	Yes	General interviewing skills	Yes	No
Ruiz Moral & Rodríguez Salvador (2003)	Family medicine residents	105	88	Yes	General interviewing skills	No	No
Scardovi, Rucci, & Gask (2003)	Family doctors	9	No	Yes	General interviewing skills	Yes	No

<sup>a</sup>Included 26 articles published since 1990 about training in interviewing skills and communications for general medical practitioners. The authors concluded a scarce number of publications. The majority do not include enough information about the learning material or the instruments of evaluation. In many cases, they are not adequate.

propose to extend basic medical education principles (WFME, 1998) to postgraduate studies in such a way that competencies are defined, and integrated evaluation methods are sought to allow for constructive feedback. This feedback should be bidirectional and allows the teacher as well as the student to see the changes generated by the training.

There are very few published studies dealing with the evaluation of training programs for skills in clinical interviewing. We have found 24 studies with mental health professionals and 42 with general practitioners and other medical specialties. Table I displays a summary of the main characteristics of the 21 studies in which pre- and posttraining measures are offered. Most of them do not define clearly the skills that are taught, they use subjective methods in the assessment, and the samples gathered are small (range: 8–25). The only study with a larger number of participants was that by Smit and Van der Molen (1995); see Table I), in which the sample was composed of 160 participants. In other studies, the participants were medical students or family medicine trainees.

We seek to contribute to the improvement of training programs in psychotherapy by describing the evaluation of a structured training program in psychotherapeutic skills based on a common factors approach. The objective is to evaluate the improvement of the performance of the trainees both overall and in each of the psychotherapeutic skills that could be attributed to this training program.

### Description of the Teaching Program

The training method is thoroughly explained in a manual by Fernández Liria and Rodríguez Vega (2002a). The manual describes the training method consisting of two levels of learning (Table II): basic and advanced. The basic level (general interviewing skills) is assessed in this study. This level of competence in psychotherapeutic interviewing was considered as the minimum standard to attain for psychiatry and psychology trainees within the National Health System of Spain. Table III presents a description of these skills. These skills are those that stimulate and maintain the therapeutic conversation and deal with grasping patients' nonverbal communication and also establishing timing. The advanced-level skills are related with the techniques used. Each skill is defined in more detail in the manual (Fernández Liria et al., 2002a). The skills teaching is practical and experiential and is done through exercises that work with each of the skills. The basic-level course includes eight 2-hr weekly sessions plus two additional sessions: one each for the pre- and posttraining course evaluations. Experiential exer-

Table II. General Course Structure

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I. Basic Level or General Psychotherapeutic Interviewing Skills
A. Listening skills
1. General attitude to listening
2. Attention to the nonexplicit
3. Attention to nonverbal communication
4. Attention to the response experimented by the therapist (use of the observing self)
5. Rhyme and compassing the narrative; timing
B. Assisting the client's narrative activity
1. Nonverbal and minimal verbal intervention facilitators
2. Paraphrasing
3. Reflecting empathetically
4. Recapitulate
5. Pose open questions
6. Pose closed questions
7. Clarifying
8. Silence
C. Assisting the formulation of alternative specific narratives
1. Interpreting
2. Confronting
3. Informing
4. Giving instructions
II. Advanced Level: Specific Techniques
A. To challenge the claim narrative
B. To connect the narrative with the biography
C. To connect the narrative with the way of thinking or the behavior
D. To connect the narrative with the significant relationship system
E. To work with emotions
F. To consolidate the new emergent narratives
G. To finish the therapy
H. Frequent mistakes

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cises and a sample of the paper-and-pencil exercises performed during the sessions are conducted in accordance with the guidance provided by the handbook. The rest of the paper-and-pencil exercises are completed by the students at home, which we estimate as 10 additional hours, and are discussed in a group meeting in the following session. The overall duration of the basic level course is 30 hr.

### Method

#### Participants

Participants included 170 trainee therapists (128 psychiatric residents and 42 clinical psychology residents) of 12 teaching units from different cities in Spain that accepted invitations to join the program organized by the Spanish Neuropsychiatry Association (mental health professionals).

#### Trainers

The trainers in each teaching unit previously attended a 30-hr intensive "train the trainers" course conducted by the authors of the manual. When giving the course, the trainers were in contact with

Table III. Specific Skills Description

Skill	Description
Listening attitude	Interviewer's attitude toward patient's communication (posture, gesture, tone of voice) that would assist or hinder patient's narrative activity
Attention to the nonexplicit	Interviewer pays attention not only to what is been said but also to what patient is silent about
Exploring incomplete speech	Interviewer locates omitted fragments and looks into the motives why patient has proceeded as such
Explicit-implicit speech	Interviewer discusses meanings that are not explicitly said but that could be deduced from what patient says
Exploring recursive speech	Interviewer brings to light themes that appear continuously
Facilitators	Interviewer gives signs to encourage patient (fixing gaze to the speaker, raising eyebrows, making hand gestures, leaning toward the speaker, emitting an inarticulate sound ("uh huh") or saying words like "yes" or "I see")
Paraphrases	A repetition of an idea that has just been expressed by the patient
Empathic reflection	Interviewer formulates a content that has been already expressed by the patient and relates it to a feeling or emotion
Recapitulation	Interviewer makes a synthesis of something that has been previously communicated by the patient
Open questions	Questions that require a response that cannot be reduced easily to a "yes" or "no" or to the contribution of a concrete fact
Closed questions	Questions that require a response that can be provided through a "yes" or "no" or the contribution of a concrete fact
Clarification	The interviewer solicits from the patient to specify (to clarify) the concrete meaning of a word or some aspect of of his/her narration

each other and with the authors through an Internet forum so that they could comment on their experiences and difficulties.

### Procedure

In this experimental, comparative, randomized controlled study, participants were assigned to either an

experimental or a control group. The control group consisted of 35 trainees randomly selected from three teaching units (those with a number of trainees large enough to conduct two seminars); an independent service carried out the randomization and assigned students by numbers. The sequence was hidden until the interventions were assigned.

In an eighth session, Marta, 19 years old, says to her therapist that she cannot stand her mother placing her clothes every morning at the foot of her bed. She fears that if she tells her, her mother will feel wounded or believe that she does not love her anymore.

Marta: I can't stand it...Every single morning I have my clothes chosen at the foot of my bed... I'm not normal...I shouldn't have these feelings...If my mother was to hear this...she has dedicated all her life to me and my brother...

Therapist:

In your opinion, the most adequate response for the therapist would be:

- a. Interpretation
- b. Empathic reflection
- c. Clarification
- d. Localization of evasive discourse

Write your response to the patient with the words you would use.

Justify, very briefly, why you have chosen that response.

Figure I. Example of a clinical vignette for paper-and-pencil evaluation.

Because of the characteristics of the intervention, neither the participants nor the intervention administrators could be blind to the branch of intervention to which participants were assigned. Both groups were assessed before and after the experimental group attended the course. The control group only attended the course after having finished this study so, between the pre- and post-intervention assessments, they only had the standard training of the residence program, which is not specifically focused on psychotherapy. The goal of the simultaneous assessment of both groups was to control for the improvement that could be attributed to the standard training received during the residency.

### Instruments

Two evaluation methods were designed. The first involved a multiple-choice paper-and-pencil questionnaire with 12 clinical vignettes, each followed by a multiple-choice test and one or two open questions designed to test skills (see Figure I for an example). This questionnaire was designed by the authors of the manual and agreed on by the rest of the research

group members. Two similar questionnaires were given before and after the training program, both with scores ranging from 0 to 24 (each vignette from 0–2). The internal consistency of the questionnaire is fairly good (Cronbach's  $\alpha = .789$ ).

In the second method, trainees took part in two 5-min role-playing interviews; acting as the interviewer, trainees explored a real relational episode in which the interviewed trainee felt uncomfortable. One interview was videotaped before and the other after the training.

### Raters

Two external therapists evaluated the interviews and two others evaluated the questionnaires. All of them were unaware of the source of the material, whether obtained from the experimental or the control group or from the pre- or posttraining assessment. To assess the degree of performance on each of the skills at every level, an ordinal categorical measuring variable was used, with three categories ordered as follows: 0 = the adequate intervention is never used; 1 = the adequate intervention is sometimes used; 2 = the intervention is

Table IV. Description of the Characteristics of the Study and Control Groups

Variable	Study	Control	Comparison
Sex			$\chi^2 = 1.487, p = .223$
Male	36 (26.7%)	13 (37.1%)	
Female	99 (73.3%)	22 (62.9%)	
Speciality			$\chi^2 = 0.525, p = .469$
Psychiatry	100 (74.1%)	28 (80.0%)	
Psychology	35 (25.9%)	7 (20.0%)	
Age (mean)	27.8	28.6	$t = -1.084, p = .280$
Year of residency			$\chi^2 = 4.951, p = .175$
First	54 (40.0%)	11 (31.4%)	
Second	36 (26.7%)	10 (28.6%)	
Third	26 (19.2%)	12 (34.3%)	
Fourth	19 (14.1%)	2 (5.7%)	
Previous assistance to brief courses on psychotherapy			$\chi^2 = 0.222, p = .638$
Yes	98 (72.6%)	24 (68.6%)	
No	37 (27.4%)	11 (31.4%)	
Supervision in psychotherapy			$\chi^2 = 0.001, p = .991$
Yes	50 (37.0%)	13 (37.1%)	
No	85 (63.0%)	22 (62.9%)	
Previous psychotherapy practice			$\chi^2 = 0.078, p = .780$
Yes	62 (45.9%)	17 (48.6%)	
No	73 (54.1%)	18 (51.4%)	
Previous systematic training on psychotherapy			$\chi^2 = 0.232, p = .630$
Yes	44 (32.8%)	10 (28.6%)	
No	90 (67.2%)	25 (71.4%)	
Personal psychotherapy			$\chi^2 = .022, p = .883$
Yes	18 (13.3%)	5 (14.3%)	
No	117 (86.7%)	30 (85.7%)	

always carried out adequately in form and time. The evaluators had previously tested their interrater reliability when assessing scores by evaluating separately three videotapes. After calculating their degree of concordance ( $\kappa = .764$ ), they reviewed the recordings together in order to unify criteria. Later, another three videotapes were scored individually, obtaining a measured concordance of .832 using the kappa index. Such a result allows us to rely on the concordance between the evaluators. An overall score was also given for each interview, ranging from 0 to 10 points.

A preevaluation of the sample size was carried out, concluding that a sample of this size allows the detection of differences in the improvement of the obtained scores of the theoretical evaluation questionnaire, with a 95% confidence and a 90% power of 1.75.

## Measures

Three measures were used:

Difference of post-pretraining course score in the paper-and-pencil questionnaire consisting of 12 vignettes, scored from 0 to 24 (each vignette from 0–2).

Difference of post-pretraining course score in the overall evaluation of videotape interviews (scored from 0–10, according to a global scoring system used in Spain).

Evaluation of each psychotherapeutic skill using role-play videos (using a scale ranging from 0 = *never*; 1 = *sometimes*; 2 = *always*).

## Statistical Analysis

To evaluate the training program's effect on the scores obtained in the theoretical questionnaire and

Table V. Comparison Post-Pre Training for Overall Scores

Variable	Experimental group		Control group		Comparison	
	Pretraining	Posttraining	Pretraining	Posttraining	Pretraining	Posttraining
Improvement in theoretical questionnaire						
Mean score	10.85	16.69	11.75	12.50		
SD	3.52	3.24	2.98	3.11		
95%CI	10.16–11.41	16.05–17.19	10.60–12.60	11.42–13.58		
<i>t</i> (168)					–1.376, <i>p</i> = .171	6.790, <i>p</i> > .001
	Experimental group		Control group		Comparison	
Kolmogorov–Smirnov's <i>Z</i>	1.039, <i>p</i> = .230		1.330, <i>p</i> = 0.058			
Effect size (Cohen's <i>d</i> )	1.726		0.246			
Mean	5.84		0.85			
95% CI	5.15–6.52		0.01–1.62			
<i>Mdn</i>	6.00		2.00			
Student's <i>t</i> (160)					7.266, <i>p</i> < .001	
Mann–Whitney <i>U</i>					616.5, <i>p</i> < .001	
Variable	Experimental group		Control group		Comparison	
	Pretraining	Posttraining	Pretraining	Posttraining	Pretraining	Posttraining
Overall mark improvement in the interview						
Mean score	4.42	6.47	4.66	5.32		
SD	1.72	1.75	1.68	1.47		
95%CI	4.12–4.72	6.16–6.77	4.00–5.12	4.81–5.84		
<i>t</i> (162)					–0.731, <i>p</i> = .466	3.503, <i>p</i> < .001
	Experimental group		Control group		Comparison	
Kolmogorov–Smirnov's <i>Z</i>	2.350, <i>p</i> < .001		1.564, <i>p</i> = .015			
Effect size (Cohen's <i>d</i> )	1.181		0.418			
Mean	2.05		0.77			
95%CI	1.75–2.34		0.24–1.29			
<i>Mdn</i>	2.00		1.00			
Student's <i>t</i> (160)					4.055, <i>p</i> < .001	
Mann–Whitney <i>U</i>					1196.5, <i>p</i> < .001	

Note. 95%CI = 95% confidence interval.

in the total score of the video interview, we compared means of the post-pre difference between the study and the control group using Student's *t* test. If the variable did not follow a normal distribution, a comparison was made through a nonparametric test (Mann-Whitney *U* test) using the medians. The effect sizes (Cohen's *d*) in both study and control groups is calculated for the theoretical questionnaire and the total score of the video interview.

To evaluate the effect over specific skills, the pre- and postassessment outcomes for each group and skill were compared using the Fleiss-Everitt test for three ordered categories of paired data. This test was preferred to the McNemar extended test because the latter does not consider the magnitude of the differences.

## Results

### Participants Characteristics

There were no significant differences in composition between the experimental and control groups (Table IV). Most of the participants were women: 73.3% in the study group and 62.9% in the control group. Also, most were trainees in psychiatry: 75.3% in the study group and 80.0% in the control group. The same distribution is found on a larger scale in Spanish teaching units. Most aspects related with the training in psychotherapeutic skills (previous assistance to brief courses on psychotherapy, supervision in psychotherapy, previous psychotherapy practice, previous systematic training on psychotherapy) of the subjects before their participation in the study were similar in both groups (see Table IV).

There were no significant differences in the preintervention course scores in the paper-and-pencil questionnaire,  $t(263) = 1.376$ ,  $p = .171$ , or in

the role-playing interview,  $t(162) = 0.731$ ,  $p = .466$ , between the experimental and control groups.

### Evaluation Results Using the Paper-and-Pencil Questionnaire and the Global Score of Interviews

The mean score on the questionnaire before the training is 10.85 (range: 3–22) in the experimental group and 11.75 in the control group (Table V). After the training, the experimental group's mean score is 16.69, showing an improvement in the questionnaire score of 5.84 ( $d = 1.726$ ), whereas in the control group the mean score is 12.50, an improvement of 0.85 ( $d = 0.246$ ). The mean global interview score before training is 4.42 (range: 0–9) for the experimental group and 4.66 for the control group and after the training 6.47 and 5.32, respectively. The experimental group's improvement in the interview global score was 2.05 ( $d = 1.181$ ) compared with 0.77 for the control group ( $d = 0.418$ ; see Table V). Once the Kolmogorov-Smirnov statistic was calculated, a nonparametric Mann-Whitney *U* test was used. For the improvement in the theoretical questionnaire, both Mann-Whitney *U* test and Student's *t* were calculated. However, both showed similar results, demonstrating the superiority of the experimental group ( $p < .001$ ).

### Evaluation Results for Each of the Specific Skills (Post-Pretraining Comparison)

In Table VI post-pretraining comparisons are shown for each particular skill. Pre-post differences were statistically significant in the experimental group and not in the control group for the following skills: listening attitude, attention to the nonexplicit, exploring incomplete speech, explicit-implicit speech, exploring recursive speech, facilitators, paraphrases, empathic reflection, recapitulation, open questions, closed questions, clarification

Table VI. Comparison Post-Pretraining for Each Skill

Skill	Study group	Control group	Correct use of skill	
			Study	Control
Listening attitude	$\chi^2 = 17.82$ , $p < .001$	$\chi^2 = 3.77$ , $p < .152$	84%	66%
Attention to the nonexplicit	$\chi^2 = 48.06$ , $p < .001$	$\chi^2 = 4.57$ , $p = .102$	65.3%	44%
Exploring incomplete speech	$\chi^2 = 53.33$ , $p < .001$	$\chi^2 = 1.19$ , $p = .551$	60.9%	32.4%
Explicit-implicit speech	$\chi^2 = 11.66$ , $p = .003$	NEC		
Exploring recursive speech	$\chi^2 = 51.43$ , $p < .001$	$\chi^2 = 5.40$ , $p = .067$	69.8%	37.5%
Facilitators	$\chi^2 = 5.44$ , $p = .066$ , <i>ns</i>	NEC		
Paraphrases	$\chi^2 = 43.63$ , $p < .001$	$\chi^2 = 4.57$ , $p = .102$	78.9%	58.8%
Empathic reflection	$\chi^2 = 62.09$ , $p < .001$	$\chi^2 = 4.17$ , $p = .125$	54.3%	20.6%
Recapitulation	$\chi^2 = 40.07$ , $p < .001$	NEC		
Open questions	$\chi^2 = 28.70$ , $p < .001$	$\chi^2 = 1.60$ , $p = .449$	85.9%	75.8%
Closed questions	$\chi^2 = 24.89$ , $p < .001$	$\chi^2 = 3.27$ , $p = .195$	84.4%	82.4%
Clarification	$\chi^2 = 59.56$ , $p < .001$	$\chi^2 = 7.54$ , $p = .023$	65.2%	41.2%

Note. NEC = not enough cases.

exploring recursive speech, paraphrases, empathic reflection, recapitulation, open questions, closed questions, and clarification. There were not enough subjects, in the study group or the control group, to evaluate the following skills: exploring elusive speech and exploring omissions. The pretraining course scores in the use of nonverbal facilitators were too high to expect improvements in both groups (81.3% in the experimental group and 81.8% in the control group).

### Discussion

The current study, using a homogeneous group of participants in a real training situation in the Spanish National Health System, is the largest one done in our country and one of the largest in a wider, global context (within the published psychotherapeutic training literature).

Different studies point out the need to define the specific skills required for a psychotherapist (Cegala & Lenzmeier, 2002) and the need to develop more efficient training programs on psychotherapeutic skills that can be assessed (Goldberg, Hobson, & Maguire, 1984). Other studies emphasize that short, structured, and manualized courses can improve the skills required for interviews (Lieberman, Cobb, & Jackson, 1989; Henry, Schacht, Strupp, Butler, & Binder, 1993). The need for a greater flexibility in manuals is also stressed (Beutler, 1999; Consoli & Jester, 2005; Vakoch & Strupp, 2000) as is the usefulness of videotape, either with real patients or with role-playing (Chan et al., 2003; Goldberg & Gask, 2002; Henry et al., 1993; Lieberman et al., 1989; Maguire et al., 1984; Miltenberger & Fuqua, 1985; Smit & Van der Molen, 1995). It has also been suggested that trainers should attend "training the trainers" courses, all of them using the same cases and exercises to ensure program homogeneity (Henry et al., 1993).

We believe that the manual (Fernández Liria et al., 2002a) and the methodology used in our study comply with most of the suggestions made in previous literature.

The difference in the increase in the scores on the paper-and-pencil questionnaire that the experimental group had is not surprising. The most interesting fact is that there was also a statistically significant difference in the increase in the global score of the video recording. Both groups started with low scores, and the experimental group improved an important average in comparison with the control group (see Table V).

The results obtained on specific skills cannot be compared with results in other studies, because in previous studies the contents taught in the training

program were not well defined and general improvement was shown without referring to any specific skill. The program used in this study thoroughly defines each proposed specific skill. This allows for a detailed comparison in future studies with other programs.

The lack of adequate evaluation instruments has been stressed (Cegala & Lenzmeier, 2002), because existing instruments are subjective and weakly structured, being essentially based on supervision of cases (Beitman & Yue, 1999; Larson et al., 1992). Although most of the published studies show a global improvement in these skills performance, in general no objective improvement was shown in specific abilities (Lieberman et al., 1989), except for those training programs with a specific psychotherapeutic trend (psychodynamic, behaviorist; Miltenberger & Fuqua, 1985).

In our study the two assessment instruments used, the theoretical questionnaire and the role-play interview evaluation, both were found to be useful. Most studies point out the usefulness of videotape for both training and evaluation (Evans, Stanley, & Burrows, 1993; Goldberg & Gask, 2002; Wagner, Lentz, & Heslop, 2002) among others. A study on the evaluation of videotape questionnaire reliability proved that a high degree of agreement between two evaluators indicates the instrument is reliable and shows that one evaluator is enough (Smit & Van der Molen, 1995). In other words, previous studies empirically support the evaluation methodology used in this study.

As a result of the number of trainees in each teaching unit in our study, there were fewer participants in the control group than in the study group, which is a limitation. In addition, the recorded interview used for evaluation was a role-play interview, much shorter than a real one. During our intervention, neither the study group nor the control group attended to any other additional training action added to the general training of the residence program. We had no other group of trained therapists who would have attended a nonspecific training, to isolate the additional effect of the experimental training compared with other nonspecific training effects with a placebo group.

Our findings uphold that this formative program in general skills of psychotherapeutic interviewing substantially aids the acquisition of trained skills in a group of trainees compared with a control group who did not attend training.

One implicit assumption in our study is that the improvement of the trained skills demonstrated in the role-playing and the paper-and-pencil questionnaire will lead to an improvement in the performance of the trainees as therapists in a real clinical context,

and this will be translated as a benefit for their patients. Because some counterintuitive findings have been reported in this field (Henry et al., 1993), further research to test this assumption should be carried out to test this hypothesis.

In future research it will be important to assess (a) whether the acquired skills are retained over time or not, as some studies point out (Moss, Margison, & Godbert, 1991), (b) whether the trainee's personal characteristics have an influence on training itself, (c) whether there is a suitable learning period to put into practice these type of programs, (d) whether progress in the trained skills actually improve the benefits of the patients, and (e) the cost-effectiveness of the program. These questions are beyond the scope of the current study but remain important questions to answer.

Because educational initiatives like the one presented here are easily transferable to other units, they do not take up a lot of time and prove to be globally and specifically efficient for acquiring interviewing skills. We suggest the need to put similar programs, structured and assessable, into action.

### Conclusion

Our data support the efficacy of the program and the usefulness of including this type of training activity in tutorial programs. Our study represents both a step toward defining methods for teaching interviewing skills competencies and a step toward a consensus in methods for assessing outcomes (competencies) of training programs.

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