Psychotherapy

Preliminary Data From a Randomized Pilot Study of Web-Based Functional Analytic Psychotherapy Therapist Training

Jonathan W. Kanter, Mavis Tsai, Gareth Holman, and Kelly Koerner

Preliminary Data From a Randomized Pilot Study of Web-Based Functional Analytic Psychotherapy Therapist Training

Jonathan W. Kanter
University of Wisconsin-Milwaukee

Mavis Tsai
Independent Practice and University of Washington

Gareth Holman and Kelly Koerner
Evidence-Based Practice Institute, Seattle, Washington

Therapists of many persuasions emphasize the therapy relationship in their work, a priority backed by strong empirical evidence. Training in how to maximize the power and potential of the therapy relationship, however, has lagged behind. A novel approach to using the therapy relationship and to training therapists in its use is provided by Functional Analytic Psychotherapy (FAP). FAP training involves eight 2-hr weekly training sessions conducted online using web-conferencing technology. The training integrates behavioral principles with a focus on trainee–trainer and trainee–trainee relationships in a highly structured course that evokes the desirable FAP therapist–trainee behaviors and collectively shapes the behaviors through reinforcement by the trainer and other trainees. In a preliminary study, 16 therapist–trainees were randomly assigned to receive either immediate FAP training or training after a waitlist period. Significant and large effects of training were found on both self-reported and observer-assessed measures for the first training group, and the waitlist training group replicated the first training group with significant within-subject change over the course of training. Finally, qualitative feedback from therapists indicated high satisfaction with the primary elements of the training protocol. Several important limitations to this preliminary study are discussed.

Keywords: dissemination, Functional Analytic Psychotherapy, therapeutic relationship, training

Use of web and e-learning technology has great potential to improve the effectiveness, efficiency, and reach of psychotherapy training (Manring, Greenberg, Gregory, & Gallinger, 2011; Fairburn & Cooper, 2011). An increasing number of online-training programs have capitalized on this technology to provide training in specific, empirically supported interventions (Beidas & Kendall, 2010). However, online web-based training to improve the power and potential of the therapy relationship has not received attention to date, despite strong empirical evidence to support the importance of the relationship to therapy outcomes (Horvath, Del Re, Flückiger, & Symonds, 2011) as well as a deep appreciation for and emphasis on the therapy relationship by therapists of many persuasions (Kanter, Rusch, Landes, Holman, Whiteside, & Sedivy, 2009).

A novel approach to using the therapy relationship and to training therapists in its use is provided by Functional Analytic Psychotherapy (FAP; Kohlenberg & Tsai, 1991; Tsai, Kohlenberg, Kanter, Kohlenberg, Follette, & Callaghan, 2009; Tsai, Kohlenberg, Kanter, Holman & Plummer Loudon, 2012). FAP's approach to the relationship is behavior analytic, yet approachable by therapists of diverse theoretical backgrounds owing to the minimal use of behavioral jargon and the way FAP can be used as an addition or complement to other interventions. Like humanistic therapists, FAP therapists aim to create relationships characterized by considerable genuineness, empathy, and positive regard, while paying attention to the minute subtleties of the therapeutic relationship; thus, FAP may be seen as a behavioral approach to developing therapeutic qualities important to a strong therapeutic alliance (Ackerman & Hilsenroth, 2003). FAP, however, is not synonymous with the alliance, as these therapist qualities are used in FAP in the service of a behavioral case conceptualization designed not only to strengthen the alliance but to directly affect client behavior through differential reinforcement (Tsai, Kohlenberg, & Kanter, 2010).

In brief, FAP encourages therapists to conceptualize and identify *clinically relevant behaviors* (CRB), which are defined as behaviors that occur in session that are functionally similar to the out-of-session behaviors of interest to the client. Two types of CRB in FAP include CRB1, which are defined as client in-session problem behaviors, and CRB2, which are defined as client improvements or goal behaviors in session. FAP encourages the therapist to create conditions that evoke and naturally reinforce improvements (CRB2s). On a clinical level, the application of FAP's mechanism of contingent natural reinforcement of CRB2 requires a therapeutic relationship in which the therapist genuinely expresses warmth, empathy, positive regard, and his or her feelings

Jonathan W. Kanter, Department of Psychology, University of Wisconsin-Milwaukee; Mavis Tsai, Independent Practice and University of Washington; Gareth Holman and Kelly Koerner, Evidence-Based Practice Institute, Seattle, WA.

Correspondence concerning this article should be addressed to Jonathan W. Kanter, Department of Psychology, University of Wisconsin-Milwaukee, PO Box 413, Milwaukee, WI 53201. E-mail: jkanter@uwm.edu

and other natural responses to the client as the interaction unfolds in the therapy hour. FAP therapists report that doing so requires not only an intellectual understanding of FAP's guidelines and the underlying behavior-analytic principles, but a genuinely loving and compassionate stance toward their clients and a commitment to take strategic risks to nurture client improvements. Examples of client daily life problems, CRBs, and typical FAP responses are presented in Table 1.

Research on FAP microprocesses and outcomes is accumulating but is still in its infancy. Because FAP grew from a behavior-analytic tradition, the research on FAP has emphasized single subject designs, with a focus on identifying the active mechanism of FAP in microprocess interactions, rather than group designs. This research has been encouraging with respect to the impact of the FAP relationship and the power of FAP's hypothesized mechanism of action on CRB2s and corresponding out-of-session behavior in single cases (Busch, Callaghan, Kanter, Baruch, & Weeks, 2010; Busch, Kanter, Callaghan, Baruch, Weeks, & Berlin, 2009; Callaghan, Summers, & Weidman, 2003; Kanter et al., 2006). Continued research on FAP is needed. In particular, randomized group designs demonstrating the effects of FAP on standardized outcome measures and refinements to the single-subject research to better isolate the mechanism of action will provide important support for initial findings.

As interest in FAP has grown, efforts to train therapists in FAP techniques have evolved to encompass the need for training not only in FAP guidelines and principles but also to develop the skill of courageous and strategic risk taking in the context of intimate and compassionate therapeutic relationships. This training emphasis on improving therapeutic skill rather than knowledge required that FAP trainings use active learning strategies, such as deliberate practice and feedback (Beidas & Kendall, 2010; Beidas, Koerner, Weingardt, & Kendall, 2011). Paralleling the process of FAP, the FAP trainers create a genuine and compassionate training environment that evokes the desirable FAP therapist–trainee behaviors in live interactions and shape these behaviors through natural reinforcement by the trainer and other trainees (Callaghan, 2006; Follette & Callaghan, 1995). The process informally, involves trainee courage, authenticity, and risk taking to evoke and respond to one another's behavior. These skills are prompted and shaped during the course meetings and practiced via homework assignments. To deliver this training without creating burdensome logistical barriers for therapist–trainees, an online course was developed in which eight trainees and two trainers meet, using web-conferencing technology for an 8-week sequence.

The current study provides an initial pilot evaluation of this online-training program focused specifically on building these FAP skills. The anecdotal results from trainers and trainees during initial pilot work indicated that the training was a powerful and memorable experience. Reports indicated increased therapist confidence with FAP techniques in particular and in the ability to create meaningful therapeutic relationships in general, thus raising the possibility that FAP training may have broad benefits across specific therapeutic modalities. These anecdotal accounts, however, previously have not been submitted to empirical evaluation.

Method

Therapist–Trainees

Announcements were e-mailed to two groups of potential participants: previous attendees of weekend FAP workshops who had indicated they wanted to be notified of further training opportunities and individuals who had e-mailed via the FAP website (www.faptherapy.com) that they were interested in online training. The first 16 eligible therapist–trainees were enrolled into the research and were randomized into either an immediate training group (Group 1) or waitlist training group (Group 2). Sixteen participants (7 female, 9 male) were recruited, including seven psychologists, two psychiatrists, four masters-level clinicians, and three graduate students. Mean age of the participants was 42 years ($SD = 11.9$), and the mean number of years of clinical experience was 12.29 ($SD = 8.13$). Fourteen of the participants were Caucasian, one was Pacific Islander, and one reported "other."

Trainers

Each training was conducted by two trainers. In each case, the lead trainer was the second author, the developer of the training. In

Table 1
Examples of Client Daily Life Problems, Related CRB, and FAP Therapist Responses

	Example 1	Example 2
Daily life problem:	A client pushes others away with insensitive demands and aggressive responses.	A lonely client avoids social situations in which he may be rejected.
CRB1:	• Requesting that the therapist reschedule sessions at the last minute and become available on Sundays. • Arguing with or criticizing the therapist if requests are denied.	• Avoiding making requests of the therapist. • Withholding personal information from therapist for fear of eliciting therapist judgment.
CRB2:	• Phrasing request in a way that acknowledges the therapist's needs. • Accepting refusal or a compromise solution.	• Making requests and disclosing personal information when anxious about judgment. • Expressing fear of judgment rather than avoiding.
Therapist responses:	• Disclose the impact of CRB1 on the therapist (therapist feels irritated, pushed away, conflicted). • Provide feedback about the positive impact of CRB2; accept skillful and reasonable requests.	• Provide feedback to client about the impact of CRB1 (therapist feels distanced, doesn't know the client's needs and so does not meet them). • Provide feedback to the client about the impact of CRB2 (therapist feels closer, understands client's needs).

Group 1, the coleader was the fourth author, an expert in dissemination of therapies with detailed knowledge of FAP, who had been in two previous online FAP groups. In Group 2, the coleader was the first author, an expert in FAP with 10 years of experience leading didactic FAP trainings but not online trainings in this format.

Training Protocol

Pretraining preparation. To prepare for the training sessions, a trainer sent an e-mail to the therapist–trainees approximately 2 weeks before the beginning of their training to orient them to the intensity of the group environment. This e-mail contained the training "vision" and a "Life History" writing assignment, which was preparation for the in-session "Life History" autobiography described later in the article. Therapist–trainees were also asked to indicate to the trainers their willingness to take strategic risks during the group so the trainers would be able to encourage appropriately based on the trainees' goals and to provide any other helpful information to the trainees.

Web-conferencing format. The training protocol was delivered through an online therapeutic learning community (www .PracticeGround.org), using a commercially available community platform (www.iCohere.com) that blended instant messaging, audio- and video-web conferencing, and streaming PowerPoint presentation capabilities. Trainees logged into an online collaboration room on the PracticeGround Web site, which displayed video of up to four trainees and both trainers simultaneously. The trainers coordinated the trainees toggling their video on and off to ensure that each trainee's video was displayed when he or she was speaking. Before the beginning of the training group, a brief practice session was conducted to troubleshoot any technical problems with the system, and trainees were encouraged to log in several minutes before the start of each session to troubleshoot any additional problems that occurred. No major technical problems occurred.

In-session training activities. A variety of in-session exercises were conducted during the training in which trainees practiced interpersonal risks and responding with natural reinforcement relevant to therapy. For example, a Life History exercise occurred during the first three training sessions. In this exercise, each trainee is requested to provide a 6-to-8-min autobiography to the group and is encouraged to take risks related to emotional expression and honesty (i.e., engage in CRB2). At the end of the autobiographical presentation, each trainee and then the trainers have approximately 30 s to provide genuine feedback or a reflection to the presenter. This is intended to function as deliberate practice of natural reinforcement of CRB2. Although trainees are responding to one another, the trainers may shape responding and provide additional feedback. Finally, trainees are encouraged to try interpersonal risk-taking behaviors and the giving of reflections with others, including their clients, and to report on these behaviors at the beginning of the next training session in the form of "risk logs."

Additional exercises included feedback on "risk logs" (described later in the article), sharing of personal mission statements with the group, discussion of areas of avoidance, "personal loss inventories," in which therapist–trainees shared personal losses with the group and received feedback, and "appreciations," in which therapist–trainees expressed specific appreciations to one

another and the trainers in the final session. In addition to the personal exercises, brief didactic presentations were incorporated to provide participants more intellectual understanding of behavioral and FAP concepts. Additional descriptions and examples of these training interventions are provided in Table 2.

Between-session homework assignments. Each week the therapist–trainees were encouraged to try the behaviors being modeled, practiced, and reinforced in the training sessions with others including friends, colleagues, significant others, and clients during the week. Therapist–trainees completed a "Daily Risk Log" to document the relevant interpersonal risks or target behaviors the therapist–trainee engaged in over the week. The night before the next group meeting, therapist–trainees e-mailed their logs to the group. Therapist–trainees were randomly assigned to different partners each week to give 1-min feedback/reflections on the risks taken during the week. Finally, after each session, therapist–trainees sent responses to a series of "Session-Bridging Questions" (e.g., What was helpful about this session? What would have made it a better experience? What were your CRB1s and CRB2s? What questions do you have? What is hard for you to say?) to the trainers to provide feedback about the quality of the training experience and as an opportunity to engage in CRB2s.

Session structure. The training sessions were highly structured and followed a session-by-session protocol. The first session began with a review of the expectations for the group, group guidelines, concerns and fears, and issues of confidentiality and safety related to the personal nature of the group. Then, a brief review of FAP's basic principles was provided, the Life History exercise was started, and homework was described and given (including Session-Bridging Questions and Daily Risk Logs). In general, subsequent sessions began with feedback/reflections on risk logs (the coleaders modeled this for the first 2 weeks and then the trainees provided the feedback to one other). The body of each session focused on personal exercises, didactic presentations, and case discussions. Each session ended with description of specific homework assignments for the following week, including daily risk logs, giving a FAP rationale to a client, completing a FAP case conceptualization, and trying a brief meditation with clients in session (see Table 3 for detailed descriptions).

Measures

FAP Impact Scale (FAPIS). The FAPIS is a 46-item self-report scale created specifically to assess the impact of FAP training on trainees. Initial scale items were written by interviewing graduate student trainees ($n = 10$) who had completed a year of intensive FAP training and supervision with the second author. These items were then shared with a group of FAP experts who indicated that they had face and content validity as indicators of FAP competency. The scale was then piloted with a second cohort of graduate trainees in the yearlong FAP training ($n = 10$). Results indicated that the scale was reliable, and total scores were normally distributed and increased approximately one standard deviation from pre- to posttraining. Qualitative analysis of items suggested that they tap several domains of FAP competency, including self-awareness, awareness of client, courage/risk taking, therapeutic love/reinforcement, values, self-disclosure, behaviorism competence/attitudes, and in-session focus. The current study analyzed the total scale score, which demonstrated good internal consistency

Table 2
Descriptions and Examples of Training Interventions

Intervention	Description and examples
Trainee emotional expression and honesty	During the Life History exercise, trainees are encouraged to be honest about the key positive and negative events of their lives and to feel what it is they are saying. For example, if a female trainee says, "I was sexually abused by my stepfather when I was 6," she is invited to stay with the emotions associated with the disclosure.
Trainee genuine feedback and reflections	Trainees are asked to give brief genuine and naturally reinforcing feedback and reflections to other trainees after hearing their life histories or other disclosures. Examples include (a) conveying compassion and validation; (b) identifying themes between disparate topics; (c) self-disclosing reactions or similar experiences; (d) linking what was shared with individual's past disclosures; (e) using metaphor.
Trainers shape responding and provide feedback	Examples include "What you said is really moving, and I notice you are starting to tear up. Let's pause and give yourself space to feel your feelings" or "You are really modeling well for our group how to directly face your vulnerability and anxiety in this moment by taking breaths and trying to make eye contact."
Risk log reflections	Risk log reflections allow for trainees to practice giving accurate empathic feedback to others to facilitate feeling seen, heard or otherwise reinforced for having shared; and/or to feel more connected to the person doing the reflecting. See examples under "Trainee genuine feedback and reflections."
Discussion of areas of avoidance	Questions include what do you tend to avoid addressing with your clients? How does this avoidance impact the work that you do with these clients? What do you tend to avoid dealing with in your life (tasks, people, memories, needs, feelings, e.g., longings, grief, anger, sadness, fears, be specific)? How do your daily life avoidances impact the work that you do with your clients?
Personal loss inventory	Trainees are encouraged to engage in a CRB2 in discussing their loss inventories to share what they have loved and lost, the hurts, disappointments, endings, and betrayals that they have endured. These disclosures are followed by genuine feedback and reflections.
Appreciations	The goodbye process in Session 8 consists of trainees writing a brief heartfelt appreciation (one to two specific sentences describing what the trainee will remember about the person, what this person said or did that helped the trainee engage in more CRB2, or a quality the trainee really appreciates) to each trainee in the group and saying it out loud.

(α = .94). Sample FAPIS items include "I am genuine in my conversations with clients," "I say things that are hard to say to my clients," "I recognize subtle improvements in my clients' behaviors in session," "I am open to all of my experiences in session," and "I notice my emotional reactions during sessions." Each item is rated on a seven-point scale (1 = "disagree strongly," 4 = "neutral/mixed," and 7 = "agree strongly").

FAP vignettes. Two brief vignettes were created to assess the impact of FAP training on therapists' written responses to hypothetical therapy situations. In Vignette 1, a 13-line transcript of a therapy interaction was provided to the trainee. In this interaction, a client expressed nervousness in response to the therapist's question about the previous session. The instructions asked the trainee to read the transcript and respond to two questions about it: (Item 1) give an FAP-informed therapist response to the client's nervousness, and (Item 2) give an example of a brief FAP rationale that the therapist may provide to the client. In Vignette 2, a single client utterance was provided to the trainee (i.e., "I really need your support"). The instructions asked the trainee to interpret the utterance as a CRB2 and provide an FAP-informed therapist response (Item 3). The content of the vignettes was created independent of any content provided in the training protocol to maximize the value of the vignettes as a test of generalization of training skill, rather than duplication of material rehearsed during training.

Responses for Items 1, 2, and 3 were coded by a rater blind to the trainee's condition or timing of the assessment. Each item was coded on a scholastic grading scale (i.e., A+, A, A−... D, D−,

F), with A+ representing an ideal FAP response, C representing a passing response, and F representing a very poor, failing response. For Item 1, high grades were given for responses that indicated that the therapist was aware that the client's nervousness could be CRB and made an attempt to discuss this possibility. For Item 2, (providing the FAP rationale), high grades were given for rationales that both demonstrated the key aspects of FAP and applied the FAP ideas to the client's specific situation. For instance, an example of an A+ response was, "So here we are, and you came to therapy wanting to work on this free-floating anxiety stuff that comes up in the context of relationships. And here it is showing up in our relationship. While I know this may be a bit anxiety provoking, I'm actually appreciative of the fact that it's showing up. Because this means that we get to observe it directly, and make contact with it, explore and be curious about it. And we can best work with it when it is directly in front of us, right here and right now." An example of a C− grade was, "The connection we have in therapy provides an opportunity for you to explore how you are in other relationships" and an example of an F grade was, "I don't know what this is." For Item 3, high grades were given for responses that suggested a compassionate natural reinforcing response.

These scores were converted for statistical purposes to a numerical scale from 0 = F to 12 = A+, and then converted back to the grading scale for interpretative purposes. To determine reliability of the coding scheme, a second coder, an advanced graduate student with 7 years of clinical and research knowledge of FAP, independently coded a random selection of 15 responses for each

Table 3
Descriptions of Homework Assignments

Assignment	Description of Assignment to Trainee
Daily Risk Log	Take at least one interpersonal risk per day, either in your therapy sessions or in daily life. Rate this risk on a scale from 1–10 (riskiest). Create a log with brief descriptions and e-mail to everyone the night before class. The purpose of this assignment is to (a) increase awareness of your 1s (problematic behaviors, what you tend to avoid) and 2s (target behaviors, movement toward what you value), and therefore your clients' 1s and 2s, (b) increase strategic risk taking on behalf of your clients' growth, and (c) build connection and trust in our group through disclosure of meaningful daily life experiences.
Give FAP Rationale to Clients	Try to give a FAP rationale to a client this week if appropriate. For example, "A primary principle in FAP is that our relationship is a microcosm of your outside relationships. So I will be exploring how you interact with me in a way that is similar to how you interact with other people, what problems come up with me that also come up with other people, or what positive behaviors you have with me that you can translate into your relationships with other people."
FAP Client Case Conceptualization Form	Complete a FAP case conceptualization to share with the group next week. Case conceptualization categories included relevant history, daily life problems, problematic beliefs, variables maintaining problems, assets and strengths, CRB1s, CRB2s, daily life goals, therapy goals, planned interventions, T1s (therapist in-session problems), T2s (therapist in-session target behaviors).
Brief Meditation with Clients in Session	Try a brief meditation at the beginning of a session to increase grounding and connection with your clients. For example, adapt the following to something that fits for each client: "I'd like to start the session by doing a short meditation to help you connect more with yourself and with me. Let's take some breaths together and settle into our bodies. May you feel connected to the depth of your feelings in our session. May you speak your truth to me, even if it feels scary. May you be at peace with whatever comes up. May you feel the warmth and depth of my caring for you."

of the three items (totaling 45 codes). The reliability coder demonstrated good reliability, using intraclass correlations (ICC), with the data coder for Item 1 (ICC = .88), Item 2 (ICC = .91), and Item 3 (ICC = .91). For analysis, these three items were averaged to produce an overall summary score.

FAP Course Evaluation. The Course Evaluation is a 5-item questionnaire that was administered to therapist–trainees after the training. The first item is an overall rating of course satisfaction: "How would you rate your experiences overall as a member of this FAP online-consultation group?", with response options ranging from 1 = "poor" to 5 = "excellent." This is followed by four open-ended questions: (1) "What have you liked or found to be most helpful about this group?", (2) "How have you been affected professionally and personally as a result of your participation in this group?", (3) "What have you not liked/what suggestions do you have for change?", and (4) "Is there anything else you want to say?" For analysis of these qualitative items, the responses were categorized into thematic categories by two coders. Disagreements were minor and were resolved by consensus.

Procedure

After providing informed consent, all therapist–trainees completed the Time 1 (pretraining) online assessment including a demographic questionnaire and FAPIS and the FAP vignettes via e-mail. Then, the Group 1 trainees received the 8-week training. After this, all trainees completed the Time 2 assessment (post Group 1) including the FAPIS, vignettes, and FAP course evaluation (for Group 1 only) using the same procedures as Time 1. The Group 2 trainees then received the 8-week training and completed

the Time 3 assessment (post Group 2) including the FAPIS, vignettes, and FAP course evaluation.

Results

FAPIS and Vignettes

To explore outcomes with respect to the FAPIS, two analyses were conducted. First, a repeated measures ANOVA with the Greenhouse–Geisser correction (Greenhouse & Geisser, 1959) was conducted to compare change from Time 1 to Time 2 (pretraining to post Group 1) for the two groups, with the interaction between group and time being the relevant statistic to determine an effect of the FAP training for the first training group (Group 1) compared with the waitlist (Group 2). The interaction was significant, $F(1, 13) = 4.97$, $p = .04$, *partial* $\eta^2 = .276$. Follow-up paired t tests indicated a significant change from Time 1 to Time 2 for Group 1, Time 1 $M(SD) = 249.13$ (37.65), Time 2 $M(SD) = 273.38$ (25.22), $t(7) = 2.46$, $p = .04$, $ES = .77$, but not for Group 2, Time 1 $M(SD) = 250.63$ (18.83), Time 2 $M(SD) = 248.00$ (26.98), $p = .92$, $ES = -.11$.

Second, to explore the change owing to FAP training for Group 2 (i.e., from Time 2 [post Group 1] to Time 3 [post Group 2]), a paired t test was conducted, indicating significant change over time for Group 2, Time 2 $M(SD) = 248.00$ (26.98), Time 3 $M(SD) = 275.63$ (17.70), $t(7) = 4.64$, $p = .004$, $ES = 1.24$. To examine whether Group 1 changed more or less owing to FAP training than did Group 2, a second repeated measures ANOVA was conducted with both groups pretraining scores entered as Time 1 and both groups posttraining scores entered as Time 2. This analysis indi-

cated a significant main effect for time, $F(1, 13) = 19.14$, $p = .001$, $partial\ \eta^2 = .596$, but a nonsignificant Group $\times$ time interaction, $p = .78$, suggesting that both groups changed significantly after training with neither group changing more significantly than the other.

To explore outcomes with respect to the vignette responses, the same analyses were conducted with the vignette summary score as the dependent variable. The Group $\times$ time interaction in the repeated measures ANOVA to compare change from Time 1 to Time 2 (pretraining to post Group 1) for the two groups was significant, $F(1, 14) = 7.30$, $p = .017$, $partial\ \eta^2 = .343$. Follow-up paired t tests indicated a significant change from Time 1 to Time 2 for Group 1, Time 1 $M(SD) = 6.13$ (1.89), Time 2 $M(SD) = 9.00$ (1.53), $t(7) = 3.89$, $p = .006$, $ES = 1.68$, but not for Group 2, Time 1 $M(SD) = 7.79$ (2.56), Time 2 $M(SD) = 8.13$ (1.95), $p = .58$, $ES = .15$.

The paired t test to explore the change owing to FAP training for Group 2 (i.e., from Time 2 [post Group 1] to Time 3 [post Group 2]) was also significant, $t(7) = 2.57$, Time 2 $M(SD) = 8.13$ (1.95), Time 3 $M(SD) = 9.21$ (1.68), $p = .037$, $ES = .60$. The second repeated measures ANOVA to determine whether Group 1 changed more or less than Group 2 indicated a significant main effect for time, $F(1, 14) = 21.61$, $p < .001$, $partial\ \eta^2 = .607$. The Group $\times$ time interaction demonstrated a trend towards significance, $F(1, 14) = 4.43$, $p = .054$, $partial\ \eta^2 = .240$, suggesting that both groups changed significantly after training and that Group 1 noticeably, but not significantly, changed more than Group 2.

FAP Course Evaluations

The mean satisfaction rating was 4.94 ($SD = .24$; $n = 16$). For the open-ended questions, all response themes endorsed by more than one participant are summarized here.

What have you liked or found to be most helpful about this group? Trainees mentioned the following as most helpful: The role of coleaders in modeling risk taking and vulnerability and in supporting group members ($n = 12$); practicing FAP in "real time" such as giving and receiving feedback within the group ($n = 8$); learning about FAP principles ($n = 7$); the sense of belonging to a responsive, cohesive group/professional community ($n = 7$); being encouraged to take emotional risks ($n = 5$); case conceptualizations/role playing/practicing interventions ($n = 5$); learning FAP experiential exercises ($n = 4$); and homework activities, including interpersonal risk logs and assignments with clients ($n = 4$).

How have you been affected professionally and personally as a result of your participation in this group? Trainees indicated greater confidence and more skill at using FAP strategies, including more authentic and open responses related to connecting with others and taking interpersonal risks in general ($n = 11$); taking strategic risks in doing therapy ($n = 10$); more ability to engage in intense, committed, and close therapy relationships with clients ($n = 7$); greater appreciation for their own strengths and/or greater self-respect/compassion ($n = 6$); increased functional awareness of their own behavior, other's behavior, or their impact on others ($n = 4$); and being more accepting and self-aware ($n = 4$).

What have you not liked/what suggestions do you have for change? Trainees mentioned that there was not enough time to cover the agenda at times ($n = 7$); and that they wanted greater

focus on concepts and clinical applications (in addition to experiential exercises) ($n = 5$).

Is there anything else you want to say? Trainees expressed heartfelt gratitude to the trainers ($n = 11$).

Discussion

This study provides preliminary support for a novel online training course to improve the therapeutic relationship and the ability of therapists to naturally reinforce their clients' clinically relevant in-session behaviors as suggested by FAP. The training content is novel in that it directly parallels the therapy process in FAP and is presumed to work according to the same mechanism—namely, natural reinforcement of desirable therapist behaviors in the training session, with the expectation that this improved behavior will generalize to the therapy room. The training protocol combines web-conferencing technology with a series of exercises designed to evoke and reinforce trainee target behaviors in the training session, and then homework assignments designed to promote generalization.

Several encouraging findings emerged from this preliminary study. First, in the initial randomized comparison between the first training group and the waitlist group, a significant training effect was found for training. This effect was demonstrated on both the FAPIS—a self-report measure of FAP competencies with clients—and a blind, reliable observer-based assessment of skill with key FAP techniques. Second, this combination of findings was replicated when the waitlist group received the training. Third, qualitative feedback evaluations from therapist–trainees were consistent with the effects found and suggested that trainees were very satisfied with the training and felt that they had improved considerably, specifically in the ways targeted by the training, such as improved authentic and open responses related to connecting with others, taking strategic interpersonal risks, and improved ability to engage in intense, committed, and close therapy relationships with clients.

Both the first and second training groups changed equally on the self-report FAPIS, but the first training group may have changed more on the vignette assessment compared with the second training group. This appears to be due to the second group starting the training with higher vignette grades than the first group and a ceiling effect in which both groups were graded highly after training, with the average grade for both groups being a B+ or higher. This suggests that the training protocol was powerful with respect to raising therapist–trainees' grades on the vignettes to a high overall level.

There are several notable limitations to this research, and the results should be considered promising but preliminary. First, the participants self-selected to be in the study and included those who previously attended weekend FAP workshops. Thus, they had considerable interest in learning FAP; results may not generalize to settings in which training is mandated by administrators for therapists regardless of interest. Future research should include therapists of different levels of motivation.

Second, there were no measures of actual therapist behavior in session, client outcomes, or therapeutic relationships, and the measures used may not directly relate to improvements in outcomes or to stronger relationships in specific dyads. It could be argued that therapists who undergo this training have an

investment in believing that they improved, and this could account for the changes on the self-report FAPIS as opposed to true improvement. Furthermore, the vignette measure, although reliable and objective, has not been demonstrated to be a valid measure of skill in the therapy session. There is some question whether the skills demonstrated in the vignette responses can transfer to the therapy session, where tone, flexibility, and timing all become salient determinants of competent responding. Future research should attempt to measure therapist skill in the therapy session, perhaps through obtaining audiotapes or videotapes of sessions. That said, because of the logistical burden of measuring behavior in actual therapy after training, vignette and role-play scenarios are encouraged as important proxy measures of training outcomes (Fairburn & Cooper, 2011). Nonetheless, future research should validate the FAPIS and vignette measures against real therapy cases and move toward evaluating actual therapy outcomes and the therapeutic alliance after training.

A third limitation is that only immediate effects of training were assessed, so there is no indication that improvements after training were robust over time. For how long will effects of training last? This too is an important question for research, as the goal is for training to have a robust and positive impact on therapist behavior over time, not just immediately after the training. Future research should attempt follow-up assessment of therapist–trainees after the ending of the training period.

A fourth limitation is that the primary trainer was the developer of the training method. Thus, it is important to determine whether training results can be obtained by additional trainers. For any training protocol to have a significant impact, the protocol itself must be trainable. Thus, future research should assess the impact of FAP training using different trainers. The structured session-by-session nature of the training protocol may allow for attempts to replicate the current results.

Finally, the online nature of this training is both a limitation and a strength. The Internet has revolutionized how we interact, creating an interconnected global village, and increased access to training for many individuals. This benefit is unmistakable. Although the results of this study suggest that the online format was successful, it is not clear, however, whether the results would be more or less powerful in person. In fact, some research indicates that the Internet actually can create more closeness in face-to-face meetings than can live interactions (McKenna, Green, & Gleason, 2002). Future research may investigate the differential effectiveness of Internet trainings compared with other forms of live training and supervision, including classroom settings and traditional seminars.

This study marks the beginning of a research agenda to address these issues. Overall, the goal is not only to develop a method for improving therapeutic relationship skills in therapists as per the guidelines of FAP, but to have a direct impact on client outcomes as well. These preliminary results are encouraging that a training protocol with several novel features—including a behavioral foundation, an intense focus on the microprocess between trainers and trainees, a series of highly structured evocative exercises, and the use of online technology—is well accepted by trainees and has positive immediate effects on their self-reported FAP competency with clients and observed skill as per written vignette responses.

Future research will address questions of generalizability to more diverse therapist–trainees, generalizability to behavior in the therapy session, maintenance of gains over time, and ability of different trainers to produce positive training effects.

References

Ackerman, S., & Hilsenroth, M. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review, 23,* 1–33. doi:10.1016/S0272-7358(02)00146-0

Beidas, R. S., & Kendall, P. C. (2010). Training therapists in evidence-based practice: A critical review of studies from a systems-contextual perspective. *Clinical Psychology: Science and Practice, 17,* 1–30. doi:10.1111/j.1468-2850.2009.01187.x

Beidas, R. S., Koerner, K., Weingardt, K. R., & Kendall, P. C. (2011). Training research: Practical recommendations for maximum impact. *Administration and Policy in Mental Health, 38,* 223–237.

Busch, A. M., Callaghan, G. C., Kanter, J. W., Baruch, D. E., & Weeks, C. E. (2010). The Functional Analytic Psychotherapy Rating Scale: A replication and extension. *Journal of Contemporary Psychotherapy, 40,* 11–19. doi:10.1007/s10879-009-9122-8

Busch, A. M., Kanter, J. W., Callaghan, G. M., Baruch, D. E., Weeks, C. E., & Berlin, K. S. (2009). A micro-process analysis of functional analytic psychotherapy's mechanism of change. *Behavior Therapy, 40,* 280–290. doi:10.1016/j.beth.2008.07.003

Callaghan, G. M. (2006). Functional analytic psychotherapy and supervision. *International Journal of Behavioral and Consultation Therapy, 2,* 416–431.

Callaghan, G. M., Summers, C. J., & Weidman, M. (2003). The treatment of histrionic and narcissistic personality disorder behaviors: A single-subject demonstration of clinical effectiveness using Functional Analytic Psychotherapy. *Journal of Contemporary Psychotherapy, 33,* 321–339. doi:10.1023/B:JOCP.0000004502.55597.81

Fairburn, C. G., & Cooper, Z. (2011). Therapist competence, therapy quality, and therapist training. *Behavior Research and Therapy, 49,* 373–378. doi:10.1016/j.brat.2011.03.005

Follette, W. C., & Callaghan, G. M. (1995). Do as I do, not as I say: A behavior-analytic approach to supervision. *Professional Psychology: Research and Practice, 26,* 413–421. doi:10.1037/0735-7028.26.4.413

Greenhouse, S. W., & Geisser, S. (1959). On methods in the analysis of profile data. *Psychometrika, 24,* 95–112. doi:10.1007/BF02289823

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48,* 9–16. doi:10.1037/a0022186

Kanter, J. W., Landes, S. J., Busch, A. M., Rusch, L. C., Brown, K. R., Baruch, D. E., & Holman, G. (2006). The effect of contingent reinforcement on target variables in outpatient psychotherapy for depression: A successful and unsuccessful case using functional analytic psychotherapy. *Journal of Applied Behavior Analysis, 39,* 463–467. doi:10.1901/jaba.2006.21-06

Kanter, J. W., Rusch, L. C., Landes, S. L., Holman, G. I., Whiteside, U., & Sedivy, S. K. (2009). The use and nature of present-focused interventions in cognitive and behavioral therapies for depression. *Psychotherapy: Research, Theory, Practice, Training, 46,* 220–232.

Kohlenberg, R. J., & Tsai, M. (1991). *Functional Analytic Psychotherapy: A guide for creating intense and curative therapeutic relationships.* New York, NY: Plenum.

Manring, J., Greenberg, R. P., Gregory, R., & Gallinger, L. (2011). Learning psychotherapy in the digital age. *Psychotherapy, 48,* 119–126. doi:10.1037/a0022185

McKenna, K. Y. A., Green, A. S., & Gleason, M. E. J. (2002). Relationship formation on the Internet: What's the Big Attraction? *Journal of Social Issues, 58,* 9–31. doi:10.1111/1540-4560.00246

Tsai, M., Kohlenberg, R. J., & Kanter, J. (2010). A functional analytic

psychotherapy approach to therapeutic alliance. In C. Muran and J. Barber (Eds.), *The therapeutic alliance: An evidence-based approach to practice and training*. New York, NY: Guilford Press.

Tsai, M., Kohlenberg, R. J., Kanter, J., Holman, G., & Plummer Loudon, M. (2012). *Functional analytic psychotherapy: The CBT distinctive features series.* Great Britain: Routledge.

Tsai, M., Kohlenberg, R. J., Kanter, J. W., Kohlenberg, B., Follette, W., & Callaghan, G. (2009). *A guide to functional analytic psychotherapy:* *Awareness, courage, love and behaviorism.* New York, NY: Springer. doi:10.1007/978-0-387-09787-9