

Psychotherapy

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Online First Publication, June 29, 2023. <https://dx.doi.org/10.1037/pst0000495>

CITATION

Yamin, J. B., Cannoy, C. N., Gibbins, K. M., Krohner, S., Rapport, L. J., Trentacosta, C. J., Zeman, L. L., & Lumley, M. A. (2023, June 29). Experiential Training of Mental Health Graduate Students in Emotional Processing Skills: A Randomized, Controlled Trial. *Psychotherapy*. Advance online publication. <https://dx.doi.org/10.1037/pst0000495>

Experiential Training of Mental Health Graduate Students in Emotional Processing Skills: A Randomized, Controlled Trial

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Emotional processing interventions for trauma and psychological conflicts are underutilized. Lack of adequate training in emotional processing techniques and therapists' lack of confidence in utilizing such interventions are barriers to implementation. We developed and tested an experiential training to improve trainees' performance in a set of transtheoretical emotional processing skills: eliciting patient disclosure of difficult experiences, responding to defenses against disclosure, and eliciting adaptive emotions. Mental health trainees ($N = 102$) were randomized to experiential or standard training, both of which presented a 1-hr individual session administered remotely. Before and after training and at 5-week follow-up, trainees were videorecorded as they responded to videos of challenging therapy situations, and responses were coded for demonstrated skill. Trainees also completed measures of therapeutic self-efficacy, anxiety, and depression at baseline and follow-up. Repeated-measures analysis of variance indicated all three skills increased from pre- to posttraining for both conditions, which were maintained at follow-up. Importantly, experiential training led to greater improvements than standard training in the skills of eliciting disclosure ($\eta^2 = .05$, $p = .03$), responding to defenses ($\eta^2 = .04$, $p = .05$), and encouraging adaptive emotions ($\eta^2 = .23$, $p < .001$) at posttraining, and the training benefits for eliciting disclosure were maintained at follow-up. Both conditions led to improved self-efficacy. Trainees' anxiety decreased in the standard training, but not in the experiential. One session of experiential training improved trainees' emotional processing therapy skills more than didactic training, although more training and practice likely are needed to yield longer lasting skills.

Clinical Impact Statement

Question: Will a one-session experiential training approach improve mental health trainees' emotional processing therapy skills compared to a standard, lecture-based training? **Findings:** An experiential approach, such as utilizing observation, repetitive practice, and personalized feedback during clinical skills training, leads to more improvement in trainees' emotional processing skills compared to a lecture-based training. **Meaning:** Experiential training should be consistently incorporated into training of mental health clinicians, especially for challenging therapeutic skills. **Next Steps:** Future research is needed on the maintenance of the training effects over time, and on the impact of experiential training on real-life therapy practice and patient outcomes.

Keywords: training, trauma, emotional processing, deliberate practice

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Jolin B. Yamin received funding from Student Award (2021010094.SAP) from the Blue Cross Blue Shield of Michigan Foundation and a Dissertation Grant Award from the Society for a Science in Clinical Psychology. The authors thank the Skillsetter team for providing access to their platform for this study. The authors report how they determined their sample size, any data exclusions, all manipulations, and all measures in the study. Study data, analysis code, and research materials (including the training protocol) are available upon request.

Jolin B. Yamin played a lead role in conceptualization, data curation, formal analysis, investigation, methodology, and writing—original draft. Ciara N. Cannoy played an equal role in formal analysis. Katey M.

Gibbins played an equal role in formal analysis. Shoshana Krohner played a supporting role in investigation. Lisa J. Rapport played a supporting role in conceptualization, methodology, and writing—review and editing. Christopher J. Trentacosta played a supporting role in conceptualization, methodology, and writing—review and editing. Lori Lackman Zeman played a supporting role in conceptualization, methodology, and writing—review and editing. Mark A. Lumley played a lead role in supervision; a supporting role in formal analysis, project administration, and writing—review and editing; and an equal role in conceptualization and methodology.

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Experiences of psychosocial trauma are common, with most adults reporting at least one traumatic event in their lifetimes (Benjet et al., 2016). Such exposure has been linked to adverse physical and psychological health outcomes, impaired functioning, and reduced quality of life (Sinkler et al., 2022; Sowder et al., 2018). In addition to trauma, many individuals experience interpersonal and intrapsychic conflicts such as social rejection, secrecy, and struggles with intimacy/vulnerability or autonomy/assertion, which are also associated with poor health outcomes (Krohner et al., 2022; Kross et al., 2011; Lumley & Schubiner, 2019).

Much theory and research indicate that identifying and processing stressful experiences and conflicts improves psychological and physical health. Consistent with this research, encouraging patients to disclose their stressors and experience and process their emotions is a key therapeutic change principle (Goldfried, 2012). Commonly referred to as a “corrective experience” in psychotherapy, emotional processing represents an affective, interpersonal, cognitive, and/or behavioral shift that occurs when patients volitionally engage previously unresolved conflicts or feared/avoided situations (internal or external) and develop new responses and relations with other people (Hill et al., 2012). Many psychological treatments target emotional processing. For example, prolonged exposure therapy helps patients approach feared and avoided trauma-related material including memories, thoughts, emotions, and real-life situations through imaginal and in vivo exposures (Foa, 2011). Cognitive processing therapy asks patients to write a detailed account of their worst traumatic experience and read it in-session to help break patterns of avoidance (Resick et al., 2016). Emotion-focused and experiential therapies (Greenberg & Goldman, 2019), many forms of short-term psychodynamic psychotherapy (Abbass et al., 2020; McCullough, 2003), and emotional awareness and expression therapy (Lumley & Schubiner, 2019) also explicitly target avoided experiences.

Therapies that encourage emotional processing have shown benefits for a range of populations (e.g., Abbass et al., 2020; Asmundson et al., 2019; Lumley et al., 2017; Powers et al., 2010). These approaches, however, can be challenging to implement, and many therapists avoid doing so. The barriers have been studied specifically in the implementation of exposure-based therapies for anxiety and trauma-related disorders (Becker et al., 2004). For example, of 207 psychologists surveyed by Becker and colleagues, awareness of exposure therapy was high, but only 17% reported using it to treat posttraumatic stress disorder. Research has identified specific barriers to therapist implementation of exposure-based therapies, which include lack of adequate training, beliefs that exposure is likely to lead to an increase in symptoms or problems in therapy, and lack of confidence in one’s ability to handle a range of patient emotional reactions (Becker et al., 2004; Cook et al., 2014; Deacon et al., 2013; Kline et al., 2021). It is likely that such beliefs extend to other emotional processing treatments. For therapists in training, it can be especially difficult to directly inquire about patients’ traumas, conflicts, and other stressful experiences and to facilitate needed emotional processing. Thus, effective and targeted training experiences are needed to help address therapist-centric barriers to the implementation of such techniques.

Increasing Therapists’ Emotional Processing Skills

Drawing from prior research and from emotion-focused and exposure-based therapeutic models, we focus on three basic

psychotherapy skills that therapists need to help patients engage in successful emotional processing and that cut across various psychotherapeutic approaches. These skills, in the order that they usually progress in a session, are as follows:

Inquiring and Encouraging Disclosure of Difficult Experiences

When a person experiences stressful life events, the disclosure of information about such events has long been considered adaptive and healthy (Lumley et al., 2012; Pennebaker, 2012). Further, helping patients identify and disclose difficult experiences is a central facet of emotional processing interventions, including exposure-based, emotional-focused, experiential, and cognitive processing therapies (Foa, 2011; Greenberg & Goldman, 2019; McCullough, 2003; Resick et al., 2016). Therapists in training may often feel uncomfortable or hesitant to directly ask patients about difficult topics such as traumas, conflicts, or other issues that they anticipate might make the patient feel uncomfortable. Training, therefore, should increase therapists’ capacity to elicit such disclosure.

Working With Patient Defenses Against Disclosure

Patients commonly defend against disclosure and accessing traumatic or conflictual memories and emotions (McCullough, 2003). For example, patients may make vague statements, express a desire to avoid a memory or a conflict, become tangential or change the topic, or express fear of “losing control” or “falling apart” if they were to approach a difficult topic (Lumley & Schubiner, 2019; McCullough, 2003). Therapists, who are often very sensitive to patients’ discomfort, may retreat when encountering patients’ anxious avoidance. It is important, however, for therapists to learn to navigate patients’ defenses against disclosure by supportively but courageously challenging the patients’ defenses rather than colluding with their fears and avoidance.

Finding and Encouraging the Experiencing of Adaptive Emotions

Emotional processing calls for patients to become aware of, experience, and express emotions, and a meta-analysis of the psychotherapy process literature found that patients’ in-session emotional expression is strongly positively predictive of better therapeutic outcomes. Further, Anvari et al. (2020) found that the therapist skill of directly asking patients to focus on feelings is particularly productive for eliciting patient emotional expression. Emotion-focused, experiential, and some psychodynamic therapy models differentiate between *adaptive* or activating emotions or feelings, which are “naturally” elicited by certain experiences—and *inhibitory* or secondary feelings, which patients commonly report but are usually reactions to important adaptive feelings (Greenberg, 2012). It should be noted that all emotions can be adaptive or inhibitory, depending on the context presented by the patient; however, affective science commonly views certain emotions as reliably elicited by specific contexts (Ekman, 1992; Lazarus, 1991; Weisfeld, 2019). For example, adaptive anger typically occurs in situations when a person has been treated unjustly or victimized, adaptive sadness/grief is experienced when a person has lost

something or someone of value, and adaptive connecting feelings are experienced with those with whom closeness or love is desired. In contrast, inhibitory or secondary feelings serve to constrain activation and engagement; such feelings typically include anxiety, depression, shame, pain, and self-attack. Training that increases therapists' emotional processing skills should include techniques to improve their ability to understand the context that the patient is presenting, so that the therapist can identify the adaptive emotion for the situation (McCullough, 2003). The activation and processing of context-appropriate adaptive feelings specifically is key to many forms of therapy (Greenberg, 2012; Pascual-Leone, 2018), so therapists need to learn to encourage patients to identify, experience, and express such feelings.

Addressing Barriers to Skill Acquisition and Utilization Through Effective Training

Research suggests that common therapist training methods such as hearing lectures, reading treatment manuals, and watching training videos are limited in their ability to change therapist behavior (Frank et al., 2020; Taylor & Neimeyer, 2015). In contrast, several studies have highlighted the importance of supervisor feedback in increasing therapist knowledge, proficiency, and retention of skills (Franklin et al., 2003; Herschell et al., 2010). Beyond didactic methods and supervision, some clinical scholars highlight the application of deliberate practice in psychotherapy training, which involves practicing specific skills or behaviors repeatedly outside of the performance situation through role plays and simulations, personalized performance feedback, and experiential/reflective training approaches (Bernard & Goodyear, 2014; Ellis, 2010; Rousmaniere et al., 2017). For example, Perlman et al. (2020) found that therapists randomized to receive a deliberate practice oriented training on therapeutic alliance and facilitative interpersonal skills displayed higher postintervention level of overall therapeutic skills and significantly higher levels of specifically targeted posttraining therapist skills (i.e., empathy, capacity to bond with patient, and alliance rupture-repair responsiveness) compared to therapists who received a cognitive therapy demonstration training.

An example of a recent methodological innovation in skill training is exemplified by Skillsetter (formerly Theravue; see <https://skillsetter.com>), a web-based, deliberate practice, psychotherapy skill-building system. This system contains a large video library of actors portraying therapy patients in a variety of clinical contexts, and educators can build training modules using the videos based on specific therapeutic skills that they are targeting in training. Trainees view a video clip and are then prompted to respond to the "patient" using a specific skill or technique, and their response is videorecorded. Trainees' responses can be evaluated later by a supervisor. The system's current video library includes clips targeting a range of therapeutic skills, but—notably—does not include clips focused on emotional processing skills. More generally, we are not aware of any empirical studies focused on training for emotional processing skills, such as the ones targeted in this study. Eliciting disclosures and activating patients' avoided emotions can be especially emotionally challenging for trainees or new therapists, although the importance of helping trainees manage their emotional reactions and challenging their concerns during training has been recommended (Grant, 2006; Tangen, 2017).

Overview of the Present Study

Providing therapists with training that is experiential, that includes practice and feedback, and that addresses therapists' fears is likely to enhance psychotherapy skills. However, therapist training specifically in emotional processing skills is generally absent. Thus, we developed a brief experiential introductory training program to teach these skills to mental health trainees. We created and tested a novel single-session, remotely administered individual training experience, consistent with the supervisory tradition in our field as well as the Skillsetter platform. Rather than use the common uncontrolled pre-post study, we used a randomized design to test the effects of this novel training, and compared it to an active, didactic learning experience of the *same skills and content*, but without opportunities for practice and feedback.

We hypothesized that the experiential training would result in greater improvement in actual behavioral performance of the targeted skills from baseline to posttraining compared to the standard training, and we explored the duration of effects out to a 5-week follow-up. We also hypothesized that the experiential training would result in a greater increase in trainees' self-efficacy compared to the standard training. Because this novel training in emotional processing skills was expected to be somewhat anxiety-provoking for many trainees, we explored how the experiential training affected trainees' anxiety and depression. We also assessed trainee satisfaction with both types of training.

Method

Participants

We sent recruitment emails to trainees in a social work master's program and several clinical psychology doctoral (PhD) programs. All trainees were within their first 3 years of graduate study. A total of 110 trainees were eligible and interested in participation and completed baseline questionnaires; eight did not schedule a training session and were excluded, leaving a final sample of 102 randomized trainees. The sample averaged 26.9 years old ($SD = 5.79$); was comprised of 92 women, nine men, and one nonbinary trainee; and 62 (60.8%) identified as White/European American, 13 (12.7%) as Black/African American, seven (6.9%) as Latinx/Hispanic, nine (8.8%) as biracial, and 11 (10.8%) as "other." Just over one-third of the trainees ($n = 36$; 35.3%) were in social work, and 66 (64.7%) were in clinical psychology.

Procedure

The study was approved by the Wayne State University Institutional Review Board, preregistered on clinicaltrials.gov (NCT04511754), and conducted completely remotely via Qualtrics for questionnaires and Zoom for training from December 2020 to May 2021. Trainees provided written informed consent, completed baseline measures (self-efficacy, anxiety, and depression), and attended the single assessment/training session, which lasted about 90 min. In this session, participants first completed a pretraining behavioral assessment of the targeted therapy skills (described below) and then were randomized 1:1 into the experiential or standard (control) training conditions. Trainers and trainees were masked to assigned condition until the baseline measures and pretraining skills assessment were completed.

Both training conditions were guided by detailed protocols, and training was conducted by two female doctoral students in clinical psychology, each of whom provided training for both conditions. Immediately following training, trainees had a repeat assessment of the therapy skills and completed a general evaluation of the training. Five weeks after training, trainees completed a follow-up assessment of skills and measures of self-efficacy, anxiety, depression, and evaluation of the training. Trainees received a \$30 gift card for completing the study.

Description of Training Content

Although the two conditions differed in training methods (described below), they both presented the same content, focused on the three emotional processing skills, during a 60-min training session, conducted individually. The content of both trainings was presented to the trainee via a PowerPoint slideshow as the trainer shared her screen. The three skills are inquiring and encouraging disclosure (IED), working with defenses against disclosure (WWD), and finding and encouraging the experiencing of adaptive emotions (FAE).

IED Skill. Trainees were taught to target difficult patient experiences and be courageous in asking patients important questions explicitly and purposely about trauma or conflict, rather than asking vague opening questions or waiting for the patient to initiate disclosure (e.g., “Share with me something that has been difficult in your life. Something that is hard for you to talk about.”; “The symptoms you are describing are common reactions to stress or trauma. Are there any traumatic or other private experiences that would be helpful to share?”). Examples of important topics of inquiry, including traumas and other difficult experiences, were provided.

WWD Skill. Trainees were taught about different ways patients may react to avoid disclosure of difficult experiences, such as making vague statements, expressing desire to avoid a memory or a conflict, going on a tangent or entirely changing the topic, or expressing fear of “losing control” or “falling apart.” Trainees were then taught how to navigate patients’ avoidance of disclosure of difficult topics. For example, if a patient made vague statements when disclosing an experience, the trainee was taught to encourage the patient to provide more details by probing about the event. If a patient expressed a desire to avoid a memory or conflict, the trainee was taught to explain to the patient that the “pushing away” of these experiences may provide some temporary relief but will keep these experiences unresolved. Then, the trainee was taught to invite the patient to try or “test out” disclosing the experience in the session. If a patient became tangential or changed the topic during a difficult disclosure, trainees were trained to point out the shift then redirect the patient back to the disclosure. If a patient expressed a fear of “falling apart” during a difficult disclosure, trainees were encouraged to reassure the patient that discomfort surrounding the disclosure is temporary, give the patient confidence that they can handle it, and encourage them to give it a try in-session (e.g., “Talking about the trauma does not cause you to permanently ‘lose control’ or ‘fall apart.’ Instead, you will learn that you are stronger than you thought, and that you do not need to avoid thinking about this trauma. Why don’t we test it out? Let’s give it a try.”)

FAE Skill. To help patients access adaptive emotions, the trainees were taught to recognize other emotions that might be in the patient’s story, beyond the maladaptive (inhibitory, secondary) emotions expressed by the patient, and then explore those adaptive

emotions by inquiring about them. Trainees were taught to approach this task by asking themselves: “Given a patient’s story or context, and thinking of the natural human reaction in a given scenario, which adaptive emotions might be experienced but suppressed or avoided?” or “What emotion is the patient *not* expressing, given the experiences they are describing?” For example, if the patient’s story was about being treated unfairly or unjustly, trainees were taught to look for unexpressed anger, if the story was about loss, trainees were taught to look for unexpressed grief, or if the story was about important attachment figures or close others, trainees were taught to look for unexpressed closeness/intimacy. The trainees were then taught to inquire about those specific adaptive emotions and invite the patient to explore and experience the adaptive emotions (acknowledge the emotion, feel it in the body, etc.). An example of what a trainee was encouraged to say is, “You mentioned feeling down about your mother always being critical of you, I’m wondering if there is a part of you that feels angry with her?”

Description of Training Conditions

Experiential Training. In this condition, trainees received information about the three skills, along with examples, and practiced the skills during the training when presented short video clips of actors portraying patients. The clips shown in the experiential training were randomly chosen from a large number of clips created for the study. The trainer provided feedback to trainees after they responded to each practice clip, and the trainees repeated the practice once for each clip, incorporating the feedback they received. After each skill was taught, the trainer discussed the trainees’ reactions to the overall skill, their emotional reaction to the video vignettes, and any anxieties or barriers that the trainees foresaw in implementing the skill.

Standard Training. In this condition, the trainer provided a lecture-based training to trainees, in which trainees received a presentation about each skill, including the rationale and research supporting it, examples, quizzes, and opportunities to ask questions. Trainees did not receive any opportunities for practice or live feedback from the trainer, however.

Skills Assessment

The assessment (pretraining, posttraining, and follow-up) of each trainee’s performance in the three targeted skills was conducted via the Skillsetter platform. We created new video vignettes for this study and uploaded them into Skillsetter, which operated in the following sequence. Trainees were shown a series of eight, brief (30–60 s), prerecorded videos of diverse actors portraying patients in therapy; each video was preceded by a brief narrated audio introduction to provide context. Using their web cameras, the trainees recorded a brief, timed response after each of the eight videos as if the trainee were in the room with the patient. The same procedures were followed for the pretraining, posttraining, and follow-up assessment of skills, using eight different clips at each time point, but with similar clinical content. The videos used in the assessments were created by the study team. In these videos, actors portrayed patients who were avoiding disclosure of stressful or traumatic events, who actively displayed defenses against disclosure, and patients who were avoiding the experience or expression of adaptive emotions, specifically anger, sadness and grief, and intimacy/closeness. Each of the three assessment time points

included one video targeting the IED skill, four targeting the WWD skill, and three videos targeting the FAE skill.

Measures

Skills Performance

Trainees' self-recorded video responses for all eight videos at each of the three time points (pretraining, posttraining, and follow-up) were downloaded and subsequently coded for each of the three skills. Two female doctoral students in clinical psychology, who were not involved in the training, were trained to reliability code the trainees' responses using a structured manual, and then coded recordings independently, masked to study condition assignment. Consistent with the approach of Anderson and Patterson (2013), all skill items were coded on a 0 = *no display of skill* to 4 = *excellent skill* scale. Videos from 11 trainees were randomly selected for interrater reliability analyses, and trainee responses to each skill at each time point were coded by both coders. Intraclass correlation coefficient estimates of interrater reliability were calculated using SPSS Version 28 based on a mean-rating ($k = 2$), consistency, two-way mixed-effects model. Interrater reliability scores for all coded skills ranged from good (.72) to excellent (.98). The correlations of specific skill ratings across the different videos (different behavior samples) for each skill were relatively low at pretraining ($r = .05$ to $r = .24$), somewhat higher at posttraining ($r = .11$ to $r = .33$), and variable at follow-up ($r = -.03$ to $r = .47$). The descriptions of the specific skills coded are as follows:

IED. This skill rating reflects the extent to which the trainee made an explicit, direct, and purposeful inquiry into what the patient was not discussing, using language that clearly invites the patient to disclose, targeting any stressful conflict and/or trauma that may underlie the patient's symptoms and problems.

WWD. This skill rating reflects the extent to which the trainee worked through the patient's defense by moving forward with a confident and direct inquiry, encouraging the disclosure of avoided experiences.

FAE. This skill rating reflects the extent to which the trainee was able to go beyond the secondary emotion expressed by the patient and identify the avoided activating/primary emotion in the patient's story, inviting the patient to explore and experience the avoided emotion through a focused and deliberate inquiry.

In addition to these skills, all trainee responses from the pretraining, posttraining, and follow-up assessments for each of the three skills were also coded for trainee verbal fluency and focus/clarity (adapted from Anderson & Patterson, 2013), as follows:

Verbal Fluency. This rating reflects the extent to which the trainee was verbally at-ease in communicating, and the extent to which the response was delivered in a relaxed, confident manner and without significant signs of anxiety (e.g., broken speech, extended and awkward pauses).

Focus/Clarity. This rating reflects the extent to which the trainee's response was direct, succinct, clear, and focused rather than scattered (e.g., focused on too many topics), too long, or difficult to follow.

Questionnaires

Self-efficacy was assessed at baseline and 5-week follow-up using two self-report scales. The 16-item Counseling Challenges Self-

Efficacy subscale of the Counselor Activity Self-Efficacy Scales (labeled as "Self-efficacy [CASES]" in results tables; Lent et al., 2003) was used to assess aspects of perceived self-efficacy to cope with a number of challenging counseling situations. We also created a parallel Specific Self-efficacy subscale of 10 items that referred to emotional processing skills: eliciting disclosure of difficult topics and working with patients' intense in-session emotions. Items on both subscales were rated from 0 = *no confidence* to 9 = *complete confidence* regarding trainees' perceived confidence in their abilities to work effectively, over the next week, with each presented patient type, issue, or scenario. Item ratings were averaged for each subscale, and higher scores indicated greater self-efficacy. Both the CASES subscale (baseline $\alpha = .91$; follow-up $\alpha = .91$) and the Specific Self-efficacy scale (baseline $\alpha = .91$; follow-up $\alpha = .94$) demonstrated excellent reliability in this sample.

Anxiety and depression symptoms were assessed with the Patient-Reported Outcomes Measurement Information System (PROMIS) eight-item Anxiety and eight-item Depression scales (Pilkonis et al., 2011). Items on both scales were rated from 1 = *never* to 5 = *always* with reference to the last week and averaged to create anxiety and depression scores; higher scores indicate higher anxiety or depression symptoms. PROMIS-Anxiety (baseline $\alpha = .89$; follow-up $\alpha = .90$) and PROMIS-Depression (baseline $\alpha = .91$; follow-up $\alpha = .94$) demonstrated excellent reliability in this sample.

Satisfaction With the Training

Trainees evaluated the training through a set of five items developed for this study. Items referred to the organization of the training, presentation of information, the educational components, and trainees' overall satisfaction with the training. Items were rated from 1 = *strongly disagree* to 6 = *strongly agree*. Item scores were averaged; higher scores indicate higher satisfaction. The satisfaction scale demonstrated good reliability in this sample (baseline $\alpha = .73$; follow-up $\alpha = .78$).

Statistical Analysis

Sample size was determined via power analysis conducted using G*Power3.1. We estimated a condition difference in skill that reached at least a medium effect ($f = .25$) would be clinically significant. To detect a medium effect using a repeated-measures analysis of variance (RM ANOVA), two-tailed α at .05, and correlation of $r = .50$ between time points, a sample of 98 was needed to achieve power of 0.80. The final randomized sample size of 102 met this requirement. To test for the effects of experiential versus standard training on outcomes, "intent-to-train" analyses of all randomized trainees were conducted. Missing follow-up data (described below) were replaced using single imputation (multiple regression), predicting missing values from available baseline data, posttraining data when available, and experimental condition. To determine the independence of the three targeted skills and the independence of ratings of verbal fluency and focus/clarity, bivariate correlations within and between the skills (and their corresponding ratings of verbal fluency and focus/clarity) were calculated, averaging across the three time points (pretraining, posttraining, and follow-up).

RM ANOVAs were conducted to test for both Time main effects (e.g., both conditions improving from pretraining) and

Time \times Condition interaction effects (e.g., more improvement for experiential than the standard training) on trainees' skills from pretraining to posttraining and pretraining to follow-up. Similar RM ANOVAs were conducted on trainees' self-efficacy, anxiety, and depression from baseline to follow-up. All significance tests used a two-tailed p of .05. Effect sizes for Time and Time \times Condition effects were calculated as partial η squared (η^2), where values of .01, .06, and .14 indicate small, medium, and large effects, respectively. Effect sizes within each condition (d) were calculated as the change score (posttraining or follow-up minus pretraining) divided by the pooled (average) standard deviation of at the two time points (Lakens, 2013). By convention, d values of 0.2, 0.5, and 0.8 (or r values of .10, .30, and .50) indicate small, medium, and large effects, respectively. Independent-samples t tests were used to test the effects of training condition on satisfaction with the training at posttraining and follow-up.

Results

Participant Flow Through the Study

As shown in Figure 1, all randomized trainees ($N = 102$) completed their assigned training and the posttraining skill assessment. Most trainees (82.3%, $n = 84$) completed the follow-up assessment (both skills assessment and self-report measures), eight trainees provided only follow-up self-report measures, and 10 trainees provided no follow-up data. The two training conditions were similar in the number of trainees missing some or all follow-up data (experiential $n = 10$, standard $n = 8$).

Bivariate correlations among the three skills measured in the study, along with their corresponding ratings of verbal fluency and focus/clarity, are presented in Table 1. Within each skill, skill ratings had small-to-medium correlations with verbal fluency ($r = .20-.30$) and with focus/clarity ($r = .18-.22$), whereas fluency and focus/

Figure 1
Flow of Participants Through the Study

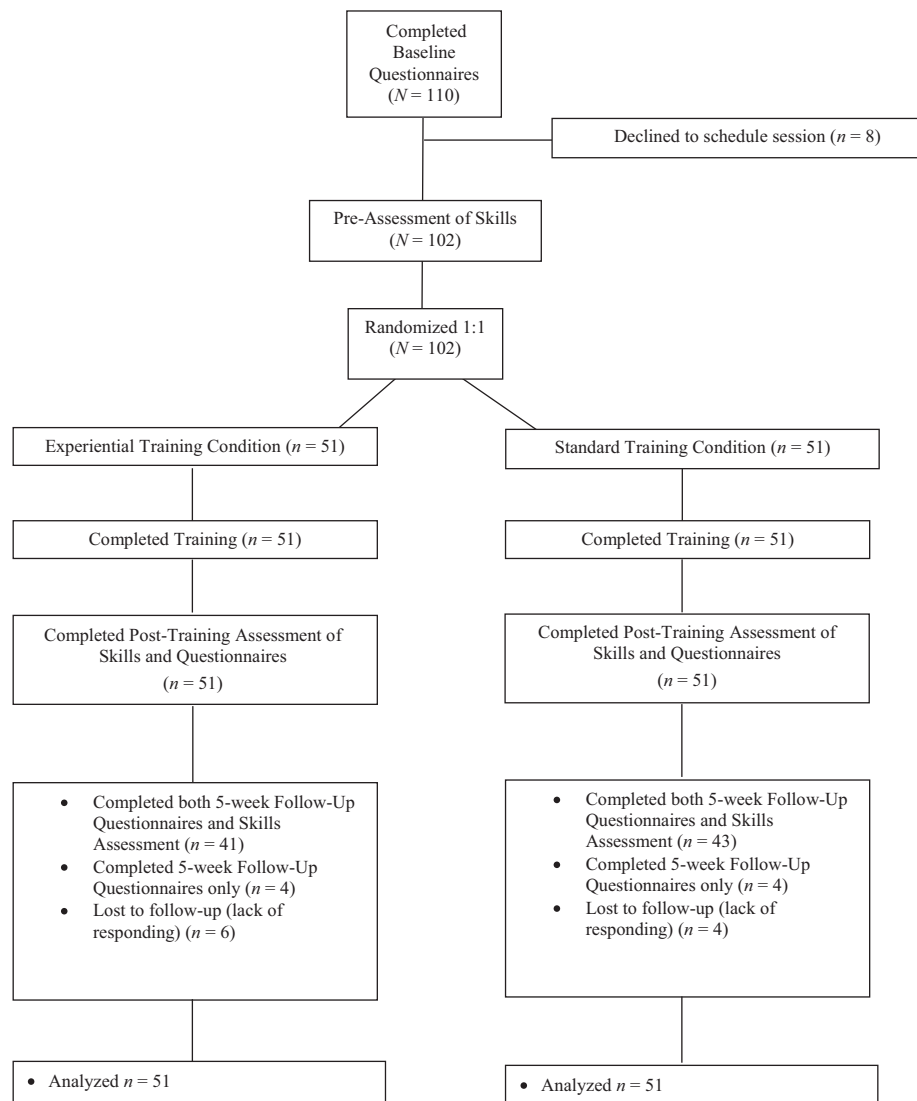


Table 1

Correlations Among Skills, Verbal Fluency, and Focus/Clarity of Participant Responses Given to Vignettes Across the Three Skills

Variable	1	2	3	4	5	6	7	8	9
1. IED Skill	—	.25	.18	.16	.20	.11	.15	.10	.08
2. IED verbal fluency		—	.44**	.18	.49**	.24*	.18	.49**	.25*
3. IED focus/clarity			—	.27*	.27**	.59**	.21	.30**	.62**
4. WWD Skill				—	.30*	.22*	.24	.32**	.18
5. WWD verbal fluency					—	.41**	.12	.75**	.34**
6. WWD focus/clarity						—	.20	.38**	.76**
7. FAE skill							—	.20	.21
8. FAE verbal fluency								—	.40**
9. FAE focus/clarity									—

Note. Correlations are averaged over pretraining, posttraining, and follow-up. IED = inquire and encourage disclosure; WWD = working with defenses against disclosure; FAE = finding and encouraging experiencing of adaptive emotions.

* $p < .05$. ** $p < .01$.

clarity had medium correlations with each other ($r = .40$ – $.44$). Also, correlations among the three targeted skills were small ($r = .15$ – $.24$), suggesting that the three skills are largely distinct. Verbal fluency, however, had medium to large correlations across the three skills ($r = .49$ – $.75$), as did focus/clarity of responses ($r = .59$ – $.76$).

Skills Assessment

IED

As shown in Table 2 and Figure 2, there were very large effects of time on trainees' IED skill from pre- to posttraining, $F(1, 100) = 79.62$, $p < .001$, $\eta^2 = .44$, and pretraining to follow-up, $F(1, 100) = 75.60$, $p < .001$, $\eta^2 = .43$. More importantly, the significant

Time \times Condition interaction indicates that the experiential training led to a greater increase than standard training (near medium effect size) in IED skill from pre- to posttraining, $F(1, 100) = 4.90$, $p = .03$, $\eta^2 = .05$, which was maintained at follow-up, $F(1, 100) = 5.05$, $p = .03$, $\eta^2 = .05$.

There was also a medium magnitude main effect of Time on the verbal fluency of the trainees' responses for the IED skill from pre- to posttraining, $F(1, 100) = 11.28$, $p < .01$, $\eta^2 = .10$, and very large Time effect from pretraining to follow-up, $F(1, 100) = 45.97$, $p < .001$, $\eta^2 = .32$. Similarly, there were very large Time effects on the focus/clarity of the trainees' responses for this skill from pre- to posttraining, $F(1, 100) = 65.22$, $p < .001$, $\eta^2 = .40$, and pretraining to follow-up, $F(1, 100) = 88.04$, $p < .001$, $\eta^2 = .47$. Neither of the Time \times Condition interactions for verbal fluency and focus/clarity

Table 2

Within-Condition and Between-Conditions Comparisons of the Inquire and Encourage Disclosure Skill (IED) Outcomes From Pre- to Posttraining and Pretraining to Follow-Up

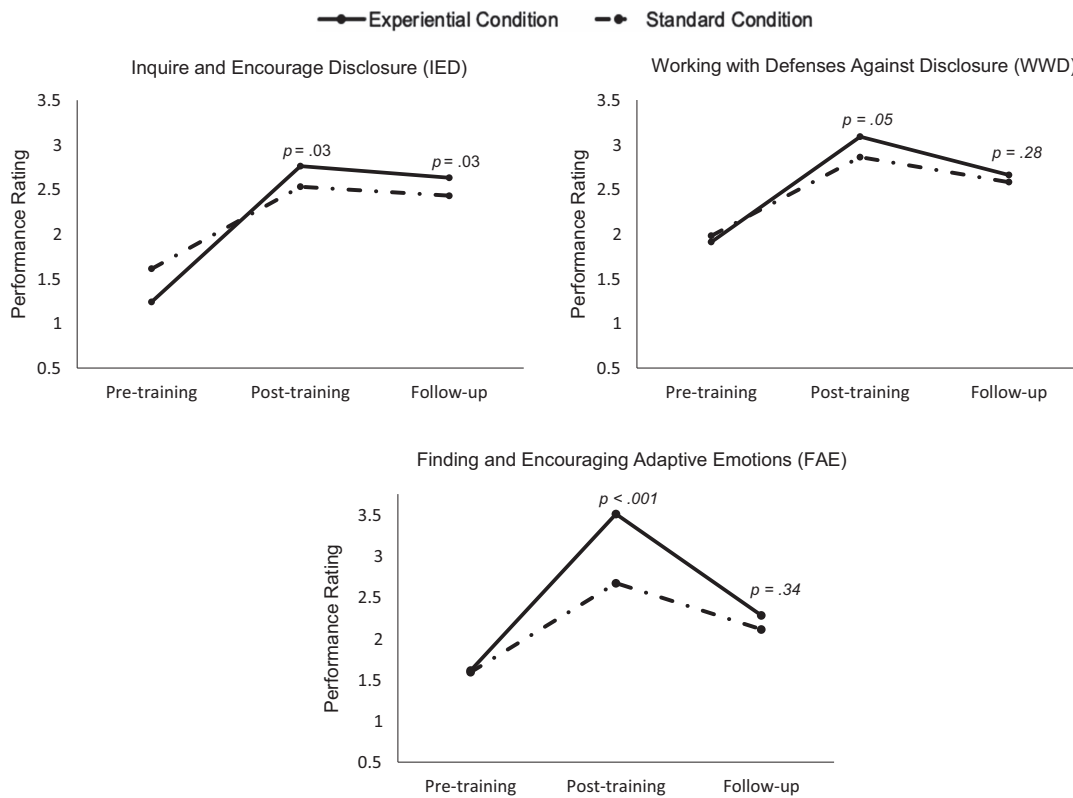
Outcome measure	Experiential condition ($n = 51$)		Standard condition ($n = 51$)		Time \times Condition Interaction		
	M (SD)	d_{within}	M (SD)	d_{within}	$F(1, 100)$	p	η^2
IED Skill							
Pre	1.24 (1.11)		1.61 (1.08)				
Post	2.76 (1.01)		2.53 (0.88)				
Follow-up	2.63 (0.77)		2.43 (0.88)				
Post–pre change	1.53 (1.54)	1.43***	0.92 (1.21)	0.94***	4.90	.03	.05
Follow-up–pre change	1.39 (1.26)	1.48***	0.81 (1.31)	0.84***	5.05	.03	.05
IED verbal fluency							
Pre	2.45 (0.88)		2.12 (0.77)				
Post	2.75 (0.80)		2.49 (0.86)				
Follow-up	2.95 (0.82)		2.84 (0.67)				
Post–pre change	0.29 (1.05)	0.36	0.37 (0.96)	0.45**	0.16	.69	.00
Follow-up–pre change	0.50 (0.96)	0.59***	0.72 (0.85)	1.00***	1.59	.21	.02
IED focus/clarity							
Pre	2.43 (1.33)		2.29 (1.30)				
Post	3.55 (0.83)		3.16 (1.05)				
Follow-up	3.55 (0.83)		3.53 (0.78)				
Post–pre change	1.12 (1.32)	1.03***	0.86 (1.15)	0.74***	1.08	.30	.01
Follow-up–pre change	1.12 (1.39)	1.03***	1.24 (1.13)	1.19***	0.21	.65	.00

Note. d_{within} is the within-condition effect size ([posttreatment or follow-up M —pretreatment M]/pooled SD of the two time points). η^2 is the between-condition effect size. All tests were two-tailed.

** $p < .01$. *** $p < .001$.

Figure 2

Comparison of Experiential Versus Standard Training on the Three Emotional Processing Skills From Pretraining Through Posttraining and 5-Week Follow-Up



were significant from pre- to posttraining or follow-up, indicating that the two conditions improved comparably.

WWD

As shown in Table 3 and Figure 2, there were very large Time effects on trainees' WWD skill observed from pre- to posttraining, $F(1, 100) = 175.44, p < .001, \eta^2 = .64$, and pretraining to follow-up, $F(1, 100) = 86.12, p < .001, \eta^2 = .46$. More importantly, a significant Time \times Condition interaction indicated that experiential training led to a greater increase than standard training in the WWD skill from pre- to posttraining, with a small/medium effect, $F(1, 100) = 3.93, p = .05, \eta^2 = .04$. The condition difference on this skill was not maintained at follow-up, $F(1, 100) = 1.17, p = .28, \eta^2 = .01$.

There were also medium/large main effects of Time on the verbal fluency of the trainees' responses for the WWD skill from pre- to posttraining, $F(1, 100) = 17.58, p < .01, \eta^2 = .15$, and pretraining to follow-up, $F(1, 100) = 10.97, p < .01, \eta^2 = .10$. Very large effects of time on the focus/clarity of the trainees' responses for this skill were also observed from pre- to posttraining, $F(1, 100) = 79.47, p < .001, \eta^2 = .44$, and pretraining to follow-up, $F(1, 100) = 89.73, p < .001, \eta^2 = .47$. A significant Time \times Condition effect indicated that experiential training led to greater verbal fluency on this skill than did standard training at posttraining, showing a medium effect, $F(1, 100) = 7.87, p < .01, \eta^2 = .07$, but not at follow-up, $F(1, 100) =$

$0.89, p = .35, \eta^2 = .01$. The Time \times Condition effect for the focus/clarity of trainees' responses for this skill was not significant from pre- to posttraining, $F(1, 100) = 2.99, p = .08, \eta^2 = .03$, or to follow-up, $F(1, 100) = 1.60, p = .21, \eta^2 = .02$.

FAE

As shown in Table 4 and Figure 2, a very large main effect of time on trainees' FAE skill was observed from pre- to posttraining, $F(1, 100) = 389.22, p < .001, \eta^2 = .80$, and pretraining to follow-up, $F(1, 100) = 59.02, p < .001, \eta^2 = .37$. The significant Time \times Condition interaction indicated that experiential training led to a greater increase than standard training in the FAE skill (large effect), from pre- to posttraining, $F(1, 100) = 29.72, p < .001, \eta^2 = .23$; however, this effect was not maintained at follow-up, $F(1, 100) = 0.91, p = .34, \eta^2 = .01$.

There was also a main effect of Time on the verbal fluency of trainees' responses for the FAE skill from pre- to posttraining, $F(1, 100) = 10.40, p < .01, \eta^2 = .09$, and pretraining to follow-up, $F(1, 100) = 11.40, p < .01, \eta^2 = .10$. A main effect of time on the focus/clarity of the trainees' responses for this skill was also observed from pre- to posttraining, $F(1, 100) = 47.07, p < .001, \eta^2 = .32$, and pretraining to follow-up, $F(1, 100) = 59.10, p < .001, \eta^2 = .37$. There was a significant Time \times Condition effect for the verbal fluency of trainees' responses for this skill from pre- to posttraining, $F(1, 100) = 4.03, p = .05, \eta^2 = .04$, and

Table 3

Within-Condition and Between-Conditions Comparisons of the Working With Defenses Against Disclosure Skill (WWD) Outcomes From Pre- to Posttraining and Pretraining to Follow-Up

Outcome measure	Experiential condition ($n = 51$)		Standard condition ($n = 51$)		Time \times Condition Interaction		
	M (SD)	d_{within}	M (SD)	d_{within}	$F(1, 100)$	p	η^2
WWD skill							
Pre	1.91 (0.55)		1.98 (0.55)				
Post	3.09 (0.68)		2.86 (0.52)				
Follow-up	2.66 (0.66)		2.58 (0.52)				
Post-pre change	1.19 (0.90)	1.92***	0.88 (0.65)	1.64***	3.93	.05	.04
Follow-up-pre change	0.76 (0.75)	1.24***	0.60 (0.72)	1.12***	1.17	.28	.01
WWD verbal fluency							
Pre	2.36 (0.60)		2.36 (0.65)				
Post	2.73 (0.67)		2.44 (0.52)				
Follow-up	2.60 (0.65)		2.50 (0.52)				
Post-pre change	0.37 (0.57)	0.58	0.07 (0.50)	0.14	7.87	.01	.07
Follow-up-pre change	0.25 (0.61)	0.38**	0.14 (0.56)	0.24	0.89	.35	.01
WWD focus/clarity							
Pre	2.75 (0.95)		2.74 (1.01)				
Post	3.51 (0.53)		3.26 (0.70)				
Follow-up	3.47 (0.52)		3.29 (0.70)				
Post-pre change	0.77 (0.74)	1.03***	0.52 (0.72)	0.61***	2.99	.08	.03
Follow-up-pre change	0.72 (0.67)	0.98***	0.55 (0.69)	0.64***	1.60	.21	.02

Note. d_{within} is the within-condition effect size ([posttreatment or follow-up M —pretreatment M]/pooled SD of the two time points). η^2 is the between-condition effect size. All tests were two-tailed.

** $p < .01$. *** $p < .001$.

from pretraining to follow-up, $F(1, 100) = 7.81$, $p < .01$, $\eta^2 = .07$, such that the experiential training condition led to a greater increase in verbal fluency than the standard condition. The Time \times Condition interaction for the focus/clarity of trainees' responses for this skill was not significant from pre- to posttraining, $F(1, 100) = 0.49$, $p = .49$, $\eta^2 = .01$, but it was significant from pretraining to follow-up, $F(1, 100) = 4.85$, $p = .03$, $\eta^2 = .05$; the

experiential condition led to a greater increase in the focus/clarity than the standard condition.

Self-Report Measures

As shown in Table 5, a main effect of Time on trainees' self-efficacy on both scales was observed, such that trainees across both

Table 4

Within-Condition and Between-Conditions Comparisons of the Finding and Encouraging Experiencing of Adaptive Emotions Skill (FAE) Outcomes From Pre- to Posttraining and Pretraining to Follow-Up

Outcome measure	Experiential condition ($n = 51$)		Standard condition ($n = 51$)		Time \times Condition Interaction		
	M (SD)	d_{within}	M (SD)	d_{within}	$F(1, 100)$	p	η^2
FAE skill							
Pre	1.61 (0.49)		1.59 (0.47)				
Post	3.51 (0.60)		2.67 (0.72)				
Follow-up	2.28 (0.82)		2.11 (0.66)				
Post-pre change	1.90 (0.77)	3.49***	1.08 (0.76)	1.81***	29.72	<.001	.23
Follow-up-pre change	0.68 (0.86)	1.02***	0.53 (0.72)	0.92***	0.91	.34	.01
FAE verbal fluency							
Pre	2.37 (0.55)		2.35 (0.52)				
Post	2.65 (0.71)		2.41 (0.62)				
Follow-up	2.63 (0.64)		2.37 (0.58)				
Post-pre change	0.28 (0.54)	0.44***	0.07 (0.54)	0.11	4.03	.05	.04
Follow-up-pre change	0.27 (0.45)	0.44***	0.03 (0.43)	0.04	7.81	.01	.07
FAE focus/clarity							
Pre	2.92 (0.93)		2.95 (1.00)				
Post	3.55 (0.61)		3.46 (0.61)				
Follow-up	3.68 (0.48)		3.37 (0.81)				
Post-pre change	0.63 (0.83)	0.82***	0.52 (0.87)	0.63***	0.49	.49	.01
Follow-up-pre change	0.76 (0.80)	1.08***	0.42 (0.76)	0.46***	4.85	.03	.05

Note. d_{within} is the within-condition effect size ([posttreatment or follow-up M —pretreatment M]/pooled SD of the two time points). η^2 is the between-condition effect size.

*** $p < .001$.

Table 5

Within-Condition and Between-Conditions Comparisons of the Self-Report Outcome Measures From Baseline to 5-Week Follow-Up

Outcome measure	Experiential condition (<i>n</i> = 51)		Standard condition (<i>n</i> = 51)		Time × Condition Interaction		
	<i>M</i> (<i>SD</i>)	<i>d</i> _{within}	<i>M</i> (<i>SD</i>)	<i>d</i> _{within}	<i>F</i> (1, 100)	<i>p</i>	η ²
Self-efficacy (CASES)							
Baseline	6.47 (1.14)		6.78 (1.28)				
Follow-up	7.19 (0.97)		7.37 (1.10)				
Change score	0.72 (1.15)	0.68***	0.59 (0.79)	0.80***	0.42	.52	.00
Specific self-efficacy							
Baseline	6.41 (1.20)		6.94 (1.41)				
Follow-up	7.32 (1.17)		7.55 (1.43)				
Change score	0.91 (1.28)	0.77***	0.61 (0.98)	0.43***	1.75	.19	.02
Anxiety symptoms (PROMIS)							
Baseline	2.70 (0.73)		2.65 (0.74)				
Follow-up	2.68 (0.73)		2.36 (0.78)				
Change score	−0.02 (0.66)	−0.03	−0.29 (0.62)	−0.38**	4.53	.04	.04
Depression symptoms (PROMIS)							
Baseline	1.81 (0.67)		1.82 (0.76)				
Follow-up	1.82 (0.77)		1.64 (0.76)				
Change score	0.01 (0.73)	−0.01	−0.18 (0.51)	0.24	2.24	.14	.02

Note. *d*_{within} is the within-condition effect size ([follow-up *M*—baseline *M*]/pooled *SD* of the two time points). η² is the between-condition effect size. All tests were two-tailed. CASES = Counselor Activity Self-Efficacy Scales; PROMIS = patient-reported outcomes measurement information system.

p* < .01. *p* < .001.

conditions significantly increased in self-reported self-efficacy from baseline to follow-up on the original self-efficacy scale, $F(1, 100) = 45.16, p < .001, \eta^2 = .31$, and on the added skill-specific scale, $F(1, 100) = 44.53, p < .001, \eta^2 = .31$. The Time × Condition interactions were not significant for either the original scale, $F(1, 100) = 0.42, p = .52$, or the skill-specific scale, $F(1, 100) = 1.75, p = .19$. Regarding anxiety, however, both the Time effect, $F(1, 100) = 6.04, p = .02, \eta^2 = .06$, and Time × Condition effects were significant. Interestingly, as shown in Table 5, the experiential condition decreased *less* in anxiety from baseline to follow-up than the standard condition, $F(1, 100) = 4.53, p = .04, \eta^2 = .04$. Regarding depression, both the Time effect, $F(1, 100) = 1.80, p = .18$, and Time × Condition effect, $F(1, 100) = 2.24, p = .14$, were not significant. Finally, ratings of satisfaction with the training were very high across both training conditions. There was no significant difference in the trainees' ratings of satisfaction with the training for the experiential (posttraining $M = 5.80, SD = 0.25$; follow-up $M = 5.77, SD = 0.32$) and standard (posttraining $M = 5.79, SD = 0.35$; follow-up $M = 5.70, SD = 0.41$) conditions at posttraining and at follow-up.

Discussion

We designed a novel, experiential clinical approach to train mental health students to engage in challenging emotional processing work with patients, and compared this experiential training to a standard, didactic training of the same content in a randomized trial. Importantly, the experiential training is the first of its kind to focus on effective yet underutilized emotional processing clinical skills of eliciting disclosure, WWD, and accessing adaptive emotions. The experiential training is novel in that it combined educational components, deliberate practice, and live feedback while addressing trainee anxieties or barriers to skill implementation. Furthermore, this study used not only self-reported outcomes but more importantly,

observer-rated measures of the actual skills of trainees. Findings indicated that experiential training led to better skill performance outcomes than standard training, particularly right after training, which suggests the value of this experiential training.

Skills Assessment Findings

Trainees who received the experiential training developed and maintained, through follow-up, their skills of eliciting patient disclosure of difficult and traumatic experiences and showed more skill improvement compared to those in the standard condition at both time points. Furthermore, *from pre- to posttraining*, trainees in the experiential condition demonstrated more improvement than the standard condition in their skills of using direct inquiries to work through patients' defenses against disclosures, and strongly improved their skills of recognizing avoided, adaptive emotions and inviting patients to explore such emotions, compared to those in the standard condition. Thus, in general, given that trainees in the experiential condition were able to practice and receive feedback about their performance, their skills improved significantly more from *pre- to posttraining* compared to the standard condition; however, the two conditions no longer differed at follow-up on two of the skills: working with defenses and finding and encouraging adaptive emotions.

The fluency and clarity of trainees' inquiries about patients' difficult and traumatic experiences did not differ between the two training conditions across time points, likely due to the general brevity of responses for this skill (i.e., asking a direct question). When navigating patients' defenses/avoidance of disclosure, trainees' responses in the experiential group showed greater improvement in fluency and clarity from pre- to posttraining compared to the standard condition; however, the fluency and clarity of responses did not differ between the two conditions from pretraining to follow-up, though trainees in both conditions

generally maintained improvement at follow-up. Interestingly, trainees did not substantially differ in the fluency or clarity of their responses for the recognizing and eliciting patients' adaptive emotions skill from pre- to posttraining; however, from *pretraining to follow-up*, the trainees in the experiential condition were more likely to deliver their responses confidently, with less anxiety, and in a more focused manner compared to trainees in the standard condition.

An overall theme of the skill performance findings is that the experiential condition led to better skills compared to the standard condition from pre- to posttraining. These findings coincide with the broader training literature which suggests that practice, feedback, supervision, and addressing barriers to skill implementation generally lead to better outcomes (Bernard & Goodyear, 2014; Ellis, 2010; Herschell et al., 2010; Perlman et al., 2020). However, the training effects at posttraining were generally not maintained at 5-week follow-up, except for the effects on the skill of eliciting patient disclosure of difficult experiences, likely due to its simplicity (e.g., asking a direct question). Overall, it is impressive that a single, 1-hr session of training led to notable skill improvement, but it is not surprising that such brief training did not lead to longer term skill maintenance for most of the skill-based measures. It is likely that more practice is needed to improve the retention of the skills initially acquired through the brief training. Nonetheless, the findings strongly support the use of experiential techniques—with opportunities for practice, feedback, and reflection—in training mental health professionals in emotional processing skills. The study also demonstrated that using an online skill-building platform can help facilitate both learning and assessment of therapy skills.

The use of standard didactic training as our control condition was a rigorous design decision, which would require demonstrating that the new experiential approach was superior to a bona fide alternative rather than some relatively inert condition (e.g., waitlist, self-guided manual reading, or training focused on different content). It is noteworthy that the standard condition, which consisted of a lecture with skill examples and quiz questions, also was followed by improvement in trainees' skills. The vast majority of the trainees reported that the standard training covered material that was novel and valuable to them, and it received very high satisfaction ratings. Although the standard training condition did not include opportunities for practice, the presentation included specific examples of each skill, which may have served as a form of "modeling" for trainees and improved learning. Further, the individual nature of the training provided more opportunities for trainees to engage with the material and ask questions, compared to workshop or classroom formats, which tend to be largely ineffective when conducted in isolation (Frank et al., 2020; Taylor & Neimeyer, 2015).

Self-Report Findings

Trainees in both conditions reported comparable increases in self-efficacy from baseline to follow-up, for handling both general challenging therapeutic situations and ones specific to the skills taught in this study. Because trainees received only one of the two training conditions, their reports of changes in self-efficacy likely reflect the fact that they received a specialized training on a new and valuable topic compared to no training at all, and they could not directly compare the experiential to the standard training to note the former's additional strengths. It is noteworthy that the lack

of condition differences in self-reported self-efficacy stands in contrast to the differences between conditions in actual performance of the skills. This difference in outcomes highlights the value of measuring actual behavior or performance change, and not relying solely on self-reports, as is done in most studies of training and supervision. These findings also reinforce the importance of observing trainees' behavioral performance in clinical training and supervision rather than relying on their self-reports.

Interestingly, whereas self-reported anxiety after standard training decreased from baseline to follow-up, anxiety remained unchanged for those receiving experiential training. Thus, anxiety—but not depression—appears to be a potential consequence of this experiential training. It is well-known that a temporary increase in anxiety is an expected component of exposure-based psychological interventions (Foa, 2011), and a parallel process may occur in emotionally challenging psychotherapy training. Not only were trainees in the experiential training expected to practice skills with the trainer, but they were also provided with feedback about their performance, which may have contributed to greater self-awareness and self-evaluation. Such potentially anxiety-provoking experiences were absent from the standard training condition. Although the unchanged anxiety observed in the experiential condition trainees may suggest that they were more aware of their performance after the training, the trainees did not display fear or avoidance of using the skills taught, as evidenced by the behavioral skill assessments. Thus, the anxiety observed in the experiential condition trainees could signal their openness to change or to trying out a new experience, a vital aspect of psychotherapy skill training.

Feedback obtained from trainees immediately after their training session illuminates how experiential training can be a useful approach, even in the face of trainee anxiety. For example, the most consistent area for improvement of the training noted by trainees in the standard training condition was the lack of opportunities for practice and application of the skills (e.g., "For improvement, I would have liked the opportunity to practice generating responses to patient vignettes and get live feedback from the instructor as opposed to selecting prespecified, multiple-choice answers."). Feedback from trainees in the experiential training highlighted that the practice and supervision aspects of the training were well-received (e.g., "I really enjoyed the opportunity to practice these skills in session and to be able to get immediate feedback. This gave me the opportunity to reflect on my response to the patients, adjust it as needed on second thought, and to overall gain confidence in my ability to handle these types of situations."). Although trainees in the experiential condition reported performance-related anxiety due to the practice component of the training, they also reported gains in the face of the anxiety (e.g., "It made me anxious mostly because of the vulnerability surrounding showing and practicing skills in front of another person. I do feel proud that I was able to do it and excited that I can take these skills into my own practice," and another trainee reported "I was able to recognize some points of uncertainty in myself, and immediately started red-flagging them. I think it has made me evaluate the way that I have handled disclosure of traumatic experiences, things I have done well and things I could improve upon, and I am excited to be able to use these new skills with my patients, as I feel this has improved my confidence in my ability to handle these situations."). These reports are consistent with our observations that helping trainees learn to facilitate their patients' emotional processing, especially when patients are avoidant

or fearful, is both crucial and beneficial, even though often anxiety-provoking for trainees.

It is possible that if given more training time, rather than a one time-limited session, further practice, feedback, and processing could have improved the anxiety. Trainees should be encouraged to test their fears about exposure-based and emotion-focused skills in supervision and in actual clinical practice with patients. Experiential learning and “testing out” of skills will likely decrease trainees’ probability overestimation of negative outcomes and catastrophizing about implementing this challenging therapeutic work.

Limitations and Future Directions

The brief duration of the training is both a strength and a limitation. First, the brevity made it convenient for both trainers and trainees, but more experiential training is likely necessary to allow for addressing trainees’ anxieties and improving skill retention over time. Future studies might provide experiential training over multiple sessions or with booster sessions. Second, although the one-on-one nature of the training allowed for individualized feedback, such an approach may not be sufficiently time- or resource-efficient to be adopted into training programs. Future research should examine small-group experiential training approaches, where trainees can practice skills by role-playing with one another and provide feedback to each other as well as receive such from a supervisor. Third, beyond the basic emotional processing skills targeted in this study, it is important for future experiential training in emotional processing to include skills focused on helping patients not only identify important adaptive emotions, but to also experience and express such emotions. It is equally important to train mental health providers to value patients’ emotional experiences and be able to “sit with” patients’ emotions and model acceptance of such experiences, rather than quickly offering down-regulation strategies to patients. It is important to note that the three skills targeted in this study were microskills, and trainees were taught how to respond to specific and distinct clinical scenarios. The three skills do not directly reflect trainees’ abilities to practice exposure-based, experiential, or emotion-focused psychotherapies more broadly, but reflect trainees’ performance on these skills given the specific clinical scenarios utilized in this study. Finally, it is vital that future studies examine the impact of experiential training in emotional processing therapy skills on real-life therapy practice, and whether such training improves clinical outcomes for patients.

Implications and Conclusions

This study has several important implications for clinical training. There is a need for helping therapy trainees learn to elicit and facilitate processing of patients’ difficult experiences and emotions. Emotional processing skills are at the core of many effective psychological treatments and should be highlighted in training and supervision of therapists. More generally, there is a need for training that is experiential, especially for challenging patient encounters. Mental health training programs have ongoing opportunities to improve the quality of training of future clinicians, and adding components of experiential training, such as deliberate practice, feedback, and addressing barriers to skill utilization into individual or group supervision will improve trainees’ performance of clinical interventions. It is also recommended that short-term training events, such as

workshops or seminars, be reinforced by opportunities for practice and feedback from an expert or a supervisor over an extended period of time. Given the recognized value of emotional processing in so many therapies and the substantial value of emotional expression in psychotherapy generally (Peluso & Freund, 2018), it is vital that trainees be given experiential opportunities to develop the abilities to achieve therapy goals.

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Received March 15, 2023

Revision received June 1, 2023

Accepted June 2, 2023 ■