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Examining the Effectiveness of a Therapist Training on the Reflective Exploration of Parenting Interactions Tool

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by

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Abstract

The current study seeks to explore the impact of a therapist training on the Reflective Exploration of Parenting Interactions Tool (REPIT, Verona, 2015), a clinical, therapist-guided exercise that aims to improve parent insight, and in turn, facilitate a decrease in parent-child conflict. The REPIT was created as a therapy exercise in which parents are guided through a series of 19 standardized questions that build their insight into their own internal processes regarding conflict with their child. Specifically, the reflection encourages exploration of how the parental internal processes impact the parent-child relationship and interact with the child thought processes to create parent-child conflict. The purpose of this study is to develop a therapist training for the REPIT and determine appropriate training components, maximizing therapist learning while balancing training efficiency. Experimental and control groups are used, with both groups completing a pre- and post-training declarative knowledge measure. The

experimental group underwent a 3-hour interactive didactic workshop, and the control group did independent review of written materials only.

The results suggest that both training methods were effective in demonstrating improvements in declarative knowledge of the REPIT, but that there were no significant differences in therapist proficiency between the training conditions. A primary limitation of the study was regarding construction of the outcome measure. Item analysis indicated that the items were low in difficulty, that some items did not discriminate low- and high-scorers adequately, and that not all of the items contributed to the overall test score significantly.

Keywords: REPIT, Reflection, Interaction, Tool, Parent-child, Conflict, Training, Workshop, Perspective-taking, Theory of Mind

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Chapter 1

Introduction

This study explored effectiveness of a therapist training on a psychological intervention for parent-child conflict. First, review of the current literature on therapist training models is offered, covering training on evidence-based practice (EBP), empirically supported treatments (ESTs), and dissemination and implementation. These concepts lead to the development of various training formats for the proposed intervention, the Reflective Exploration of Parenting Interactions Tool (REPIT). Next, an overview of the tool itself is offered, including discussion of its purpose. Finally, the training model developed for the REPIT is outlined.

Therapist Training on Specific Interventions

Terminology and scope. Many different terms are used to describe interventions that have been supported by research. This paper will use the term *evidence-based practice* (EBP) to describe "the integration of the best available research with clinical expertise" (American Psychological Association [APA], 2008). Next, the term *empirically-supported treatments* (ESTs) will refer to researched interventions that have conformed to scientific research criteria as outlined by Chambless and Hollon (1998). Finally, there is a body of research that explores dissemination and implementation of EBP, exploring how training is distributed to therapists and adopted into practice (Beidas & Kendall, 2010). The purpose of the current study is most aligned with dissemination and implementation research, informing the development of appropriate

training materials for the REPIT. This research stands to contribute to future exploration of the effectiveness of the REPIT intervention as a whole.

Dissemination and implementation research overview. A 2010 review article written by Beidas and Kendall outlines research on dissemination and implementation of EBP, including exploration of outcomes related to training components (e.g., workshop versus web training versus manual versus supervision), workshop teaching method employed (e.g., passive, lecture-oriented therapist training versus active learning strategies), training content (e.g., details of sessions or focus on overall principles), and type of outcome measure used (e.g., self-report questionnaire versus independent observation). These components were outlined for each of the studies that were reviewed (all based on therapist training in specific psychological interventions).

Training components. Components of therapist trainings that studies have explored have included workshop, a web training, a manual, or clinical supervision (Baer, Rosengren, Dunn, Wells, & Ogle, 2004; Beidas, Barmish, & Kendall, 2009; Cross, Mattheiu, Cerel, & Knox, 2007; Gega, Norman, & Marks, 2007; Hawkins & Sinha, 1998; McVey et al., 2005; National Crime Victims Research & Treatment Center, 2007; Sanders, Murphy-Brennen, & McAuliffe, 2003; Sholomskas, Syracuse-Siewart, Rounsaville, Ball, & Nuro, 2005). Sholomskas et al. (2005) identified that the gold standard for therapist training is a workshop, a manual, and clinical supervision. A cutoff score that has been used in the measurement of therapist proficiency is 80% (Beidas & Kendall, 2010). However, each of the studies outlined above had difficulty with the therapist trainees achieving proficiency at the 80% level. There was some variation in these findings related to differences in outcome measures used.

Workshop teaching methods. Within a workshop training model, studies have explored trainings that involved passive, didactic lectures as well as trainings that have included more interactive learning activities (experiential learning, role-plays, computer exercises). Research has supported the incorporation of more interactive learning activities, as didactic instruction has limited impact on behavior change (El-Tannir, 2002), and interactive learning is particularly helpful for the acquisition of clinical skills (Cross et al., 2007). Sholomskas et al. (2005) explored differences in knowledge, adherence, and skill acquisition for different training regimens (a. manual only, b. manual and web training, or c. manual, didactic training, and supervision). These conditions yielded improved knowledge, adherence, and skill as the training components increased. However, even with the highest dose training, only 54% of therapists reached proficiency in adherence and skill, and knowledge outcomes were not significantly different between groups. Additionally, competence was not observed to improve between those who received post-training supervision and those who did not.

Training content. Within didactic-style training, limitations of current dissemination and implementation research exist around differences in training content for specific psychological interventions. Some trainings of EBPs detailed session-by-session protocol, while others taught overall principles and the theory underlying the intervention. A limitation of the current research is on outcome differences between these two approaches of didactic-style training. However, perhaps the impact of these finer differences is decreased or overshadowed by the significant differences found between either didactic style and a more interactive learning style (with more favorable outcomes associated with the latter; Cross et al., 2007; El-Tannir, 2002).

Outcome measures.

Self-report. Regarding outcome measures used in therapist training, most studies have used self-report measures of knowledge, satisfaction, and comfort with the tool, as well as provider perception of alliance, adoption, and burnout (Crits-Cristoph et al., 1998; Henry, Strupp, Butler, Schacht, & Binder, 1993; Moyers et al,, 2008; Sanders et al., 2003; Sholomskas et al., 2005). Some of these were standardized psychometrically sound measures, and some included investigator-created non-standardized measures.

Declarative knowledge measures. Still another type of outcome measure that has been used is a measure of declarative knowledge (a content-focused test) given to the therapist after the training to assess how much was learned. Declarative knowledge measures are helpful in identifying the factual knowledge that an individual has at baseline. More specifically, pre-training questionnaires may be helpful in identifying how much individuals know prior to the training (Abu-Zaid & Khan, 2013; Hailikari, Katajavuori, & Lindblom-Ylanne, 2008; Sternberg, 2014). Pre-test scores can serve as a helpful comparison standard to assess the amount of knowledge participants acquired through a training, using performance change scores between pre- and post-test (Rittle-Johnson, Star, & Durkin, 2009; Sternberg, 2014).

Independent observation. More rigorous studies included independent observation of the therapist during a role play and used a coding system for therapist adherence, skill, competence, interviewing style, therapist characteristics, or interpersonal processes (Bein et al., 2000; Henggeler et al., 2008; Henry et al., 1993; Miller, Yahne, Moyers, Martinez, & Pirritano, 2004; Morgenstern, Morgan, McCrady, Keller, & Carroll, 2001; Schoener, Madeja, Henderson, Ondersma, & Janisse, 2006; Sholomskas et al., 2005; Siqueland et al., 2000). Independent

observation addresses concern that knowledge change is different than behavior change, and that knowledge change does not always lead to behavior change (Miller, Sorensen, Selzer, & Brigham, 2006).

Regarding the outcomes of therapist training research using independent observation, this body of research has yielded less noticeable differences pre- to post-training than those using therapist self-report (Miller & Mount, 2001). In addition, there is a broader range of skill levels using independent rating (from poor to good; Morganstern et al., 2001). This research has also identified a training difficulty with sustaining adherence and skill over time. Some studies demonstrated mixed findings with adherence being sustained at follow-up (Henggeler et al., 2008; Luoma, Hayes, Twohig, et al., 2007). Several studies using independent observation show more promising results, however. First, Miller et al. (2004) used observational versus self-report measures to measure outcomes of a training in motivational interviewing (MI). In this study, a delayed-training waitlist group demonstrated modest gains in observed proficiency. These gains were sustained through follow-up post-training. However, therapist self-reports of MI skillfulness did not relate to proficiency levels observed in practice. Second, Miller and Mount (2001) used both self-report and observational measures with findings that demonstrated retention at four-month follow-up. Third, Schoener et al. (2006) showed improved skill and intervention-consistent behavior (though therapists did not achieve proficiency). Fourth, Henry et al. (1993) explored independently observed outcomes of four training conditions (two-day workshop, two-day workshop and videotape feedback, two-day workshop plus six coaching sessions, and two-day workshop plus coaching and feedback). All four conditions increased therapist competence, and results were sustained at four-month follow-up for all groups except

the workshop-only group. In addition, the groups receiving feedback and/or coaching reached proficiency in intervention spirit and intervention-consistent responses. Finally, client responses were also improved in the most intensive training group, with the largest effect being a decrease of intervention-inconsistent therapist responses.

Despite the mixed findings of therapist training research using independent observation, this methodology is considered the most rigorous form of outcome measurement, given its ability to address limitations of therapist self-report, and its ability to address the limitations of measurements of declarative knowledge (most notably being the concern that knowledge change is different than behavior change, and that knowledge change does not always lead to behavior change).

Conclusion. In sum, research on therapist trainings has explored the influence of various training components (didactics, interactive workshops, manual, coaching, supervision), various outcome measures (self-report satisfaction, confidence, declarative knowledge measures, observer report protocol adherence, etc.), and still other variables associated with knowledge acquisition. While findings have been mixed, generally interactive workshops plus follow-ups with individual coaching and supervision have found some of the most promising results. As far as outcome measures go, self-report satisfaction and competence yielded higher proficiency rates than observation, but both yielded sustained gains over four months following the training. In order to further inform the development of appropriate training materials, this discussion will now turn to exploration of therapist trainings used for other psychological interventions that specifically target parent-child interactions. Several other training models for commonly used parent-training EBPs will be explored. First each EBP will be described, followed by a focus on

the therapist-training components and related outcome measures used in training therapists on the EBP.

Overview of Training Models for other Parent-Training EBTs

There are several commonly used EBPs with parent-training components, the most common which are summarized below (Parent-Child Interaction Therapy, Collaborative Problem Solving, and Parent Management Training/Problem Solving Skills Training). Along with a general outline of the EBP, training modalities for certification in each EBP are described.

Parent-child interaction therapy (PCIT; Eyberg, 1988). PCIT is an interactive intervention with parents and their children, seeking to improve the quality of the parent-child relationship by transforming the parent-child interaction patterns. PCIT utilizes a combination of behavioral therapy, play therapy, and parent training in order to facilitate more effective discipline techniques and improvement of the parent-child relationship (McNeil, Filcheck, Greco, Ware, & Bernard, 2001).

Structure of PCIT. Herschell, Calzada, Eyberg, and McNeil (2002, p. 10) described that treatment is completed in 10 to 16 weekly, 1-hour sessions. A comprehensive PCIT treatment program includes (a) a pretreatment assessment of child and family functioning; (b) feedback, teaching, and coaching of parents in the CDI skills; (c) teaching and coaching of parents in the PDI skills; (d) teaching generalization skills; and (e) a posttreatment assessment of child and family functioning. Follow-up assessments are recommended, and booster sessions should be provided, if needed.

Therapist certification in PCIT. Varying levels of formal certification exist, with trainings outlined by PCIT International (PCIT International, 2016). In addition, PCIT

workshops are offered at venues such as national conferences or community mental health centers. In order to administer PCIT as a certified practitioner, the clinician must have accomplished a minimum of 40 hours of face-to-face training with a Certified Master Trainer or Level II Trainer. These trainings are hands-on and can also occur within a co-therapy format with a Certified Level 1 Trainer. Some trainings are a workshop format in which face-to-face interactions occur and others can be administered with online training modules.

These trainings must occur a minimum of two times per month and can occur with in-person supervision with a Certified Level 1 Trainer (with one individual or in a group) or via phone or web-conferencing with a Certified Master Trainer or Level 2 Trainer. Live case observation and feedback or video review must occur with four PCIT sessions from a Certified Level 1 Trainer.

PCIT training materials. Outside of formal certification, text and video training materials have also been created, which are outlined here. Regarding text-based training materials, Eyberg and Calzada (1998) authored a comprehensive treatment manual. In addition, Hembree-Kigin and McNeil (1995) authored a textbook that outlines PCIT and provides recommendations for implementation. Video-based trainings are also available (APA, 2008; Herschell et al., 2002; PCIT Web Course, 2016).

Collaborative problem solving (CPS; Greene & Ablon, 2006). Another established EST is CPS, which encourages adults to work together with kids to solve problems in skill-building and mutually beneficial and pragmatic problem-solving. In this way, CPS involves increased reciprocity. Behavioral challenges of children and adolescents are addressed with skill development such as problem-solving, flexibility, or frustration tolerance. Also, parents receive

instruction around reasons for their child's problem behavior, improving positive attention, and giving effective parental commands (Greene et al., 2004). Four implementation steps of the CPS model have been described (Pollastri, Epstein, Heath, & Ablon, 2013): (a) Identify and understand the child's concern about the problem to be solved and reassure him or her that imposition of adult will is not how the problem will be resolved, (b) Identify and share the adults' concerns about the same issue, (c) The child is invited to brainstorm solutions together with the adult, (d) The child and adult work together to assess potential solutions and choose one that is both realistic and mutually satisfactory. Through this approach, CPS uses a reciprocal interaction to solve problems that are catalysts for challenging behavior, in a durable way, while improving relationships, thought processes, motivation and confidence.

Structure of CPS. Greene, Ablon, and Goring (2003) describe that CPS is manualized, but session content and duration are not circumscribed. Greene et al. (2004) further described, "Rather, in keeping with calls for greater matching of therapeutic ingredients to the needs of individual children and families, therapists chose from among six treatment dimensions in determining the specific content of each session," (Greene et al., 2004, p. 1158. Within each session, therapists have a choice to focus on any combination of such five treatment modules as, (a) educating adults about "pathways" to non-compliant behavior; (b) educating parents about appropriate parent decision-making in instances of parent-child conflict; (c) medication education (helping adults understand that some pathways may be more effectively treated pharmacologically); (d) family communication (identifying and altering communication patterns (e.g. sarcasm) that may fuel oppositional outbursts; and (e) cognitive skills training (remediating additional cognitive issues that are not otherwise being addressed. CPS has been developed in

this flexible way so based off of their assessments, therapists can identify the needs of each child and their family. Furthermore, this component of CPS enhances the ecological validity of this approach.

Therapist training in CPS. In order to become certified in CPS, therapists must complete Tier 1 and Tier 2 training, which include training alongside two Certified Trainers and conducting a full day Introductory Training on their own. If necessary, an additional two-hour overview may be requested. Participants have access to all official training materials for introductory and Tier 1 trainings. In order to become a Certified Trainer, all three steps must be completed.

CPS training materials. CPS is also manualized, but session content and duration are not circumscribed. A participant must complete such certification requirements as reviewing a video-recording that is 10-45 minutes long and individualize feedback will be provided before the next recording is submitted. In order to advance to the next step, three recordings are required to be completed. In Step 3, 12 sessions of group supervision are required and these sessions are held for one hour every other week. Within these supervision groups, each participant will present cases and receive feedback from the facilitator as well as colleagues within the certification program. In Step 4, participants must complete two one-hour teleconferences. Within this teleconferences, applicants are presented with vignettes and asked to answer questions and provide guidance to the presenter as if they were supervising a case using the CPS model. Feedback and coaching are provided to the participant and within two coaching meetings, baseline criteria for competence are necessary to advance to the next step. Within the fifth step, measures of declarative knowledge utilized to assess whether participants are able to effectively

address common but challenging questions about the CPS approach. Following successful completion of a brief quiz, participants can serve as qualified CPS Certified Practitioners.

Parent management training and problem-solving skills training (PMT & PSST; Kazdin, Esveldt-Dawson, French, & Unis, 1987). Still other evidence-based treatments have included components for alleviating parent stress responses directly. PMT involves extensive parent involvement, and is described as "one of the most well-studied therapies for children with oppositional defiant disorder and conduct disorder," (Kazdin, Whitley, & LaGreca, 2006). Kazdin and Whitley (2003) found that building parent problem-solving through PMT was effective in reducing stress for parents when paired with PSST for treating their child. In their study, PMT improved parent problem-solving, and served to remedy stress associated with the child's behavioral concerns. Kazdin's model focuses on teaching and reinforcing prosocial problem solving skills among children with disruptive behavior disorders in order to promote their ability to effectively manage potentially volatile interpersonal situations. Within the sessions, participants learn problem solving skill training through practice, modeling, role-playing, corrective feedback, and social and token reinforcement (Nock, Ferriter & Holmberg, 2007).

Structure of PMT/PSST. Kazdin et al. (2006, p. 346) described the structure of PMT as follows:

> In PMT, the therapist and the parent meet for each session and interact directly as part of the process of developing effective parenting practices in the home. "Inept" parenting practices before treatment are associated with child noncompliance and aggression, and improved parenting practices following PMT are associated with the reduction of those

> behaviors... Each treatment lasted for approximately 12 sessions (weekly basis, administered individually). Occasionally, however, optional sessions were provided to address a skill or problem area within the session or to complete a session that was curtailed as a result of parent lateness.

Therapist training in PMT/PSST. Certification is offered in Parent Management Training (PMT), in which a practitioner must complete (either in person or via webinar) Basic PMT Training and an Advanced PMT Training (Parent Management Training Institute, 2016). Kazdin (2008) also authored a manual for use in the certification process, *Parent Management Training: Treatment for Opposition, Aggressive and Antisocial Behavior in Children and Adolescents*. The first half of this book outlines the research supporting PMT while the second half of the book serves as a manual to be completed throughout the ten one-on-one sessions. Then, a therapist is to complete ten individual training sessions with a certified trainer. A maximum of five of these sessions may be added at the discretion of the instructor. These training sessions will incorporate such concepts as modeling, observation, charting, challenging questions, being creative, building confidence, case supervision, and sending in audio or video recordings of sessions. In order to sustain the integrity of the treatment, (a) therapists followed a treatment manual that delineated each session; (b) each therapist saw training cases in each condition; (c) materials were provided to foster correct execution, including checklists that prescribed the necessary materials for each session, the specific themes or tasks, and in-session notes and outlines; (d) documentation of the session summarized what transpired and how the child or parent progressed; and (e) ongoing clinical supervision…"

PMT/PSST training materials. As stated above, Kazdin authored a manual for use in the PMT/PSST certification process, *Parent Management Training: Treatment for Opposition, Aggressive and Antisocial Behavior in Children and Adolescents* (2008). The first half of this book outlines the research supporting PMT while the second half of the book serves as a manual to be completed throughout the ten one-on-one sessions. Training videos are also used (Yale Parenting Center, 2016). Training materials have not yet been published for PSST, though instructions are described in "Problem-Solving Skills Training and Parent Management Training for Oppositional Defiant Disorder and Conduct Disorder," (Zisser & Eyberg, 2010).

Summary. In sum, the most commonly used behavioral and cognitive-behavioral parent training interventions use a variety of therapist training components and outcome measures to ensure therapist proficiency, with 80% proficiency being a standard training outcome cutoff for therapists training to use these types of tools. In general, multiple training modalities are used (interactive didactic-style training as well as manual review and in some cases, supervision). At this point, this paper has covered therapist training components generally, as well as therapist training components for commonly used psychological interventions specific to parent-child conflict. As a final domain of study prior to outlining the proposed therapist training for REPIT, the following section seeks to provide a general outline of the REPIT, followed by theoretical underpinnings that informed its development.

Structural Overview of the REPIT

Components of established ESTs. Many commonly used behavioral interventions are built on core assumptions drawn from Applied Behavior Analysis, Social Learning Theory, and cognitive-behavioral theory more generally. These approaches adhere to the assumptions that

persistent conditions of behavior are maintained in the current environment, and that unobservable or cognitive behaviors also cause behavioral issues (Watson & Gresham, 1998). Many evidence-based child-focused interventions have demonstrated effectiveness in improving child problem behaviors (Barkley & Benton, 2013; Reid, Trout, & Schartz, 2005; Ware, Fortson, & McNeil, 2003), though few include formal components that improve parent identification of their own negative thoughts and assumptions, in turn influencing their interactions with their child. However, most rely on establishment of the parent-child relationship as a necessary precursor to effective child behavior interventions (Barkley, Edwards, Laneri, Fletcher, & Metevia, 2001; McNeil & Hembree-Kigin, 2010; Nixon, Sweeney, Erickson, & Touyz, 2003). The following sections outline established ESTs and describe the therapist training models and materials associated with it.

Reflective Exploration of Parenting Interactions Tool (REPIT). The REPIT (Verona, 2015) is used to help parents explore their perceptions of their child or adolescents' maladaptive behaviors, and how their own beliefs and perceptions about their child influence relational conflict. The process outlined above is facilitated by 19 open-ended questions to the parent from the therapist during an interview-style intervention. This intervention encourages the parent to enter into the mind of their child and explore ways in which they can think positively about their child and foster behaviors that support these thoughts. The proposed clinical, therapist-guided exercise, leads the parent through the following reflective process. First, the overall structure of the REPIT is outlined in order to provide the reader with a framework with which to better understand the theoretical underpinnings of the REPIT. After the outline of REPIT structure,

purpose and theoretical foundations are described. For clarity, the questions are here divided into five parts with a description and rationale provided for each part.

Part I. First, the parent identifies what they think is the source of the conflict. Typically, this is a problem behavior that the child is engaging in. The parent is encouraged to phrase their thoughts in a belief statement, diffusing the thought in order to look at the behavior more objectively. They reflect on their emotional response and other impacts of the behavior, a necessary step before they develop more insight into influences on their emotional response.

1. Think of a behavior or characteristic about your child which you would like to see change and complete the following: Child's Name is/does …
2. Now put this into a belief statement which may or may not include the reason for this behavior: I believe my child …
3. What emotions arise when you think about the above-stated belief?
4. Please rate the intensity of these emotions on a scale from 0-10 as you sit here and think about your belief statement (#2).
5. The behavior occurs (frequency): _____
6. The above negatively impacts my child and my relationship (rates 0-5, *strongly disagree – strongly agree*).
7. This behavior or characteristic impacts our family (rates 0-5, *strongly disagree – strongly agree*).

Part II. In the second set of questions, the parent is asked to reflect on their own emotions and thoughts toward their child and the situation. This reflection is aimed at helping the parent be mindful of their own thoughts and values. Then, they begin to explore their child's thoughts and

values, engaging in perspective-taking. For example, a parent and teen may have ongoing conflict about the teen's responsibility (e.g., homework or chore completion). When the parent is asked to reflect on their own thoughts toward their child, the parent may begin to discuss worries for the child's future. The parent may then say, "I think Child's Name believes that other things are more important to him, that he's too busy and tired to do the things I want them to."

8. I am concerned about the long-term effects of this behavior (rates 0-5, *strongly disagree – strongly agree*).
9. I currently believe that I am having a positive impact on this behavior (rates 0-5, *strongly disagree – strongly agree*).
10. What do you think your child believes about themselves in regard to this behavior or characteristic? Complete the sentence. I think Child's Name believes …

Part III. In the third set of questions, the parent is asked how the child thinks the parent views them. For example, the parent may say, "Oh, my son would say, 'Mom just thinks I'm lazy and selfish.'" The parent is also asked what behaviors they demonstrate that lead the child to think they believe that. This often leads into parent exploration of their own history and experiences, and how those influence their conflict with their child. In addition, parents explore what current communication patterns and behavior toward their child are contributing to the conflict. Influenced by Acceptance and Commitment Therapy approach (Hayes, Pistorello, & Levin, 2012), the parent is given the opportunity to identify their personal values that guide their actions. By assessing which communication patterns and behaviors are incongruent with their own values, the parent grows better able to understand how their history and experiences with

the environment have influenced their values, beliefs, and perceptions, and recognizing how these influence their thoughts, behaviors, and language with their child.

11. Now enter into the mind of your child. From your child's perspective, what does your child think YOU believe about them, in regards to this same behavior? If your child were speaking to someone, what would they say? (Please express in your words. Don't worry if your child would actually speak in this way.) Complete the sentence: My mom/dad believes I'm …
12. What behaviors do you demonstrate that would lead your child to think that this is what you believe about them? Think about what you say, what you do, your facial expressions, etc. Complete the sentence: Child's Name believes that I think this because I …

Part IV. Fourth, the parent explores what they would prefer their child to be thinking instead (e.g., "I want my son to know that I think he is capable and able to have an impact in his own world."), and begins building motivation to make needed change.

13. What would you like them to believe about themselves? Complete the sentence: I would like Child's Name to believe …
14. What would you like them to think that you believe about them? Complete the sentence: I want Child's Name to believe I think they are …
15. Do you believe it is currently possible for your child to develop this belief about themselves?
16. Are you prepared to do what it takes to support the development of this new belief?

Part V. In the last set of prompts, the parent quantifies what they want to do differently and sets goals about their expectations of themselves and of the outcome. They also plan ahead for any limitations that may arise, identifying potential solutions.

17. What actions can you take to show and support the development of this new belief?
18. Please guess what percentage of the time during the next week you expect to successfully apply your new behaviors.
19. Please guess what percentage of the time during the next week you expect to see an improvement in your child's behavior.
20. What else do YOU need to successfully apply your new behaviors within your parenting interaction?

Because of their intentional reflection on their own history and experiences, the parent may be better able to maintain better emotional composure and de-intensify parent-child conflict. Finally, through the reflective process, the parent develops the ability to change maladaptive parenting patterns and behaviors, moving to better communication of their desired message.

As stated above, these five parts and 19 questions work together to help parents explore their perceptions of their child or adolescents' maladaptive behaviors, and how those influence relational conflict.

Conclusion. With the aim to help parents explore their perceptions of their child or adolescents' maladaptive behaviors, and how their own beliefs and perceptions about their child influence relational conflict, the REPIT uses 19 open-ended questions (divided into five parts) during a therapist-to-parent interview-style intervention. This intervention encourages the parent to enter into the mind of their child and explore ways in which they can think positively about

their child and foster behaviors that support these thoughts. In Part I, the parent identifies what they think is the source of the conflict. They reflect on their emotional response and other impacts of the behavior, a necessary step before they develop more insight into influences on their emotional response. In Part II, the parent is asked to reflect on their own emotions and thoughts toward their child and the situation. This reflection is aimed at helping the parent be mindful of their own thoughts and values. Then, they begin to explore their child's thoughts and values, engaging in perspective-taking. In Part III, the parent is asked how the child thinks the parent views them. The parent is also asked what behaviors they demonstrate that lead the child to think they believe that. This often leads into parent exploration of their own history and experiences, and how those influence their conflict with their child. In addition, parents explore what current communication patterns and behavior toward their child are contributing to the conflict. In Part IV, the parent explores what they would prefer their child to be thinking instead (e.g., "I want my son to know that I think he is capable and able to have an impact in his own world."), and begins building motivation to make needed change. Finally, in Part V, the parent quantifies what they want to do differently and sets goals about their expectations of themselves and of the outcome. They also plan ahead for any limitations that may arise, identifying potential solutions. To provide more context out of which this REPIT intervention was developed, the theoretical foundations are now discussed.

Theoretical Foundations

Acceptance and commitment therapy. Many of the REPIT principles align with principles outlined in ACT including: behavioral congruence with values, acceptance, defusion,

and self-as-context. The Association for Contextual Behavioral Science citing Hayes (2016) defines ACT as:

> a unique empirically based psychological intervention that uses acceptance and mindfulness strategies, together with commitment and behavior change strategies, to increase psychological flexibility. Psychological flexibility means contacting the present moment fully as a conscious human being, and based on what the situation affords, changing or persisting in behavior in the service of chosen values.

***Behavioral congruence with values*.** The parent explores how their own history and experiences influence their conflict with their child, and what current communication patterns and behavior toward their child are contributing to the conflict (Hayes, 2016). The parent also has the opportunity to identify personal values that guide their actions. By assessing which communication patterns and behaviors are incongruent with their own values, the parent builds insight and recognition into the impacts of their thoughts, behaviors, and language on their interactions with the child.

***Acceptance*.** ACT also focuses on accepting circumstances that one is unable to control or change externally. The goal of this phase of ACT is not the static accomplishment of a particular set of behaviors. Rather, the key is an ongoing process of accepting, choosing, and taking action (Hayes et al., 2012). Regarding application in the REPIT, there are times in which parents feel minimal control over their child's behaviors, resulting in increased distress for the parent during conflict. The ACT practice of acceptance is reflected in the REPIT, particularly the concept that whether or not changes occur in external behavior or circumstances, the parent's ability to think about the conflict differently can decrease their distress and build their ability to

practice acceptance of the parts of the child or conflict that are difficult to change. As a result of intentionally accepting circumstances that may not be ideal, the parent may experience less internal tension and become more open to engaging in adaptive behaviors rather than avoidant or confrontational behaviors.

Defusion. Often times, clients experience pain with struggling within their private internal experiences. These thoughts are taken literally and stories are created to justify and explain their actions. As a result, amplification of this suffering occurs and rigidity of responding become difficult to overcome. In order to create greater psychological flexibility, by discerning words in a nonliteral context, clients are able to loosen the relationship between their thoughts. Within Acceptance & Commitment Therapy (ACT), defusion is the method of creating nonliteral contexts in which language can be observed as active, ongoing, and within a relational process. As Luoma, Hayes, and Walser (2007) suggest, "Language can be observed in the moment as language: we can watch what the mind says, rather than be a slave to it…We do not have to be driven by our words" (p. 18). Defusion works to still validate the experience of thoughts and emotions while having a more mindful perspective of them. It is important to look at thoughts and emotions while having a more mindful perspective of them. It is important to look at thoughts through a mindful perspective with greater behavioral flexibility in order to gain greater contextual control over them.

Within the REPIT, similar to defusion, clients are encouraged to intentionally observe their thoughts and emotions in a way that is looking *at* them rather than *from* them. As a result, clients will become less fused to these thoughts and identify ways in which they value behaving

with their child rather than acting as a product of their reaction to how they perceive their child is feeling.

Self-as-context. Within Acceptance & Commitment Therapy (ACT), there are experiential exercises and metaphors that help individuals contact the sense of self-as-context (Hayes, 2016). Self-as-context refers to the idea that each individual has a continuous and secure *I* from which they experience events. The person is distinct from those events and the goal in noticing this is to help develop a more solid sense of ourselves as individuals who observe or experience events, independent from the particular experiences being had in that moment. By gaining a greater sense of present moment awareness, clients are able to more intentionally experience ongoing, nonjudgmental contact with psychological and environmental events as they occur in the moment. As a result, they may be able to live less within the conceptualized past or future and more in the present moment by being less conceptual, fused, and more responsive. With less contact to the present moment, client's behaviors tend to be more driven by fusion, avoidance, and rationalizing, which results in continuing patterns of behaviors similar to other behaviors that have occurred in the past.

Within the REPIT, by encouraging parents to notice their thoughts of past experiences that may be dictating their present perceptual moments, individuals are able to discern what is presently happening with less judgment and more psychological flexibility. By having less judgment, parents will be better able to struggle less when they are experiencing events and more fully be engaged in the present moment with their children.

Overall, to best understand the theoretical underpinnings of the REPIT, correlations are drawn to the theoretical foundations of ACT. ACT concepts of behavioral congruence with

values, acceptance, defusion, and self-as-context components woven through the REPIT exercise, and assist the parent in exploring and managing their own thought processes and responses.

Relational importance of understanding the other. Similar to the core processes of ACT and more specifically, self-as-context, the concept of perspective-taking is helpful in recognizing that others' thoughts and internal processes are different between two individuals within the same experience. Understanding the perspective of the other person is an important general relationship skill and conflict-resolution skill. Perspective-taking can be thought of as, "actively considering a particular situation—or the world more generally—from another person's point of view." (Batson & Shaw, 1991 as cited in Goldstein, Vezich, & Shapiro, 2014).

Galinsky, Ku, and Wang (2005) outline that intentionally being less judgmental and coordinating ourselves to be more in sync with another person cause us to maintain more satisfying social bonds and social harmony. Further, empathizing with another person through perspective-taking strategies fosters connectedness and cognizance about how the other person may feel (Farrant, Devine, Maybery, & Fletcher, 2012). Next, Goldstein et al. (2014) identify how perspective-taking increases self-other overlap, enhancing empathy for the other. Conversely, empathy for another individual is essential when making an effort to understand the other's perspective (Greiner, 2011).

Related to perspective-taking, is the concept of theory of mind. Theory of mind refers to the mental processes involved in understanding mental and emotional states, and how they contribute to our own and other's behaviors and perspectives (Ontai & Thompson, 2008). In line with parental hopes that children become able to consider others' feelings and perspectives,

parents can model these reflections on interaction with the child. By doing this reflection, parents are better able to understand their child's needs, frustrations, and concerns when conflict arises. For example, parents may gain awareness that these behaviors are related to the child's deeper desire to satisfy some need, rather than a direct effort to frustrate the parent. As a result, parents may become less reactive by focusing their attention on their child's unique perspective, rather than their own.

Parent-child Conflict Theory.

Interaction of factors in parent-child conflict. Extensive research posits that parent-child conflict is associated with family functioning through its impact on parent-child relationship satisfaction, marital stability, individual physical and psychological health, and overall wellbeing (Anthony et al., 2005; Sandler, Wheeler, & Braver, 2013). In addition, there is a confluence of other factors that interact to impact parent-child conflict. Conflictual interchanges are influenced by parent maladjustment (Finzi-Dottan, Manor, & Tyano, 2006; Rossman, Hughes, & Rosenberg, 2000), child maladjustment (Clark, Watson, & Mineka, 1994; Hawes & Dadds, 2005; McNeil & Hembree-Kigin, 2010), biological factors such as hypo- and hypercortisolism (Sturge-Apple, Davies, Cicchetti, & Manning, 2012), and even parental marriage quality (Zimet & Jacob, 2001). Deković (1999) found that particular personality characteristics and temperaments, such as demonstrating being overly reactive (Barrett, Fox, & Farrell, 2005; de Haan, Soenens, Deković, & Prinzie, 2012; Yücel et al., 2012) greatly increase the amount of conflict between mothers, fathers, and adolescents unidirectionally.

Further, conflict between family members is not unidirectional, but occurs in reciprocal exchanges. For instance, research has found that when children demonstrate more adaptive

emotional regulation, parents' supportiveness in emotional discussions increases. Also, children demonstrated more adaptive emotional regulation when parents were more supportive (Emery, Fincham, & Cummings, 1992; Morelen & Suveg, 2012; Saxbe, Ramos, Timmons, Rodriguez, & Margolin, 2014; Schermerhorn, Cummings, & Davies, 2008). Next, Zimet and Jacob (2001) found that parent marital relationship quality is impacted by child maladjustment. Additionally, the match of parent and child temperament plays a role in both child adjustment (Ramos, Guerin, Gottfried, Bathurst, & Oliver, 2005) and parent-child conflict (Rossman et al., 2000). The reciprocal interplay of these many family system factors influences parent-child conflict and family adjustment as a whole. As illustrated, there are a plethora of variables that play a role in the emergence of parent-child conflict. Given the many factors at play, it is no surprise that relational conflict is experienced at various times in all parent-child relationships.

Impact of parent history. Every parent has a lifelong history of formative experiences that inform ongoing thought patterns and ways of being in the world, and inform their interaction with their child specifically. An important part of this reflective process as a parent is recognizing how one's history and experiences influence parenting styles and responses. Without engaging in this insight and reflective process, parents may over-respond or inappropriately respond in conflict with their child. This personal reflective process is a foundation for the following steps, which outline how the parents' preconceived notions apply to the parent-child relationship specifically.

Limitations of common EBPs. Improving the parent-child relationship often decreases the frequency of conflicts (Hindman, Riggs, & Hook, 2013; Stuart & Jose, 2012), or enables the parent to engage in more mindful parenting which helps the dyad to move through moments of

conflict more efficiently (Duncan, Coatsworth, Gayles, Geier, & Greenberg, 2015; Edwards, Sullivan, Meany-Walen, & Kantor, 2010; Turner & Sanders, 2006). Additionally, the majority of EBPs that involve parenting interventions begin with improved parent-child relationship as a foundation, followed by other strategies such as skill training, structure changes, or adjustment of parental responses. However, in many cases where relationships between parents and children is significantly taxed and deprived, parents become exhausted in their efforts, and the reinforcers of parenting efforts feel minimal. This creates a barrier to EST success, related to a parent's exhaustion and lack of motivation to continue implementing intervention. Bolstering parent resources is pivotal in these cases.

REPIT utility in building parent resources. The REPIT works to assist with therapeutic progress when common barriers to EBP success are faced. Common barriers to success for EBPs in parent-child conflict often include parent lack of resources such as time or energy, lack of adherence to treatment structure (appointments, practices), as well as the many factors listed above that influence parent-child conflict in the first place. These barriers occur at various points in conflict for non-clinical families as well as for those whose difficulties warrant clinical concern. Given these difficulties, not all children and families are able to successfully execute the intervention prescribed. Furthermore, even when executed well, some dyads are less responsive to intervention. Other factors that contribute to lack of treatment responsiveness include difficult child temperament (Clark et al., 1994; McNeil & Hembree-Kigin, 2010; Yaman, Mesman, van Ijzendoom, & Bakermans-Kranenburg, 2010;), strenuous parent-child temperament match (Ramos et al., 2005) or even a clinical disorder (Hawes & Dadds, 2005). These factors can be slow to change or unlikely to improve (Oetzel & Scherer, 2003). Further,

when identified problem behaviors are difficult to change in the short term, parents experience exhaustion and lack of motivation to continue their efforts (Ladnier & Massanari, 2000). These are high-risk periods for ending treatment, at the same time being important times to continue treatment. Also, when parent-child conflicts arise that encompass behaviors or characteristics that are difficult to change, parental hopelessness increases (Ladnier & Massanari, 2000; Marsiglia, Kulis, Garcia Perez, & Bermudez-Parsai, 2011), and family frustration increases (Cicognani & Zani, 2009). All the while, flexibility, problem-solving, and openness to treatment become more important (Prinz & Miller, 1994; Thompson, Bender, Lantry, & Flynn, 2007). Thus, to decrease conflict and move forward with improving the parent-child relationship when other barriers halt progress, the REPIT works to bolster parent coping and motivation, further impacting the family system.

Theory conclusion. The theoretical foundation of the REPIT draws on Acceptance and Commitment Therapy, including such components as behavioral congruence with values, acceptance, defusion, and self-as-context. In addition, theory behind the REPIT includes the social metacognitive process of perspective-taking. Next, the REPIT is designed to add a layer to commonly-used behavioral interventions, when limitations arise related to the complexity of predictive factors of parent-child conflict (parent-child relationship satisfaction, marital stability, individual physical and psychological health, and overall wellbeing) and outcomes (parent and child adjustment, marital quality, biological factors). By improving parent insight into their own values and beliefs and how those are impacting interactions with their child, parent coping and motivation is bolstered. The next section is focused on outlining the therapist training components of the REPIT.

Therapist Training Components for REPIT

Given the evidence supporting multi-modal components to therapist training, two training components were explored in this study. Specifically, interactive didactic-style instruction with role-modelling was explored, and manual review alone was explored.

Interactive didactic workshop. In order to train clinicians on use and administration of the REPIT, practitioners participated in a three-hour workshop that used didactic instruction on overall principles and theory, video examples, and interactive learning exercises such as clinician role-play of REPIT administration. The workshop was co-led by the author of the REPIT and the primary investigator of this study. Teaching strategies included videos of sample REPIT administrations with parents who experienced consistent parent-child conflict. Clinicians also practiced administering the REPIT through role-play in pairs during the workshop. Before and after the workshop, clinicians were required to demonstrate their ability to administer the REPIT intervention independently by completing a declarative knowledge measure of concepts taught in the workshop.

Written materials. Effectiveness of the REPIT manual on building therapist proficiency was also explored, with a control group simply reading the manual between the pre- and post-test of declarative knowledge.

Hypotheses

In review, the purpose of this study is to develop a therapist training for the REPIT and determine the effectiveness of different training components. Hypotheses are the following:

1. Significant differences will be found on pre- and posttest change scores between the experimental group and the control group.

2. Those who received the REPIT training in the interactive didactic form (experimental group) will demonstrate significantly higher performance scores in the posttest measures compared to those who simply reviewed the manual (control group).

Chapter 2

Methods

Participants

Participants were 40 licensed clinicians or graduate-level clinicians in training, with 20 in the control group and 20 in the experimental group. Regarding training level, DeViva (2006) compared practicing clinicians to student clinicians, and did not find significant differences on skill attainment after training on a specific intervention. So for the purposes of this study, both licensed clinicians and student clinicians were considered. Participants were recruited through a training advertisement circulated to licensed clinicians and student clinicians in the community. See Appendix A for Participant Recruitment Letter used to advertise for participants. Participants were compensated with a free lunch and a $5.00 gift card for their participation. Informed consent to use training tests for research purposes were obtained by all participants (see the informed consent document in Appendix B). In addition, this study was approved by the Human Subjects Research Committee at George Fox University.

Materials

REPIT. The Reflective Exploration of Parenting Interactions Tool (REPIT, Verona, 2015) is an individually administered therapeutic intervention tool that navigates parents through a series of 19 standardized questions aimed at broadening their perspective to include their child's point of view, thereby decreasing parent-child conflict. See Appendix (C) for the complete interview.

Declarative knowledge pre- and post-training measure. The declarative knowledge pre- and post-test training measure was developed by the main author of the current study. The pre- and post-test training measures consists of 16 multiple choice questions designed to assess clinical and theoretical knowledge attained through the REPIT training workshop. The pre- and post-test training measures are comprised of identical multiple choice items with four possible choices each. Internal consistency was measured using Cronbach's alpha, which was measured at .107 for the pre-test and .381 for the post-test. See Appendix F for the complete pre- post-test training measure.

Demographics measure. The current study recorded such demographics characteristics as participants' identified gender and educational level specific to Master's level training or doctoral level students. Participants expressed interest in attending the REPIT training or engaging the control group by responding to a recruitment email and were able to anonymously identify the level of training they were enrolled in, either being a Master's level counseling program or a doctoral level training program.

Procedure

This study used a nonrandomized convenience-sample, pre-post experimental design. The experimental group consisted of 20 clinicians who participated in the REPIT training workshop. The control group consisted of 20 clinicians who were provided only the written materials and video that was utilized in the training. More specifically, the participants within both conditions received the Powerpoint slides explaining administration of the REPIT and its theoretical underpinnings, such as the relevance of Acceptance and Commitment Therapy to the

REPIT's approach. Both conditions also viewed the video example of Theory of Mind (perspective-taking).

Experimental group. The experimental group attended a three-hour interactive didactic workshop on the theoretical underpinnings of the REPIT, including relevant components of Acceptance and Commitment Therapy, lecture and a video example on perspective-taking, and instruction specific to administration of the REPIT, including a demonstration of REPIT administration. To ensure adequate opportunity for interaction with the instructors, the experimental group was divided between two identical workshops, with three weeks between them, so that half of the group went to the first workshop, and the other half attended the second workshop.

Control group. Unlike the experimental group, the control condition participants did not engage in a collaborative learning environment that those in the experimental training group experienced. Rather, individuals in the control condition read the written materials independently and did not have the option to ask specific questions or receive clarification from the instructor regarding content. Also unlike the experimental condition, the control condition participants did not receive verbal instruction or demonstration of administration. Control condition participants typically completed their research participation in a maximum of thirty minutes. The time that lapsed between the first and last control group participants was three months.

Data Analysis

Using the Statistical Package for the Social Sciences (SPSS, IBM Corp., 2015), a 2 (treatment versus control groups) x 2 (pre- and post-test) repeated-measures analysis of variance (ANOVA) was conducted. Should significant differences or interaction be found, post-hoc

analyses will be conducted using Tukey's HSD. Finally, a Sobel test was used to determine whether demographics were significant moderators. Significance was not reached so a power analysis was not completed.

Chapter 3

Results

Performance Differences Between Demographic Groups

Of the 42 participants, 34 were female (81%) and 8 were male (19%). Regarding the experimental group, 18 were female (86%) and 3 were male (14%). Within the control group, 16 were female (76%) and 5 were male (24%). A *t*-test was used to test for gender differences in performance change scores (difference between pre- and post-test scores). Results indicated that there were no statistically significant differences in performance between males and females in either condition.

Next, the performance of participants in Master's level counseling programs (n = 15, 35.7%) was compared to doctoral level students (n = 27, 64.3%) using a *t*-test. Results indicated that there were no statistically significant differences in performance change scores between licensed clinicians and graduate students.

Training Effectiveness

With the use of a $p < .05$ criterion for performance change scores no outliers among the cases were found. No cases had missing data, N = 42. To explore the effectiveness of the training, pre- and post-test scores were compared between the experimental and control groups, and between men and women. For this comparison, a repeated measures multivariate analysis of variance was conducted. Figure 1 illustrates that there was a significant main effect of time (pre- and post-test; F (1, 40) = 61.911, $p < .001$, $\square^2 = .608$, power = .89). However, the interaction

effect between time and grouping (experimental versus control group) was not significant (F (1, 40) = .191, p = .664, $\square^2$ = .005, power = .66). In addition, neither of the interaction effects including gender yielded significance (see Figure 1).

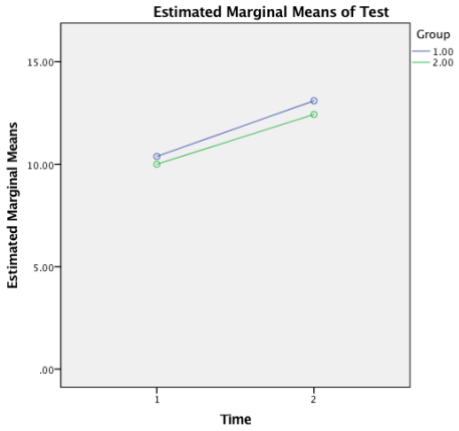

Figure 1. Interaction effect between time and grouping.

These findings indicate that participants demonstrated significant improvement between the pre- and post-test conditions. These findings are shown in Table 3 illustrating pre-test Item Statistics for the experimental group and in Table 4 showing post-test item statistics for the same experimental group following the training participants received. However, the in-person training did not have significantly greater impact than independent material-review. In addition, males and females performed similarly in all conditions.

Outcome Measure Item Analysis

Difficulty index. Further exploration of results was done at the item level. Table 1 outlines item difficulty, listed separately for pre-versus post-test and experimental vs. control groups. The item difficulty index (DI) was calculated as a percentage of the total number of

correct responses to each of the test items. The DI is calculated using the formula $p = R / T$, in which p is the item difficulty index, R is the number of correct responses, and T is the total number of correct and incorrect responses combined from all participants who completed the pre and post test measures.

Table 1.

Item Difficulty Index

	Experimental Group		Control Group	
Item	Pre-test	Post-test	Pre-test	Post-test
1	0.90	0.81	0.62	0.90
2	0.38*	0.67	0.24*	0.52
3	0.57	0.52	0.67	0.52
4	0.62	0.62	0.48	0.71
5	0.76	0.86	0.86	0.95
6	0.62	0.86	0.57	0.90
7	0.38	0.48	0.67	0.76
8	0.57	0.86	0.90	0.90
9	0.33*	0.76	0.48	0.86
10	0.48	0.24*	0.10*	0.24*
11	0.52	0.81	0.62	0.90
12	0.48	0.76	0.76	1.00
13	0.33*	0.62	0.52	0.57
14	0.62	0.67	0.62	0.86
15	0.81	0.86	0.81	0.90
16	0.43	0.76	0.95	0.90

Note. *Difficulty Index below .35.

Findings identify item 10 as a particularly difficult item, with fewer of the experimental group answering correctly at the post-test than at the pre-test.

Discrimination index. Next item discrimination index was calculated by identifying a high- and low-scoring group. The high-scoring group were those whose pre- and post-test sums were in the top 25%. The low-scoring group were those whose pre- and post-test sums were in the bottom 25%. Item discrimination index was calculated by subtracting the number of participants in the low-scoring group who answered the item correctly, from the number of participants in the high-scoring group who answered the item correctly. Table 2 lists the results. To identify the items with the highest discriminant ability, the item discrimination index scores were summed across pre- and post- and experimental and control conditions. The items that discriminated low-scorers from high-scorers most effectively were items 4, 10, 11, and 14. The items that discriminated low-scorers from high-scorers least effectively were items 6, 7, 8, and 13.

Correlation between items and total score. The point biserial correlation coefficients between items and test scores were calculated to identify the specific test items that contributed the most to overall test scores. Table 5 illustrates these results. Items 2 and 11 demonstrated strong correlations with overall test scores (r = .706, r = .687, respectively). Items 4, 12, and 13 demonstrated moderate correlations with overall test scores (r = .504, r = .507, r = .528, respectively). Finally, item 3 demonstrated a weak correlation with overall test score (r = .459). Items 1, 7, 9, 10, 14, and 16 did not correlate with overall test score. Items 5, 6, 8, 15 demonstrated zero variance on overall test score, so were not included.

Table 2.

Item Discrimination Index

	Experimental Group		Control Group		
Item	Pre-test	Post-test	Pre-test	Post-test	Sum
1	2	2	2	1	7
2	1	3	0	-1	4
3	1	2	1	3	7
4	3	3	2	2	10*
5	1	1	1	1	4
6	1	1	0	1	3**
7	1	1	-2	1	1**
8	1	1	-1	1	2**
9	3	2	3	-1	7
10	3	4	0	1	8*
11	1	2	5	2	10*
12	3	2	2	0	7
13	0	2	-1	1	2**
14	4	1	2	3	10*
15	2	1	2	0	5
16	3	1	0	1	5

Note. * best items. ** worst items.

Table 3

Pre-test Item Statistics for Experimental Group

	Mean	SD
1	.9048	.30079
2	.4762	.51177
3	.6667	.48305
4	.7619	.43644
5	.8571	.35857
6	.7143	.46291
7	.4286	.50709
8	.6667	.48305
9	.3810	.49761
10	.6190	.49761
11	.6667	.48305
12	.5714	.50709
13	.4286	.50709
14	.7143	.46291
15	.9524	.21822
16	.5714	.50709

Table 4

Post-test Item Statistics for Experimental Group

	Mean	SD
1	.9524	.21822
2	.7619	.43644
3	.6190	.49761
4	.7619	.43644
7	.6190	.49761
9	.9048	.30079
10	.2857	.46291
11	.9524	.21822
12	.9048	.30079
13	.6667	.48305
14	.7619	.43644
16	.9048	.30079

Table 5

Phi Coefficients Between Items and Point-Biserial Correlations Between Items and Total Scores

Item	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Total
1		-.125	-.175	.400	-	-	-.175	-	-.073	.141	-.050	-.073	-.158	-.125	-	-.073	.013
2	-.340		.252	.213	-	-	.252	-	-.181	.106	.400	.200	.553	.213	-	-.181	.706
3	.459*	-.135		-.208	-	-	-.212	-	.080	.062	.285	.080	.069	.252	-	.414	.459
4	.580**	-.139	.079		-	-	.252	-	-.181	.106	.400	.580	.316	-.313	-	-.181	.504
5	.331	-.156	.289	.091		-	-	-	-	-	-	-	-	-	-	-	-
6	-.205	-.030	-.447*	-.354	-.258		-	-	-	-	-	-	-	-	-	-	-
7	.281	-.248	.408	.032	.354	-.304		-	-.255	-.372	.285	.080	.277	.022	-	-.255	.282
8	.459*	-.742**	.357	.079	.000	.000	.204		-	-	-	-	-	-	-	-	-
9	.255	.037	-.069	.208	.040	.062	.311	.139		.205	-.073	-.105	-.229	-.181	-	.447	.019
10	-.255	.159	-.139	.022	-.320	.372	.085	-.139	.010		.141	.205	-.224	.106	-	-.154	.281
11	.115	-.135	-.071	.079	-.289	.000	-.408	.143	-.277	-.347		.689	.316	-.125	-	-.073	.687
12	.375	-.138	.000	.194	-.079	.091	-.028	.408	.283	.113	-.204		.115	-.181	-	-.105	.507
13	-.047	.138	-.408	.032	.079	.335	-.167	-.408	-.085	.085	.204	-.222		.079	-	-.229	.528
14	.154	-.030	.224	-.106	.043	.067	.122	.224	.062	.155	.000	.091	-.304		-	-.181	.234
15	.689**	-.235	.316	.400	.548*	-.141	.194	.316	.175	-.175	-.158	.258	-.258	.354		-	-
16	-.281	.055	-.408	-.032	-.354	.091	-.417	-.204	-.113	.311	.204	.028	.167	.304	-.194		.019
Tot	.666**	-.142	.250	.409	.154	.128	.284	.356	.465*	.314	-.018	.480*	.080	.518*	.519*	.124	.414

Note. Pre-test item correlations are to the left, and post-test item correlations are to the right.

Chapter 4

Discussion

This study explored effectiveness of a therapist training on a psychological intervention for parent-child conflict. Research on therapist trainings has explored the influence of various training components (didactics, interactive workshops, manual, coaching, supervision), various outcome measures (self-report satisfaction, confidence, declarative knowledge measures, observer report protocol adherence, etc.), and still other variables associated with knowledge acquisition (Baer et al., 2004; Beidas et al., 2009; Cross et al., 2007; Gega et al., 2007; Hawkins & Sinha, 1998; McVey et al., 2005; National Crime Victims Research & Treatment Center, 2007; Sanders et al., 2003; Sholomskas et al., 2005). While findings have been mixed, generally interactive workshops plus follow-ups with individual coaching and supervision have found some of the most promising results, based on research by Sholomskas et al. (2005) which identified the gold standard for therapist training to be a workshop, a manual, and clinical supervision. A cutoff score that has been used in the measurement of therapist proficiency is 80% (Beidas & Kendall, 2010).

As far as outcome measures go, self-report, declarative knowledge, and observational measures have been used. Regarding the use of declarative knowledge outcome measures, both pre- and post-training questionnaires are recommended to help identify how much individuals know prior to the training (Abu-Zaid & Khan, 2013; Hailikari et al., 2008; Sternberg, 2014). Pre-test scores can serve as a helpful comparison standard to assess the amount of knowledge

participants acquired through a training, using performance change scores between pre- and post-test (Rittle-Johnson et al., 2009; Sternberg, 2014). Regarding self-report and observational outcomes measures, self-report satisfaction and competence yielded higher proficiency rates than observation, but both yielded sustained gains over four months following the training (Henry et al., 1993; Miller & Mount, 2001; Morganstern et al. 2001).

Therapist training practices for existing and commonly-used evidence-based practices were explored. Parent-Child Interaction Therapy (Eyberg, 1988) uses a certification process that involves hands-on workshops, supervision, online training modules, and written training materials (PCIT International, 2016). Collaborative Problem Solving (Greene & Ablon, 2006) uses a certification process that involves a workshop and administration of an introductory training. Finally, to train in Parent Management Training and Problem-Solving Skills Training (Kazdin et al., 1987), therapists use written materials independently, though video training materials are also optional.

Because the focus of this study is on developing a training for the REPIT (Verona, 2015), the REPIT's items and sections were explored, followed by a discussion of the theoretical foundations of the intervention. Regarding theoretical foundation, the REPIT builds on concepts from Acceptance and Commitment Therapy, including behaviors congruent with values (Hayes, 2016), acceptance (Hayes et al., 2012), defusion (Luoma, Hayes, & Walser, 2007), and self-as-context (Hayes, 2016). In addition, the social metacognitive process of perspective-taking (Goldstein et al., 2014) is involved, with some questions requiring parents to take the perspective of the child. Next, the REPIT is designed to add a layer to commonly-used behavioral interventions, when limitations arise related to the complexity of predictive factors of parent-

child conflict (parent-child relationship satisfaction, marital stability, individual physical and psychological health, and overall wellbeing; Anthony et al., 2005; Sandler et al., 2013) and outcomes (parent and child adjustment, marital quality, and biological factors; Clark et al., 1994; Finzi-Dottan et al., 2006; Hawes & Dadds, 2005; McNeil & Hembree-Kigin, 2010; Rossman et al., 2000; Sturge-Apple et al., 2012; Zimet & Jacob, 2001). By improving parent insight into their own values and beliefs and how those are impacting interactions with their child, parent coping and motivation is bolstered.

Prior research suggests that the level of training necessary for learning is determined by the skill or task characteristic being taught (Arthur, Bennett, Edens & Bell, 2003; Green & Bavelier, 2008; Hughes et al., 2013). Commonly-used EBPs for parent-child conflict (PCIT, CPS, PMT/PSST) all use different training approaches. While the training methods used in this study did not include supervision, the other two major training methods were incorporated (interactive didactic and written materials). Specifically, interactive didactic-style instruction with role-modeling was explored (experimental group), and independent review of written materials alone (control group) was explored. Participants were 42 psychologists and psychologists-in-training, 21 in each group. The outcome measure used was a declarative knowledge pre- and posttest training measure developed by the main author of the current study. See Appendix E for the Post-Exercise Follow Up Measure. The pre- and post-test training measure consists of 16 multiple choice questions designed to assess clinical and theoretical knowledge attained through the REPIT training workshop.

Results indicated that there were no significant differences between demographic groups (neither gender nor level of education). Males and females performed similarly in all conditions.

These results suggest that individuals with various levels of training may be adequately able to learn how to administer the REPIT through interactive didactic or written material review. Results of the current study did not support the hypothesis that there is a significant difference between the experimental group and the control group on pre- and post-test change scores. Although there were no statistically significant differences in change scores between the two groups, both groups demonstrated performance change scores that indicated some improvement from pretest to posttest. These patterns of improvement demonstrated a positive linear relationship.

Further exploration of results was done at the item level, using difficulty index, discrimination index, and item correlations with total score. Findings identified item 10 as a particularly difficult item, with fewer of the experimental group answering correctly at the post-test than at the pre-test. Regarding the findings of the discrimination index, the items that discriminated low-scorers from high-scorers most effectively were items 4, 10, 11, and 14. The items that discriminated low-scorers from high-scorers least effectively were items 6, 7, 8, and 13. Finally, item score correlations with overall test scores were explored to determine the contributions of each of the items to the overall test score. Items 2 and 11 demonstrated strong correlations with overall test scores (r = .706, r = .687, respectively), indicating that items 4, 12, and 13 demonstrated moderate correlations with overall test scores (r = .504, r = .507, r = .528, respectively). Finally, item 3 demonstrated a weak correlation with overall test score (r = .459). Items 1, 7, 9, 10, 14, and 16 did not correlate with overall test score. Items 5, 6, 8, 15 demonstrated zero variance on overall test score, so were not included.

In sum, based on this research, future research would benefit from a different kind of outcome measure. Even with items pared down to preferable items based on item analysis, the measure's reliability (Cronbach's alpha) was very limited. Ideally, the outcome measure would include items that were well-balanced on item difficulty index (neither too difficult nor too easy), and items that were able to effectively discriminate high-scorers from low scorers. Finally, each of the items on the ideal outcome measure would contribute to the overall test score.

As a whole, these findings are limited based on the limitations of the outcome measure demonstrated above. However, the outcome measure did demonstrate therapist improvement in proficiency after the training conditions. Therapist proficiency was not demonstrated to be significantly better for the workshop group than the independent review of written materials group, suggesting that if the outcome measure were valid, review of written materials alone may be sufficient therapist training for the REPIT.

Strengths and Limitations

This study has several methodological strengths. First, the study was carefully designed to include evenly-distributed experimental and control groups. Both groups included participants who were enrolled in either Master's in counseling programs (35.7% of the sample) or doctoral level training programs (64.3% of the sample). Furthermore, both groups demonstrated similar demographics in regard to gender, with the experimental group being 86% female and 14% male) while the control group was 76% female and 24% male. However, the majority of the participants overall were females within each group, a finding which may be representative of psychology training programs, but which is less representative of the general population.

Second, another strength associated with this study was the levels of training included (including an independent review of written materials sample as a control group instead of simply a non-intervention control group). There was not any apparent reason to suggest that time or practice might be confounding variables, so it stands to reason that without any intervention, scores would remain stable from pre- to post-test.

Third, the teachers who conducted the training remained consistent between two training sessions. Within the experimental group that received the REPIT training, there were 21 trainees who were comprised from two groups of 10 individuals and 11 individuals. Both of these groups received the bulk of their workshop training from the author of the REPIT, and were provided supplemental information regarding ACT from the lead author of this research. By sustaining consistency between the two control conditions, personnel characteristics of the trainers do not influence the effectiveness of the training.

Nevertheless, the results of this study should be interpreted in light of several limitations. The primary limitation was regarding the content of the pre- and post-test outcome measure. The outcome measure should be improved for future research, eliminating items that do not contribute to the overall test score, ensuring that the items demonstrate appropriate test difficulty (the existing measure yielded relatively low difficulty index scores), and ensuring that the items successfully discriminate between low-scorers and high-scorers. Second, future research may benefit from conducting workshops within a closer time frame between each other, preventing potentially confounding effects of accumulating external training (for psychologists in training). Third, future research can build on prior research that explores the use of supervision as another layer of training, and includes observation and subjective reports as outcome measures in

addition to the declarative knowledge measure. In addition, future research may benefit from exploring the impact of didactic instruction delivered in video format (though the lack of interaction inherent in this model likely decreases its effectiveness as described by prior research). Finally, future research would benefit from exploring the contributions of each of the specific components of the workshop, identifying strengths and components worth revision. By identifying training strategies that are sufficient in promoting competence in a particular content area, future training workshops may be better able to recognize the most effective approach to teach trainees within a particular domain.

Conclusion

In conclusion, the present study sought to explore the effectiveness of two different modalities of therapist training on the REPIT (Verona, 2015; interactive didactic workshop and independent review of written materials). The results suggest that both training methods were effective in demonstrating improvements in declarative knowledge of the REPIT, but that there were no significant differences in therapist proficiency between the training conditions. A primary limitation of the study was regarding construction of the outcome measure. Item analysis indicated that the items were low in difficulty, that some items did not discriminate low- and high-scorers adequately, and that not all of the items contributed to the overall test score significantly.

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Appendix A

Participant Recruitment Letter

Dear Potential Participant,

My name is Molly Winterrowd, and I am a doctoral candidate in the Clinical Psychology Program at George Fox University. I am writing to invite you to participate in my dissertation study. My research focuses on examining the effectiveness of the Reflective Exploration of Parenting Interactions Tool (REPIT, Verona, 2015) Workshop Training. Specifically, I am investigating the effectiveness of this intervention training in improving therapists' competence in administering the REPIT to clients.

Eligible participants are students who:

1. Male or female graduate-level psychology student or practicing therapists
2. May see clients for concerns related to parent-child conflict
3. Are a resident of Oregon, U.S.A.

Participation in this survey is expected to take 1 hour to 3 hours of your time for training. Your participation is completely voluntary and confidentiality will be maintained. No data will be collected that could be used to identify you.

To participate in this study, please sign the attached consent form.

This study is being supervised by Dr. Kathleen Gathercoal, PhD and has been approved by the Human Subjects Research Committee at George Fox University (##########). If you have any questions, you are welcome to contact me by email at: mwinterrowd13@georgefox.edu, or by phone at (503) 680-5310.

Best,

Molly Winterrowd, MA
Doctoral Student
George Fox University
Graduate Department of Clinical Psychology
mwinterrowd13@georgefox.edu | (503) 680-5310

Kathleen Gathercoal, PhD
Professor of Psychology
George Fox University
Graduate Department of Clinical Psychology
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Appendix B

Informed Consent for Participation

I, _____, understand that my participation in this intervention and research project is voluntary and that I can withdraw from the project at any time without penalty. I understand that I will be allowed to review materials related to the REPIT Training Workshop once it is completed. I understand that this material will be used only for the purposes of benefitting my ability to administer the REPIT and for the doctoral dissertation of Molly Winterrowd. I also understand all data will be kept de-identified and secured to protect my confidentiality. Only the researchers involved (Ms. Winterrowd and Dr. Gathercoal) will have access to my identifying information. A large group summary of demographic information collected will be presented for publication. There will be no reference to my name on any of the research material or public indication that I participated in this research project. I also understand that the investigator is required by State law to disclose any report of suicidality, homicidality, or abuse of a child or elder. I understand that I may contact Ms. Winterrowd at mwinterrowd13@georgefox.edu or Dr. Kathleen Gathercoal at 503-554-2376 if I have questions or concerns about my participation in, or any part of, the research project.

By signing, I agree to participate in the research project, under the terms noted above.

Signature of participant: _____Date: _____

Signature of witness:_____Date: _____

Appendix C

Pre Exercise Assessment

Pre Exercise Assessment

Name: **Date:**

1. **Please indicate the problem behavior that creates the most parent-child conflict between you and your child.**

2. **Review rating scale and give current numbers.**

The above negatively impacts my child and my relationship.

0 1 2 3 4 5

This behavior or characteristic negatively impacts our family.

0 1 2 3 4 5

I am concerned about the long term effects of this behavior.

0 1 2 3 4 5

I currently believe that I am not having a positive impact on this behavior.

0 1 2 3 4 5

Things I am specifically doing:

3. Tell me what you hope to gain or learn from the REPIT intervention?

4. What behaviors and/or emotions are in this moment feeling like they need to be addressed?

5. What do you need to be supported?

Appendix D

Reflective Exploration of Parenting Interactions Tool

Reflective Exploration of Parenting Interactions Tool (REPIT)
By Danni Verona, OTR/L

1. Think of a behavior or characteristic about your child which you would like to see change. Share this with your listening partner by completing the following:
   (Child's name) is or does

2. Now put this into a belief statement which may or may not include the reason for this behavior: *I believe my child*

3. What emotions arise when you think about the above stated belief?

4. Please rate the intensity of these emotions on a scale from 0-10 as you sit here and think about your belief statement number 2.

5. This behavior occurs (frequency):

6. The above negatively impacts my child and my relationship.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
0	1	2	3	4	5

7. This behavior or characteristic impacts our family.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
0	1	2	3	4	5

8. I am concerned about the long term effects of this behavior.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
0	1	2	3	4	5

9. I currently believe that I am having a positive impact on this behavior.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
0	1	2	3	4	5

10. What do you think your child believes about themselves in regard to this behavior or characteristic? Complete the sentence:
I think (child's name) believes

11. Now enter into the mind of your child. From your child's perspective: What does your child think YOU *believe* about them, in regards to this same behavior? If your child were speaking to someone, what would they say? (Please express in your words. Don't worry if your child would actually speak in this way). Complete the sentence:
"My mom/dad believes I'm…"

12. What behaviors do you demonstrate that would bring your child to think that this is what you believe about them? Think about what you say, what you do, your facial expressions, etc. Complete this sentence:
(Child's name) believes, that I think this because I…

13. What would you like them to believe about themselves? Complete this sentence:
I would like (child's name) to believe…

14. What would you like them to think that you believe about them?
I want (child's name) to believe I think they are…

15. Do you believe it is currently possible for your child to develop this belief about themselves? Are **you** prepared to do what it takes to support the development of this new belief?

16. What actions can you take to show and support the development of this new belief?

17. Please guess what percentage of the time during the next week you expect to successfully apply your new behaviors?

18. Please guess what percentage of the time during the next week you expect to see an improvement in your child's behavior?

19. What else do **you** need to successfully apply your new behaviors within your parenting interaction?

Appendix E

Post Exercise Follow Up

Post Exercise Follow Up

Name: **Date:**

1. ***How long has it been since our completion of the REPIT?***
2. **Review rating scale and give current numbers.**

. The above negatively impacts my child and my relationship.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
0	1	2	3	4	5

This behavior or characteristic negatively impacts our family.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
0	1	2	3	4	5

I am concerned about the long term effects of this behavior.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
0	1	2	3	4	5

. I currently believe that I am not having a positive impact on this behavior.

Strongly Disagree	Disagree	Somewhat Disagree	Somewhat Agree	Agree	Strongly Agree
0	1	2	3	4	5

3. **Tell me what you gained or learned from your last session?**

Things I am specifically doing:

4. **How successful do you think you have been in applying your new concepts and behaviors? Scale of 0-10:**

5. **Will you be continuing these concepts/behaviors or would you like to revise them to address what you are now seeing as a priority of need?**
   Continuing **or** **Revising**

6. **Talk about the behaviors and/ or emotions that are in this moment feeling like they need to be addressed?**

   .

7. **What do you need to be supported?**

Appendix F

REPIT Training Pre Test

REPIT TRAINING PRE-TEST

1. What is the primary aim of the REPIT tool?
    a. Change the child's behavior
    b. Change the parents' behavior
    c. Change the child's perspective of their parent's behavior
    d. Change the parent's perspective of their child's behavior
    e. Change the child's siblings' behaviors

2. According to the creator of the REPIT, which aspect of Reflective Thinking Skills are most foundational in influencing this theory?
    a. Psychodynamic constructs
    b. Client-centered approach
    c. The cognitive / behavioral construct
    d. Interpersonal interactions
    e. Gestalt

3. Who can administer the REPIT intervention?
    a. Clinicians with Psychology Masters level degrees
    b. The parent to themselves
    c. Clinicians with doctoral degrees
    d. Teachers with Masters level degrees
    e. Clinicians with Psychology Masters level degrees who have attended this training and passed this exam.

4. According to the REPIT tool approach, what is the value of understanding your own perspective of why another person engages in a particular behavior?
    a. In order to understand the reciprocal impact between our interactions, beliefs, and behaviors
    b. In order to build empathy for others in order to progressively transform their behaviors
    c. So we can learn ways in which to have children model our behaviors
    d. In order to change others' behaviors to benefit ourselves
    e. In order to more effectively advocate for the ability to engage in our own enjoyable behaviors

5. If a subject who is having the REPIT administered to them goes off track of the intervention, what is the correct response by the administrator?
    a. Immediately discontinue administration of the REPIT intervention
    b. Allow the space for the subject to continue in the direction they choose
    c. Allow for flexibility in altering intervention to individual needs of subject while redirecting their attention to engaging in the structured interview aspect of the REPIT
    d. Remain congruent to the chronological structure of the intervention and dismiss the subject's attempts to explore alternative thoughts
    e. Advise the subject that they must continue to the REPIT intervention script

6. Who is in the intervention room when the REPIT is being administered?
    a. The child's doctor
    b. The child
    c. The child's babysitter / secondary caretaker
    d. One / both parent(s) / the primary caretaker
    e. The whole family

7. For the REPIT intervention, which concept does *Social Thinking* impact the most?
    a. Interactions with ourselves
    b. Companies / Organizations
    c. Group dynamics
    d. Individuals who have limited interest in exploring the perspective of another human being
    e. Interactions with others

8. Which skill is most closely related to the goal of the REPIT intervention?
    a. Empathy building / perspective-taking / Theory of Mind
    b. To treat panic attacks / Generalized Anxiety symptoms
    c. Distress tolerance / Symptom reduction
    d. Coping skills for depression
    e. Behavioral activation strategies for subjects to become motivated to complete tasks

9. What does the REPIT tool facilitate awareness about?
    a. Ways in which to encourage children to engage in behavioral modification
    b. Developing greater awareness about appropriate social cues and how to adjust behaviors to match appropriate social interactions
    c. Developing a behavior chart and tangible ways in which to modify behaviors through positive reinforcement
    d. Shift belief patterns in regards to our interactions with others
    e. How to effectively communicate personal concerns about interactions to others

10. What is one aspect that reflective thinking most impacts:
    a. Our core beliefs
    b. Negative views regarding others' dysfunctional behaviors
    c. Engaging in inappropriate behaviors in public
    d. Distorted thoughts about ourselves
    e. Atypical behaviors

11. How is the REPIT administered?
    a. Out of order with abiding by the subject's preference for the order or questioning
    b. In chronological order with more in-depth awareness of thoughts discussed towards the end of the intervention.
    c. With two clinicians administering the REPIT tool to one subject

d. By only allowing yes or no responses to the questions that the clinician administers to the subject
e. Beginning from the most in-depth questions and ending with the less sensitive questions

12. What is the purpose of the REPIT?
    a. To limit the frequency of maladaptive behaviors the parent and child engage in
    b. To help the parent accept more responsibility for their child's negative behaviors
    c. To encourage the child to explore motivational interviewing and become more willing to engage in positive behaviors
    d. To utilize the concepts of theory of mind, acceptance, mindfulness, and perspective-taking to help subjects increase their ability to engage with their child with less distress and frustration towards their child's negative behaviors
    e. To decrease the total amount of conflictual interactions the parent and child engage in

13. Approximately how long does it take to administer the REPIT and what is the typical duration of the administration?
    a. 8 sessions / 50 minutes each
    b. 15 minutes
    c. 1-2 sessions / each approximately 1 hour
    d. Long-term therapy (1 year minimum)
    e. 4 hours for administration

14. Which areas do cognitive/behavioral constructs affect?
    a. Occipital Lobe
    b. Basil Ganglia
    c. Areas of functioning and co-regulation
    d. Serotonin
    e. Auditory Cortex

15. What is the primary population of individuals the REPIT is used for with interventions?
    a. Patients with severe mental health conditions / psychosis
    b. Parent Child Interactions
    c. Geriatric patients without children
    d. Couples therapy
    e. Patients with Autism Spectrum Disorder (ASD)

16. How can the REPIT be modified to fit the needs of the subject?
    a. If the subject becomes tangential, the administrator may allow time for the subject to explore their thoughts regarding a specific question and then, redirect the subject to continue answering the questions in chronological order
    b. The subject may begin leading the REPIT by asking and answering questions on own
    c. The subject may complete REPIT intervention at leisure without administrator present
    d. The administrator may begin asking non-standardized questions to subject
    e. The administrator may provide potential answers for the subject

Appendix G

Curriculum Vitae

MOLLY JEAN WINTERROWD

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503-680-5310

EDUCATION

2015-present	Doctoral Candidate- Graduate Department of Clinical Psychology (graduation in May, 2018) George Fox University, Newberg, OR *Dissertation*: Examining the Effectiveness of the Reflective Exploration of Parenting Interactions Tool (REPIT) Training Workshop *Advisor*: Celeste Flachsbart, Psy.D.
2013-2015	Master of Arts in Clinical Psychology Graduate Department of Clinical Psychology George Fox University, Newberg, OR
2007-2011	Bachelor of Arts in Psychology and Comparative Sociology University of Puget Sound, Tacoma, WA *Thesis*: The Effect of Team Sports on Wellbeing of Youth

CLINICAL WORK

08/2017-Present	Pre-doctoral Clinical Psychology Intern Big Island Substance Abuse Council Hilo, HI
08/2017-Present	Pre-doctoral Clinical Psychology Intern Hawai'i Island Family Health Center Hilo, HI
08/2017-Present	Pre-doctoral Clinical Psychology Intern I Ola Lāhui Rural Hawai'i Behavioral Health Honolulu, HI
06/2016-06/2017	Assessment and Therapy Practicum Student

Oregon Health Sciences University (OHSU): Family Medicine at South Waterfront Campus
Portland, OR

07/2016-06/2017 Therapy Practicum Student
Evergreen Clinical
Portland, OR

07/2015-07/2016 Assessment and Therapy Practicum Student
NW ADHD Treatment Center
Sherwood, OR

01/2015-08/2017 Behavioral Health Crisis Consultant
Providence Newberg Medical Center & Willamette Valley Medical Center
Newberg, OR

08/2014-06/2015 School-Based Behavioral Health Practicum Student
Yamhill-Carlton School District
Yamhill-Carlton, OR

05/2014-01/2017 Assisted Care Practicum Student
Integrated Services Network
Newberg, OR

OTHER WORK EXPERIENCE

02/2012-06/2015 Part-time Operations Assistant
Therapists Unlimited- Genesis Healthcare Company
Lake Oswego, OR

08/2011-01/2014 Youth Treatment Specialist – On-call Relief Staff
Chehalem Youth and Family Services- Integrated Service Network
Newberg, OR

11/2011-08/2017 Head Soccer Coach
13-year-old girls team & 7-year-old girls team
Oregon Soccer Academy & Bernie Fagan Soccer Camps
Portland, OR

01/2011–06/2011 Recreational Therapy Intern
Lakewood Child Study and Treatment Center
University of Puget Sound Department of Psychology
Tacoma, WA

01/2009–05/2011 Refugee Tutor
Asymmetric Tutoring Program for Somalian Refugees
University of Puget Sound
Tacoma, WA

TEACHING

04/2016-08/2017 Clinical Foundations Teaching Assistant
Graduate Department of Clinical Psychology
George Fox University, Newberg, OR

03/2016 Adolescent Development. Schools Part II Guest Lecturer
Undergraduate Department of Psychology
George Fox University, Newberg, OR

03/2016 Child Psychopathology: Generalized Anxiety Disorder Guest Lecturer
Undergraduate Department of Psychology
George Fox University, Newberg, OR

03/2016 Human Development Guest Lecturer
Graduate Department of Clinical Psychology
George Fox University, Newberg, OR

12/2014-05/2016 Human Development Teaching Assistant
Graduate Department of Clinical Psychology
George Fox University, Newberg, OR

RESEARCH

Winterrowd, M. (expected 2017). Tentative name: Examining the Effectiveness of the Reflective Exploration of Parenting Interactions Tool (REPIT) Training Workshop. To be submitted to: *Journal of Attachment Parenting.*

Winterrowd, M., Dean, C., & Cha, J. (2016). Participant perception of process group therapy for young adults with Autism Spectrum Disorder. (Accepted for Poster Presentation at American Psychological Association Convention).

Rabie, A., Coleman, K., Goins, L., Winterrowd, M. (2016). Speak Up! The Right to Refuse Abuse: A School-Program for Child Sexual Abuse Prevention. (Accepted for Juliette's House to educate teachers, parents, and students about child sexual abuse and prevention).

Cha, J., Flachsbart, C., Stere, H., Cha, J., & Winterrowd, M. (2015). Outcomes of a School-Based Self-Regulation Skills Program on First Grade Students. *Poster presented at Oregon Psychological Association Annual Meeting*, Eugene, OR.

Winterrowd, M. (2011). The effects of team sports on overall wellbeing. *University of Puget Sound,* 1 25. Psyc492A: Perspectives on Behavior University of Puget Sound. Department of Psychology. Taught by Catherine Hale.

Winterrowd, M. (2010, December). The Effects of Economic Demand and Satiation on Behavior. *University of Puget Sound,* 1-17. Psyc360A: Explained Analysis and behavior University of Puget Sound. Department of Psychology. Taught by Robin Foster.

Saito, S., Vasquez, K., Walton, K., & Winterrowd, M. (2009). The effects of foreign accents and distractions on comprehension test scores. *University of Puget Sound,* 1-20. Psyc301A: Experimental Applied Statistics University of Puget Sound. Department of Psychology. Taught by Chris Jones.

Lam, Z., Schneider, W., & Winterrowd, M. (2009). What women want: An in depth study of the relationship between symbols of nurturance and attraction. *University of Puget Sound,* 1-10. Psyc201A: Experimental Applied Statistics University of Puget Sound. Department of Psychology. Taught by Jill Nealey-Moore.

HONORS AND AWARDS

2015	Special Commendation Award Graduate Department of Clinical Psychology George Fox University, Newberg, OR
2011	Pi Beta Phi Life-long Commitment Recognition
2010	Pi Beta Phi Academic Scholar Award
2010	University of Puget Sound Women's Soccer Senior Captain
2009	University of Puget Sound Women's Soccer Class Leader Role
2009	Pi Beta Phi Good Citizenship Award

UNIVERSITY & DEPARTMENTAL INVOLVEMENT

10/2017	Healthy Halloween Culinary Committee Chair Outreach Project I Ola Lāhui Rural Hawai'i Behavioral Health Honolulu, HI
09/2017	Kupuna Health Fair (Hawai'i Senior Health Fair) Outreach Project I Ola Lāhui Rural Hawai'i Behavioral Health Honolulu, HI

12/2015-Present	Oregon Association of Student Councils Alumni Group Salem, OR
08/2015-08/2017	Pediatric Psychology Special Interest Group Graduate Department of Clinical Psychology George Fox University, Newberg, OR
12/2015-03/2017	Health Psychology Special Interest Group Graduate Department of Clinical Psychology George Fox University, Newberg, OR
08/2015-05/2016	Student Council Member Graduate Department of Clinical Psychology George Fox University, Newberg, OR
2014-2017	Peer Mentor Graduate Department of Clinical Psychology George Fox University, Newberg, OR
2014-2017	Student Interviewer Graduate Department of Clinical Psychology George Fox University, Newberg, OR
2013-2014	New Faculty Interviewer Graduate Department of Clinical Psychology George Fox University, Newberg, OR
12/2013-04/2014	Banquet Planning Committee Graduate Department of Clinical Psychology George Fox University, Newberg, OR
12/2013	Christmas Luncheon Volunteer Lambert House Adult Day Care Facility- Volunteers of America Oregon
09/2013-08/2017	Multicultural Committee Graduate Department of Clinical Psychology George Fox University, Newberg, OR
09/2013-05/2017	Community Worship / Gatherings Graduate Department of Clinical Psychology George Fox University, Newberg, OR
09/2013-05/2017	Gender and Sexuality Committee Graduate Department of Clinical Psychology

	George Fox University, Newberg, OR
09/2013-08/2017	Sherwood Field House Indoor Co-ed Soccer League Sherwood, OR
12/2012-08/2017	Soccerplex Women's and Co-ed Soccer Leagues Portland, OR
05/2012–09/2017	Alumni Council Admissions Committee University of Puget Sound, Tacoma, WA
05/2012–09/2017	Alumni Fund Class Agent University of Puget Sound, Tacoma, WA
12/2010–05/2011	President- Order of Omega Greek Honors Society University of Puget Sound, Tacoma, WA
2009-2010	New Faculty Interviewer Department of Psychology University of Puget Sound, Tacoma, WA
09/2009–12/2009	Fundraising Volunteer- Wristbands for Haiti Pi Beta Phi Sorority Organization University of Puget Sound, Tacoma, WA
09/2009–08/2010	Tacoma Co-ed Soccer League, Tacoma-UPS Comeback Sports Organization, and Chambers Bay Golf Course University Place, WA
09/2008–05/2011	Arrow Correspondent and Communication Chair University of Puget Sound, Tacoma, WA
09/2008–05/2011	Finance Committee Member- ASUPS University of Puget Sound, Tacoma, WA
01/2008–05/2011	Relay For Life Event Organizer University of Puget Sound Tacoma, WA
09/2007–12/2010	Canned Food Drive Event Organizer Student Athletic Advisory Council

	University of Puget Sound Varsity Athletics Tacoma, WA
09/2009-05/2011	Athletic Tour Guide University of Puget Sound Varsity Athletics Tacoma, WA
09/2007–12/2009	Feed the Homeless Event Organizer Fellowship of Christian Athletes: Friday Night Feed the Homeless University of Puget Sound Varsity Athletics and ASUPS Club Tacoma, WA
09/2007–08/2008	Statistician for Donations University of Puget Sound, Tacoma, WA
07/2007–08/2008	Leadership Camp Counselor Oregon Association of Student Councils

RELEVANT COURSEWORK

Supervision and Management of Psychological Services I – II
Professional Issues I – II
Consultation, Education, & Program Evaluation I
Substance Abuse
Statistics
Biological Basis of Behavior
Health Psychology
Acceptance & Commitment Therapy
Child/Adolescent Therapy & Assessment
Group Psychotherapy
Psychodynamic Psychotherapy
Multicultural Therapy
Integrative Approaches to Psychotherapy
Research Team I – 1V
Cognitive/Behavioral Psychotherapy
Cognitive Assessment
History & Systems of Psychology
Child/Adolescent Psychopathology
Social Psychology
Learning, Cognition, & Emotion
Family & Couples Therapy
Clinical Foundations II
Personality Assessment
Theories of Personality/Psychotherapy

Clinical Foundations of Treatment
Ethics For Psychologists
Psychometrics
Human Development
Psychopathology

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