



# Experience-Based Competency Training in Child and Adolescent Psychotherapy

## A Pilot Study With University Students

Johannes C. Ehrenthal<sup>1</sup> , Johannes Clauss<sup>2</sup>, Alexandra von Tettenborn<sup>2</sup>, and Corinna Reck<sup>2</sup>

<sup>1</sup>Department Psychologie, Humanwissenschaftliche Fakultät, University of Cologne, Germany

<sup>2</sup>Department Psychologie, Fakultät für Psychologie und Pädagogik, Ludwig-Maximilians-Universität München, Munich, Germany

**Abstract:** *Background:* Compared to adult psychotherapy training, there is little knowledge about the use of standardized actor-patients (SPs) for the development of professional competencies for younger patient populations. *Objective:* We assessed the effectiveness of two university-based training programs for diagnostic as well as intervention skills in child and adolescent psychotherapy. *Methods:* Psychology students took part in two courses on the development of diagnostic competencies ( $N = 59$ ) and on intervention skills ( $N = 51$ ). We applied active and experience-based learning strategies, including exercises on self-awareness, mindfulness, peer role-play, and the use of SPs. Competence gain as well as a general evaluation of the seminars were assessed by self-report. *Results:* For both seminars, self-reported competence increased significantly with a large effect. The retrospective evaluation of learning success and acceptance ratings of the didactic formats were high. *Conclusions:* Experience-based trainings that include SPs are a feasible option for child and adolescent psychotherapy. The findings are discussed from a conceptual as well as a practical perspective.

**Keywords:** training, competency development, therapist, professional development, standardized actor-patients

### Erfahrungsbasiertes Kompetenztraining in der Kinder- und Jugendlichenpsychotherapie. Eine Pilotstudie mit Universitätsstudierenden

**Zusammenfassung:** *Hintergrund:* Im Vergleich zur Psychotherapieausbildung für Erwachsene fehlt es an Wissen über den Einsatz von standardisierten Schauspielpatient\_innen (SP) für die Entwicklung professioneller Kompetenzen für jüngere Patient\_innenpopulationen. *Fragestellung:* Wir untersuchten die Effektivität zweier universitärer Trainings zu diagnostischen und interventionellen Fertigkeiten in der Kinder- und Jugendlichenpsychotherapie. *Methoden:* Psychologiestudierende nahmen an zwei Kursen zur Entwicklung diagnostischer Kompetenzen ( $N = 59$ ) und Interventionsfertigkeiten ( $N = 51$ ) teil. Wir setzten aktive, erfahrungsbasierte Lernstrategien ein, darunter Übungen zur Selbstwahrnehmung, Achtsamkeit, Peer-Rollenspiele und Schauspielpatient\_innen. Subjektiver Kompetenzgewinn wurde im Fragebogen sowie durch eine allgemeine Bewertung des Seminars erfasst. *Ergebnisse:* In beiden Seminaren stieg das subjektive Kompetenzerleben signifikant mit einem großen Effekt an. Retrospektive Bewertung des Lernerfolgs und Akzeptanz der didaktischen Formate waren hoch. *Schlussfolgerungen:* Erfahrungsbasierte Trainings unter Einbeziehung von SPs für die Kinder- und Jugendlichenpsychotherapie sind machbar. Die Ergebnisse werden unter konzeptuellen und anwendungsbezogenen Aspekten diskutiert.

**Schlüsselwörter:** Ausbildung, Kompetenzentwicklung, Therapeuten, Professionelle Entwicklung, Standardisierte Schauspielpatienten

Modern psychotherapy training is a unique challenge that comprises a mixture of art, craft, and science. While the art aspect, usually through inspiration and teaching by master therapists, as well as the craft of developing content and curricula have always been core components of skill acquirement in professional development, there is less systematic research on the science of teaching and learning psychotherapy. This is not because of a lack of awareness for these issues (see Alberts & Edelstein, 1990; Ford, 1979; Matarazzo & Garner, 2003; O'Toole, 1979), but related to

other factors that made clinicians focus on general training packages or program development (Herschell et al., 2010; Hilsenroth et al., 2006). The relative absence of research is especially true for psychotherapy training in Germany, where a large part of specialization and licensure training has been conducted in private institutes outside of universities. The upcoming transformation of psychotherapy training, resulting in a basic licensure qualification after completing an MSc program in clinical psychology before starting another 5 years of postgraduate specialization

that qualifies the psychologist to offer insurance-covered psychotherapy (Rief, 2020; Wilhelm et al., 2020), will change the need for research on general as well as specific components and methods for fostering professional development and competency.

While therapist competency is not necessarily related to outcome in child and adolescent psychotherapy in general (e.g., Collyer et al., 2020), indirect indicators of higher levels of competency such as higher formal levels of training (Atkins & Christensen, 2001; Prout & DeBerard, 2017; Stein & Lambert, 1995) or more practical experience of doctoral student therapists (Powell et al., 2010) may be related to a better outcome or patients or families completing therapy. However, the evidence for specific effects of training on treatment success, especially in licensed professionals, is mixed (see also Liness et al., 2019). Nevertheless, clinical training can enhance student competencies (Beidas & Kendall, 2010; O'Donovan et al., 2005; Rakovshik & McManus, 2010). Some reasons for inconsistencies in the results may be linked to the fact that there are different definitions of therapist expertise (Hill et al., 2017), different models regarding which competencies are needed to deliver successful treatment, and which perspectives on training should be adopted (e.g., Beidas & Kendall, 2010; Hatcher, 2015; Roth & Pilling, 2008; Weck, 2013). In addition, some characteristics of competent and effective therapists are more modifiable than others (Heinonen & Nissen-Lie, 2020). To complicate matters even further, competency models for child and adolescent psychotherapy differ from training models for adults regarding structure and content, including a focus on the ability to form a positive alliance over time with patients as well as their parents (Sburlati et al., 2011). All of this calls for more research in this area.

Several models are helpful for conceptualizing areas and levels of skill development in the development of psychotherapy training. For example, Miller (1990) proposed a framework with four stages, from the acquisition of knowledge of basic facts (“knows”) via knowledge about clinical application (“knows how”) and being able to demonstrate clinical skills in safe environments (“shows how”) to the application of these areas of knowledge in real clinical settings (“does”). The content of what has to be taught at different levels of proficiency is usually defined by related licensure acts and organized into key competencies, which are then defined by enabling competencies. These, in turn, can be translated into direct learning goals. In addition to this organization of knowledge and skill levels, concepts of teaching and learning that focus on competence development need to be taken into account.

A basic framework for enhancing and deepening students' understanding of topics is specified by *experiential*

*learning* (Kolb, 2014), which describes a circular pattern that focuses on direct experiences to help individuals observe and reflect on the content, and then deduct general principles of the respective matter before thinking ‘forward’ regarding new application and experimentation. Thus, experiential learning is an active and creative way of gaining knowledge and skills and contrasts with classical lectures with passive recipients. Research on experiential learning largely supports its efficacy (Burch et al., 2019). However, experiential, experience-based learning may rather be seen as a general, process-oriented principle that guides teaching but does not necessarily adhere to the needs of a strict operationalization of content and outcome partly required in university-based teaching, for example, regarding the demands of assessing specific skills in a formal examination in the future German training system for psychologists (Rief, 2020). Therefore, competency-based learning focuses on creating a coherent curriculum that combines predefined competencies with optimal teaching methods and adapted assessment tasks, as commonly found in medical education (Frank et al., 2010). From a practical perspective, experiential learning provides a broad framework for education models, including freedom for adaptation and creativity, while competency-oriented learning focuses on the operationalization of competencies, learning goals, and teaching and assessment methods. Both approaches use innovative and interactive didactic methods such as feedback, video feedback, peer role-play, and the use of standardized actor-patients.

While feedback is a basic tool of teaching and learning, it plays a special role in experiential learning. On the one hand, it can transfer individualized knowledge from more experienced therapists to those who learn, which can be a predictor of self-reported learning success (Ehrenthal et al., 2020), but it also helps to understand different perspectives on one's own behavior. Also video feedback, i.e., watching one's own interactions, facilitates autonomy and self-evaluation (Kluger & DeNisi, 1996; Ozcarar et al., 2009; van de Ridder et al., 2008). Peer role-play helps to bring clinical situations to life in a flexible, personal, and usually less anxiety-provoking manner. Participants can either be provided with written scripts or role-play spontaneously, also based on experiences with own patients, which sometimes deepens their clinical understanding by perspective-taking (Lane & Rollnick, 2007). Last but not least, standardized actor-patients (SPs) can be employed for psychotherapy training. Actor-patients, for example, have the advantage of being less familiar than peers in role-play situations, adding to a sense of reality for participants. Most importantly, they can be trained to reliably play a role defined by the curriculum-creators, which either helps to practice but also to assess one or

several competencies in an objective or structured way (Ehrenthal, Dinger et al., 2019). Paparo and colleagues (2021, p. 3–4) summarize the advantages of simulated learning activities, including SPs and peer role-play, as a means of bridging a gap between theory and practice, providing a safe, learner-centered environment, enhancing curriculum control, being more sustainable than direct interactions with patients, helping to condense and preserve relevant knowledge by developing typical ‘illness scripts’, preparing students for unusual but highly impactful clinical events, and fostering student participation and engagement. Standardized actor-patients are becoming increasingly important to competency-oriented training in psychotherapy, psychosomatic medicine, and psychiatry (Alpers & Steiger-White, 2020; Ay-Bryson et al., 2020; Decker et al., 2011; Ehrenthal, 2019; Kühne et al., 2018, 2021; Ottmann et al., 2020; Nikendei et al., 2019; Partschefeld et al., 2013).

The use of actor-patients in the training of competencies in child and adolescent psychotherapy is of critical relevance. On the one hand, playing children is probably more difficult for students, as it cannot be assumed that all participants of a training course, especially at the level of university students, have had thorough practical experiences with own siblings or other children, limiting their knowledge about typical behavior and interpersonal dynamics. In addition, using actual children or adolescents in training sessions or even examinations would rightfully raise serious ethical and possibly legal concerns (for an overview of risk factors and recommendations for after-care and debriefing of SPs, see also Kühne et al., 2018). For all these reasons, research on the use of innovative methods in experiential and competency-oriented learning in child and adolescent psychotherapy needs to be conducted. In fact, to our best knowledge, we are not aware of published studies that systematically address these issues.

Aim of the current pilot-study was therefore to assess self-reported competence gain and evaluation of two university-based, experiential training formats that included the use of actor-patients in the field of child and adolescent psychotherapy. We hypothesized an increase in self-reported ratings of overall competence as well as a positive evaluation of the formats.

## Methods

Students pursuing their MSc in Clinical Psychology and Cognitive Neuroscience and an elective subject of Developmental Psychology at the Ludwig Maximilian University of Munich took part in obligatory courses. We collected routine data at two time points: before the start of each seminar (self-reported competence) and after the end of each seminar (self-reported competence, specific evaluation of working with standardized actor-patients, general evaluation of learning success).

We calculated differences between pre- and postmeasurements utilizing dependent *t*-tests as well as related effect sizes<sup>1</sup> (Dunlap et al., 1996; Morris & DeShon, 2002). In general, we report how we determined our sample size, all data exclusions (if any), all manipulations, and all measures in the study.<sup>2</sup>

## Seminars

### Seminar 1: Assessment and Clinical Diagnostics in Child and Adolescent Psychotherapy

Aim of the seminar was to increase knowledge and competence regarding the recognition and assessment of common mental disorders in children and adolescents, related maladaptive behaviors, and interactional patterns. Furthermore, we focused on helping the students to develop communicative competence for dealing with common, disease-related, and specific challenges in assessment situations with young patients and their parents. Using the general framework of Sburlati et al. (2011) as a guideline, we set priority on generic therapeutic competencies (e.g., building a positive relationship, conducting a thorough assessment, understanding the impact of relevant age-specific characteristics, practicing professionally) and to some degree, although more on a theoretical level, understanding therapy-specific competencies, such as factors maintaining disorders, components of a possible treatment plan, and the need for collaborative work.

### Participants

Fifty-nine (89.4%) of the 66 participating students in four consecutive seminars in the years 2014 to 2016 filled out questionnaires before and after the seminar. Of the participants, 82.8% identified as female, 17.2% as male.

Each seminar had three instructors: a female professor of clinical psychology with a focus on cognitive-behavioral

<sup>1</sup> Using the formula according to Dunlap et al. (1996):  $d = t_c[2(1-r)/n]^{1/2}$

<sup>2</sup> Data and code can be obtained upon reasonable request from the first author.

**Table 1.** Gains in self-reported competencies in the assessment and intervention seminar

Scale	Pre M (SD)	Post M (SD)	T	d
Self-reported competence assessment (N = 59)	3.16 (.78)	4.31 (.70)	-14.08***	1.53
Self-reported competence interventions (N = 51)	2.96 (.68)	3.84 (.66)	-9.98***	1.31

Note. \*\*\* $p < .001$ . Effect size  $d$  is displayed so that larger values mean a larger increase of self-reported competence from pre- to postseminar.

and interactional methods in treating children, their parents, and parent-child-dyads; a male instructor, then at a postdoc level with key expertise in adult psychodynamic treatment; and a female clinical psychologist with a cognitive-behavioral specialization in child and adolescent psychotherapy.

In addition, there were two professional adult male actors trained for addressing predefined role scripts as well as improvising according to the needs of the seminar demands. The actors were initially recruited through personal contacts and trained by the university personnel by providing short vignettes that captured key elements of common mental disorders such as ADHD, depression, anorexia nervosa, social anxiety, and by discussing the aims of the courses as well as key didactic points or common questions. The goal of this preparation was to ensure that the actors had understood key principles of the relevant disorders and their interactional impact rather than demanding strict adherence to a given script, as this seemed more fitting with the overall flexible approach of the course regarding varying material and cases in response to situational demands (for research on more formalized training, see Ay-Bryson et al., 2021). Actors were given financial compensation for their work.

#### Procedure

Each seminar comprised short preparatory sessions and then a 16-hour compact course conducted from Friday to Sunday. The preparatory sessions informed the students about the general format, provided material for diagnostic criteria and interactional challenges of common psychiatric disorders in the related age group, and defined small groups of students. Those groups prepared a short introduction into a diagnostic category based on DSM-5 categories (American Psychiatric Association, 2013), including a role-play to display and use at the compact course, which later served as the basis for role-playing exercises with peers and standardized patients.

The compact course usually started with an introduction to the topic and seminar format, including the development and formulation of feedback rules and foundations of therapeutic communication. Other input included methods for assessing relational patterns based on the relationship axis of the Operationalized Psychodynamic

Diagnosis system (OPD-2; see Ehrental, 2012; Ehrental & Benecke, 2019), which was taught by a brief introduction, followed by ratings of a short video of an actual young adult patient as well as further case discussion, if necessary. During each seminar, there was time to respond to topics and questions from the students, for example on how to assess suicidality. In addition to longer blocks of working with peer and standardized patient role-play in small groups as well as the whole seminar group, there were also short exercises from actor training to foster self- and body-awareness and empathy with children and adolescents as well as time for reflection and discussion. In the first courses, there was also video-based self-reflection of role-playing; however, because the general feedback from the early cohorts indicated that this had a large negative impact on students feeling comfortable enough to open up, and the format of video-based feedback reduced flexibility in role-playing from the perspective of the instructors, we dropped this element in the subsequent courses.

#### Measures

We assessed self-reported competence at the beginning and immediately after the course utilizing a self-constructed questionnaire. Seven items were initially rated on a Likert-type scale from 1 (*fully agree*) to 6 (*do not agree*). However, for reporting and all analyses, we decided to recode the data so that higher numbers represent a higher agreement. The translated items can be found in the Appendix A (Table A1). For the analyses, we computed a mean score of all items. The internal consistency of the scale was good both before (Cronbach's  $\alpha = .84$ ) and after (Cronbach's  $\alpha = .86$ ) the seminar.

After the seminar, another questionnaire assessed the experience of working with the standardized patients on 8 items coded as above; the items can be found in Table 2. Here, reliability was acceptable (Cronbach's  $\alpha = .70$ ). A third questionnaire then addressed the general evaluation of learning success from the course. Again, 8 items, found in Table 3, were coded as described above. The reliability of the measure was good (Cronbach's  $\alpha = .82$ ).

**Table 2.** Evaluation of working with standardized patients in the assessment seminar

Item	Range	M (SD)
I took the conversations with the standardized patients seriously.	5–6	5.76 (.43)
I found the conversations with the standardized patients to be authentic.	3–6	5.53 (.75)
I felt the conversations with the standardized patients were realistic.	3–6	5.44 (.73)
In the conversations with the standardized patients, I felt authentic.	1–6	4.97 (1.00)
I found the conversations with the standardized patients helpful.	4–6	5.78 (.53)
I found the conversations with the standardized patients helpful for assessing diagnoses.	3–6	5.31 (.77)
I found the conversations with the standardized patients helpful for assessing relationship patterns.	2–6	4.58 (1.18)
I would recommend the conversations with the standardized patients as a learning method.	4–6	5.85 (.45)

Note. All scales have a theoretical minimum of 1 and a maximum of 6.

**Table 3.** General evaluation of learning success of the assessment seminar

Item	Range	M (SD)
I achieved learning success through the seminar.	4–6	5.56 (.60)
The feedback from my fellow students was relevant to my learning success.	1–6	4.93 (1.32)
The feedback from the standardized patients was relevant for my learning success.	2–6	5.34 (1.01)
Feedback from the instructors was relevant for my learning success.	2–6	5.53 (.88)
After the seminar, I feel more confident in recognizing diagnoses.	2–6	4.75 (1.09)
After the seminar, I can shape the relationship in diagnostic interviews more consciously.	3–6	4.95 (.88)
The interventions are helpful for possible future therapeutic work.	4–6	5.66 (.58)
In the future, diagnostic interviews will be easier for me.	3–6	5.06 (.80)

Note. All scales have a theoretical minimum of 1 and a maximum of 6.

### Results

There was a significant and large increase in self-reported competence from before to after the assessment seminar (see Table 1). In addition, working with the standardized patients was evaluated as very positive (Table 2), as was the evaluation of learning success from the whole seminar format (Table 3).

### Seminar 2: Interventions in Child and Adolescent Psychotherapy

Aim of the intervention seminar was to increase the knowledge and competency regarding basic cognitive-behavioral intervention techniques in children and adolescents as well as to foster a general understanding of fundamental principles of psychotherapy. Again, using the model of competencies of Sburlati and colleagues (2011) as a guideline, we focused on generic therapeutic competencies, CBT competencies (e.g., formulating and implementing case formulation and treatment plan, fostering age-appropriate levels of collaboration, including parents, using age-sensitive language or therapy tools), and getting to know specific CBT techniques.

### Participants

This time, 51 students (86.4%) out of a total of 59 participating students from four seminars filled out questionnaires before and after the seminars; 80.4% identified as female, 19.6% as male. Forty-three of the participants of the intervention seminars also participated in the assessment course. Again, there were three instructors and two actors, as described above. This time, however, the actors were briefed on key issues of how children and adolescents may react to certain types of interventions, based on their knowledge of mental disorders from the previous seminar.

### Procedure

The format was similar regarding preparatory sessions, general length, and structure of the seminar, exercises from actor training, as well as peer and actor-patient role-playing. This time, students prepared key cognitive-behavioral interventions with the help of German manuals for a variety of common mental disorders in small groups. In the preparation for the seminar, we ensured that interventions for externalizing as well as internalizing problems were trained, and also that there were cases with younger children, sometimes including family mem-

**Table 4.** Experience of working with standardized patients in the intervention seminar

Item	Range	M (SD)
I took the conversations with the standardized patients seriously.	2–6	5.35 (.84)
I found the conversations with the standardized patients to be authentic.	3–6	5.08 (.88)
I felt the conversations with the standardized patients were realistic.	2–6	4.96 (.99)
In the conversations with the standardized patients, I felt authentic.	1–6	4.79 (1.23)
I found the conversations with the standardized patients helpful.	4–6	5.75 (.48)

Note. All scales have a theoretical minimum of 1 and a maximum of 6.

**Table 5.** General experience of learning success of the intervention seminar

Item	Range	M (SD)
I achieved learning success through the seminar.	2–6	5.50 (.75)
The feedback from my fellow students was relevant to my learning success.	1–6	5.21 (1.14)
The feedback from the standardized patients was relevant for my learning success.	3–6	5.37 (.77)
Feedback from the instructors was relevant for my learning success.	3–6	5.63 (.77)
After the seminar, I feel more confident in the use of the interventions.	2–6	4.92 (1.03)
After the seminar, I can use the interventions more consciously.	3–6	4.98 (.83)
The interventions are helpful for possible future therapeutic work.	3–6	5.48 (.83)
In the future, it will be easier for me to use interventions in therapeutic situations.	1–6	4.75 (1.14)

Note. All scales have a theoretical minimum of 1 and a maximum of 6.

bers, as well as with adolescents. In addition to getting to know and trying out the interventions, reflecting on experiencing consequences of techniques, roles, and interactional patterns during the interventions were key elements of the format.

### Measures

Similar to the first part of the study, we assessed self-reported competency before and after each seminar utilizing a questionnaire. Again, seven self-constructed items were initially rated on a Likert-type scale from 1 (*fully agree*) to 6 (*do not agree*). For reporting and all analyses, we also decided to recode the data so that higher numbers represent a higher agreement. Items are found in Appendix B, Table B1. For the analyses, we computed a mean score of all items. Internal consistency of the scale was good both before (Cronbach's  $\alpha = .81$ ) and after (Cronbach's  $\alpha = .85$ ) the seminar.

After each seminar, another two questionnaires assessed the experience of working with the standardized patients (Table 4) and general evaluation of learning success (Table 5), the former this time with 5 items, the latter with 8 items coded as described above. For the instrument assessing working with standardized patients, reliability was acceptable (Cronbach's  $\alpha = .79$ ), and for the general assessment it was good (Cronbach's  $\alpha = .81$ ).

### Results

Again, there was a significant and large increase in self-reported competence from before to after the seminar (Table 1). Evaluations of working with standardized patients (Table 4) and general learning success (Table 5) were again very positive, as indicated by the high values.

## Discussion

To our knowledge, this is the first published paper on experience-based and competency-oriented formats to increase students' knowledge and competencies for assessment and interventions in child and adolescent psychotherapy using innovative didactic formats such as standardized patients. We found students' subjective evaluation of competencies to increase with large effects, and a very positive evaluation of working with standardized patients as well as general learning success.

The results are generally in line with findings from adult populations (Kühne et al., 2021; Nikendei et al., 2019). While one could argue that formats like this would generally produce large effects, as they were at the time of the training quite rare at the level of university teaching, it is noteworthy that the course proved challenging to both students and actors, as they had to empathize with

and play children and adolescents. Especially the high ratings of working with standardized patients indicate that it is both possible and feasible to use adult actor-patients in role-playing for working with children. While we cannot conclude from this data that the use of SPs was a driving force behind the positive effects and evaluation, data from adult training tentatively point toward a possible relationship, at least in the experience of the participants (Ehrenthal et al., 2020). The same is true for other parts of the training that appear to be very helpful for the students, such as the exercises from actor-training, including awareness and empathy (e.g., a child imagination exercise); these variables, however, were not directly addressed in our evaluation.

There are also some other limitations to our study. First and foremost, we modeled the training around a mixture of theoretical assumptions, university course requirements as well as clinical experience. Therefore, one could argue that they were not derived purely from existing literature on training in child and youth psychotherapy, and that disentangling the interplay of different components and factors is difficult, if not impossible. And, of course, without randomization, we cannot be sure enough that the observed changes emerged because of the intervention format itself. However, as there was no research on similar competency training formats for this age group in German university settings, we aimed to incorporate multiple components to maximize the possible effects (see Herschell et al., 2010). In addition, this nonrandomized pilot study represents a first step in establishing a more thorough research program, including additive and dismantling designs. Because the data were collected in a purely routine setting, and because we wanted to ensure strict anonymity for the participating students, we had fewer data available than we would have wanted regarding personal information, including practical experience as well as personal experience with psychotherapy or other possibly relevant variables (e.g., Rek et al., 2018). Also, our sample size does not allow for more complex analyses taking into account possible predictors of learning success (Ehrenthal et al., 2020) and also potential dependencies between learning success in the assessment and the intervention seminar. In addition, it would be important to assess change regarding observable behavior (see, for example, Partschefeld et al., 2013). This is also important for the planned competency-based assessment in the new psychotherapy curriculum. Please also note that, in our study, we used self-constructed questionnaires. Although their content was adapted from instruments from other studies that showed effects of training not just via questionnaire but based on the frequency and competence of related interventions in actual therapy sessions (Nikendei et al., 2019), they were not

formally validated beforehand. Also, self-reports generally measure self-efficacy expectations more than actual competency levels. While self-efficacy expectations can be related to a more favorable clinical performance (Larson & Daniels, 1998), we presently do not have the data to test this in our sample. Therefore, in future studies, other measures should be employed that allow for a broader comparison of the results and benchmarking as well as expert ratings. At the same time, the development of new self-report as well as observer-based measures with good psychometric properties is an important task for the future of experience-based training formats in psychology. And last but not least, it is safe to say that the development of competencies is a central but certainly not the only challenge in university-based psychotherapy training (Gee et al., 2022).

From a practical perspective, we find several aspects important. First and foremost, instructors need to be qualified as therapists as well as in didactic concepts for experience-based learning. This is especially true for working with different age groups. Instructors should be at ease with showing their own clinical and interactional skills and with helping to create a mindful and positive learning environment. In general, four to five disorders or areas of interventions could be prioritized and trained in each course. From the perspective of training, we tried to condense input but increase role-play as well as time for reflection and discussion (see Appendix C, Table C1, for a prototypical timeframe). During role-play with peers and SPs, the students were instructed to play for 7–10 minutes in a given role and then reflect on it in a standardized and brief manner, before changing roles. Thus, all participants had the opportunity to experience the training in different roles (therapist, patient, observer) several times and were also able to interact with the SPs more than once. Although we did not force individuals to play the therapist role, we tried our best to encourage the students to engage actively in the training formats, usually with success. Creating a safe and respectful atmosphere is mandatory for students to benefit as much as possible. For example, we reserved time and used short episodes played by actors on how feedback should *not* be conducted and then reflected in the group on these issues, before implementing a special feedback instruction. Also, professionals conceptualizing seminars like this should consider that sometimes less is more. In other words, trying to extract core principles of interventions is a prerequisite for not overburdening the seminar with content and expectations. Standardized patients should be carefully selected and thoroughly trained (Kühne et al., 2021). On the other hand, if they are qualified, they may also add valuable input not only to the role-playing itself but also help with exercises and ideas of how students can get into

the different roles needed for this kind of work. In our case, we found mutual trust, flexibility, and the development of the seminar formats in close cooperation with the professional actors to be key elements in this endeavor. Furthermore, over time, the actors became important in recruiting suitable colleagues for future training as well as coaching those regarding professional requirements. At the same time, it is important to have a clear and appropriate payment structure to ensure the high quality of the standardized patients, which also means ensuring financial resources for this area.

Adding to what we already mentioned about ethical concerns in the Introduction, we deliberately decided against recruiting children or adolescents as actors. From our experience, professional standardized patients can play roles in the age range of elementary school or late kindergarten. Again, it is important to keep in mind that actors don't need to be children, but rather must be able to interact in a way that evokes challenges for the participants that are as similar as possible to what actual therapists experience when working with children and adolescents. The generally high ratings on the perception of working with the SPs in Table 4 add some evidence that this was possible, at least in a good enough manner. Systematic research on comparing perceptions of SPs and real patients (see Ay-Bryson et al., 2020) would be more difficult to conduct than in the field of adult psychotherapy.

In general, when planning related seminars, one should also keep in mind that individuals learning psychotherapy probably face different challenges at different stages of their career (Rønnestad & Skovholt, 2003), and that this should also translate in adapting training (Sharpless & Barber, 2009). Further ideas on how to plan experiential learning formats can be found elsewhere (Ehrenthal, Dinger et al., 2019; Kühne et al., 2021; Paparo et al., 2021). And last but not least, seminars like this are a learning experience for the instructors as well. Bringing an open mind for own personal and professional development usually helps to enjoy the beauty of working with bright, young professionals while helping them to develop and refine necessary skills.

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#### ORCID

Johannes C. Ehrental

 <https://orcid.org/0000-0002-9428-3763>

#### Jun.-Prof. Dr. phil. Johannes C. Ehrental

Department Psychologie

University of Cologne

Bernhard-Feilchenfeld-Str. 11

50969 Köln

Germany

[johannes.ehrental@uni-koeln.de](mailto:johannes.ehrental@uni-koeln.de)

## Appendix A

**Table A1.** Items measuring competence in the assessment seminar

I experience myself as confident when it comes to assessing diagnostic information.
I am likely to cope well with difficult situations in diagnostic interviews.
I know models that help me identify relationship patterns.
I find it easy to make clinical psychological diagnoses.
I understand how psychiatric diagnoses and relationship patterns may be related.
I find it easy to empathize with clients' psychological difficulties.
I usually recognize the motives behind clients' symptoms and difficult behavior.

## Appendix B

**Table B1.** Items assessing competence in the intervention seminar

I experience myself as confident in terms of conducting psychotherapeutic interventions.
I am likely to cope well with difficult situations in therapy sessions.
I know models that help me identify patterns (cognitions, behavior, emotions, relationships).
I find it easy to put psychotherapeutic interventions into practice.
I understand how psychiatric disorders and patterns of cognitions, behaviors, emotions, and relationships may be related.
I find it easy to empathize with the role of the therapist.
I feel confident in treatment planning.

## Appendix C

**Table C1.** Hypothetical example seminar timetable for the assessment seminar

Day	Times	Content
1	14:15-16:00	Introduction (40 minutes) Basic communication techniques (20 minutes) Developing feedback-rules (15 minutes)
	16:20-18:00	Empathy-exercise (20 minutes) Theoretical input and role-play (30 minutes) Role-play with peers and standardized actor patients (50 minutes)
2	09:00-13:00	Assessing relational patterns (60 minutes) Mindfulness exercise (20 minutes) Theoretical input and role-play (30 minutes) Role-play with peers and standardized actor patients (130 minutes)
	14:00-17:00	Theoretical input and role-play (30 minutes) Role-play with peers and standardized actor patients (150 minutes)
3	09:15-13:00	Theoretical input and role-play (30 minutes) Role-play with peers and standardized actor patients (165 minutes) Evaluation and feedback (30 minutes)

*Note.* All content areas include discussion in the main group and the small groups if applicable. Short breaks were usually taken after 90 to 120 minutes. If needed, the timeslots for role-play could also be used for additional practical demonstration by the instructors in front of the main group.