

## Functional Assessment of Skills for Interpersonal Therapists: The FASIT System

For the assessment of therapist behavior for  
interpersonally-based interventions including Functional Analytic Psychotherapy  
or FAP-enhanced treatments

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Several contemporary behavior therapies exist that espouse the importance of the therapeutic relationship including Functional Analytic Psychotherapy (FAP), Dialectical Behavior Therapy (DBT), and Acceptance Commitment Therapy (ACT). Each of these therapies has described the importance of focusing on the process of what occurs in session between the client and therapist in an effort to change client behavior. This interpersonal aspect is shared not only by behavior therapies but by numerous other paradigmatically driven interventions. Functional Analytic Psychotherapy posits that the mechanism of clinical change is therapist contingent responding to client problem and improved behaviors in-session. This suggests that the therapists conducting these types of interpersonally-oriented psychotherapies possess a corresponding set of interpersonal skills to be effective. The Functional Assessment of Skills for Interpersonal Therapists (FASIT) manual presents an approach to assessment and classification of behavioral repertoire problems that can prevent effective delivery of interpersonally-oriented psychotherapies such as FAP. The manual begins with a discussion of its purpose, the selection of target therapist behaviors for improvement, therapist self-assessment questions, questions used by the supervisor to assess the therapist, and a discussion of idiographically based tracking devices that can be developed using the FASIT system. The bulk of the FASIT manual presents definitions and examples of particular therapist problems in five domains or classes of interpersonal functioning. These classes include: Assertion of needs; bi-directional communication (providing and receiving feedback); problems with conflict resolution; disclosure skills related to developing interpersonally close relationships; and difficulties with the experience and expression of emotions. There is a repeated emphasis throughout the manual on the purpose of identifying and targeting therapist skills for change. It is highlighted for the reader that therapist skills which directly impact his or her ability to conduct interpersonally-oriented psychotherapies can be reasonable behaviors targeted for change by a supervisor. The FASIT manual provides a basic behavioral approach to assessing these therapist responses in order to assist with the identification, documentation, and amelioration of such problems in the context of supervision and training. Developing more effective interpersonally-oriented psychotherapy therapy skills should continue to be driven by its direct impact on alleviating client distress with these clinical interventions.

**Key Words:** Functional Analysis, Analytic, Psychotherapy, Assessment, Therapist, Skills, Interpersonal, Behavior, Interpersonal, Therapy

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This system is used to assist therapists in learning interpersonally-based behavioral and cognitive behavioral interventions including Functional Analytic Psychotherapy (FAP; Kohlenberg & Tsai, 1991) or FAP-enhanced treatments such as FAP Enhanced Cognitive Therapy (FECT; Kohlenberg, Kanter, Bolling, Parker, & Tsai, 2002) and FACT (Callaghan, Gregg, Marx, Kohlenberg, & Gifford, 2004). The Functional Assessment of Skills for Interpersonal Therapists (FASIT; pronounced “facet”) system is designed to target therapist problem and improved behaviors relevant to effectively conducting FAP. This manual is designed to be used with the Functional Idiographic Assessment Template (FIAT) system (Callaghan, in press). The FIAT manual specifies the classes of behaviors used with the Client Forms (FIAT-C pre and FIAT-C post) and Therapist Forms (FIAT-T pre and FIAT-T post) of the assessment template. The FIAT system is more expansive than this counterpart focusing on therapist skills. However, there are both parallels and important differences between the two systems. There are many

similar impersonal skills deficits that can appear with clients and with therapists alike. However, there will be some important differences, particularly with how these behaviors may occur, that make the FASIT system unique.

There are several essential skills for therapists to be able to be effective in FAP and other interpersonally-based psychotherapies. These skills include discriminating the impact of both client behaviors on them and their impact on the client. Responding effectively to clients remains imperative, including making requests for different client behaviors and disclosing the impact the client has on the therapist in the moment. Another fundamental skill required by therapists conducting FAP and other contemporary behavior therapies (including Acceptance Commitment Therapy; Hayes, Strosahl, & Wilson, 1999) is the therapist's ability to identify, experience, and then respond to his or her own emotional experience. Therapists in training may show difficulties in any of these areas; all of these skills are addressed in the FASIT manual.

The FASIT manual specifies classes of therapist problem behaviors seen in interpersonally focused interventions. These descriptions are based on the function of behaviors as they affect the therapist's ability to conduct FAP and other interpersonal interventions. Some of these behaviors are experiential or intrapersonally focused; however, the impact of those behaviors ultimately resides in an interpersonal context.

The purpose of this manual is to create highly individualized or idiographic assessment materials for each individual therapist in an effort to help the therapist improve in his or her ability to conduct an intervention. Examples of these assessments are included in the appendix of this manual. For a more thorough description of the types of assessments that can be created and examples of assessments of client assessment, the reader is referred to the FIAT manual. There is no one right way to create these idiographic assessment devices; they should each be tailored to the needs of the therapist, the supervisor, and even the particular on-going intervention with a client.

As with any nomenclature, the language used here is specific not only to the paradigm employed but also the author. The main idea for the FASIT system was to create a common language for frequently observed therapist behaviors that impede their ability to conduct an interpersonally-based behavioral intervention. This vernacular is intended to aid communication, assessment, and research in the community. With a new system employing a new vocabulary, it will take therapists and supervisors time and effort to become familiar and facile with the terms used here. As with systems of diagnosing or assessment, the more practice with the FASIT and its terminology, the greater its utility for the user.

### **Minimal Requirements**

The use of the manual assumes that therapists have a working knowledge of the principles of FAP and have an understanding of the administration of assessment devices in accordance with the ethical principles of test administration, or are receiving training in one or both of these areas.

*Understanding of Response Classes.* Users are also expected to have an understanding of behavior analysis, particularly of functional response classes of behavior. Briefly, a *response class* is a group of operant behaviors that have a particular effect regardless of the form the response might take (i.e., its topographical features). The distinction of form or topography versus function requires therapists and supervisors differentiate the effect or impact that the therapist's behavior is having rather than merely watching what the therapist is doing in one moment. For example, a therapist may make a humorous remark to a client. This will only be understood as effective or ineffective depending on the impact of that statement has on the client. The humorous remark may serve to make the client feel more at ease and more willing to disclose or the client could also feel distanced by this comment or even disrespected. Of

course this will depend some on the content of the humorous remark, but it will ultimately depend on what function the remark has on the client in that situation. (It should be noted that simply because the therapist makes one bad joke, this does not mean the therapist has important problems; this will be determined by a much broader sample of behavior.

Functional classes are understood idiographically and are based on the analysis of each particular therapist's problem and effective behaviors. For example, a therapist may be silent, overly familiar, especially formal, and so on. If each of these behaviors functions to allow the therapist to avoid talking about the emotional experience he or she is having in response to the client or in supervision, even though the behaviors have different topographies, they could all be instances of the same response class. It is the supervisor's and therapist's task to recognize the function of a response rather than identifying a behavior based merely on its topography.

Response classes in this manual are grouped into five main categories. Each of the classes is defined by a basic function served by the behaviors in the class. The classes described below are non-orthogonal. Each of the classes may overlap with other behavioral problems or deficits that the therapist exhibits. If the therapist shows problems in one class, it should not be assumed that the therapist does not show problems in another class. The choice of determining which class the behavior is a member of (e.g., problems with assertion of needs versus difficulties with conflict) is given to the supervisor in coordination with the therapist. The FASIT is designed primarily for clinical utility with respect to supervision and training goals. If the assessment serves the therapist and the supervisor to categorize the behavior one way over another, they would be encouraged to make that choice. The choice of classification of responses is made in as much as it serves the assessment and training of the therapist's skills in the service of the intervention for their clients.

### **Criteria for Inclusion of Class as Problem Behavior**

It is essential that the user understand that these classes define different repertoires that may be a source of attention in the process of supervision and training therapists. It would be expected that most individuals express some instances of each of the classes during their lives. Engaging in many of these behaviors periodically as determined by contextual variables would be very effective (e.g., escape behaviors, acquiescing to others' needs, etc.). To be assessed as a problem area, behaviors in each class need to be problematic for that therapist. The therapist with problem behaviors engages in these strategies inflexibly or with such salience that the behaviors interfere with their ability to effectively conduct the intervention. Problem behaviors are defined as ineffective or effective relative to the goals of training in FAP or other interpersonally based interventions through the shaping of a repertoire with social contingencies (Follette, Naugle, & Callaghan, 1996).

In some ways, this presents complications. There is a difficult process of discriminating therapist behaviors that are under the purview of supervision and those that are better addressed in the supervisee's own psychotherapy. This manual cannot possibly provide a definitive solution to this challenge, but the following rough guideline is offered. Therapist behaviors that impact the supervisee's ability to conduct the psychotherapy or intervention effectively and are clearly seen to impact their skills development in this domain are reasonable targets for supervision and the use of the FASIT system. Therapist behaviors that are viewed by the supervisor or supervision team as less effective in the therapist's broader functioning but that do not directly impact their ability to effectively conduct the intervention are not necessarily appropriate targets for identification using the FASIT or intervention in supervision. Situations will not typically be so clean cut, and there will of course be overlap between these two areas. The essential issue here is to remind therapists and supervisors that the therapist behaviors that are viewed as requiring amelioration should be those that are clearly tied to the skills being developed for that

intervention. It would be important to continue to refer to a conceptualization of the therapist's skills using the FASIT to remind supervisor and therapist which behaviors are being address and the reason.

### Organization of the Manual

Each of the classes described below begins with a definition of the class and then explicates each of the instances in the class that may be a focus on attention in supervision and clinical situations. These class and instance descriptors are then followed by specific assessment questions to be asked by the therapist and then by the supervisor. The Manual is organized for each class so that problems with *Contextual Cues/Discriminative Stimulus Functions* precede the *Response Repertoire* problem areas.

*Contextual Cues/Discriminative Stimulus Functions* include *Problems with Identification or Specification* that are defined as difficulties with identifying, labeling (tacting; Skinner, 1957) or specifying elements of the defined class. It is **essential** to determine whether or not the therapist has the skills to identify the features required of the targeted class before assessing the therapist's response repertoire. For example, if a therapist demonstrates a lack of ability to respond to feedback given by others, the supervisor or therapist **must** assess whether the therapist has the skills to discriminate that feedback has been given and the therapist has determined whether this feedback is accurate or inaccurate. If there are deficits in this area, and the supervisor or therapist attempts to alter the *Response Repertoire* of *Lack of response to feedback*, it is likely the therapist will still be unable to respond effectively in novel situations.

*Problems with Appropriate Contextual Control* define other contextual cue problems therapists may have. These behaviors are characterized by a lack of discrimination of situations, times, or other persons with whom to engage in the response. For example, for therapists with *Problems with Emotional Experience and Expression*, the therapist may be unable to specify the conditions under which emotional expression would be more effective. These conditions include with whom to engage in the response, the time or other setting factors to consider, and the situation where this would be more effective to do.

The *Response Repertoire* section includes instances of the expression of each response the therapist may engage in for the targeted class. This section includes escape, avoidance, excess, and deficits of behaviors relevant to the class.

### A Note on Function, Form, and the FASIT

As described with the FIAT system, the FASIT manual attempts to describe behaviors in terms of function, but it does not provide a precise functional analysis as defined by a detailed specification of stimulus, response, and consequences. The FASIT attempts to detail and give a consistent language to those behaviors that have the general function for the therapist of impeding their ability to effectively conduct FAP or other interpersonally-oriented therapeutic intervention.

The ultimate goal of using the fast should remembered, to aid with the assessment and intervention of therapist problem behaviors and the development of more effective skills with respect to conducting their interventions with clients.

## Assessment

It will be important that supervisors, peer supervisors, and therapists view either live sessions or video tapes of sessions to assess for the problems detailed in this manual. While not required, it may be helpful for therapists to code sessions for client and therapist behaviors using the Functional Analytic Psychotherapy Rating Scale (FAPRS; Callaghan, 1999)

Identifying problem behaviors can occur by watching a live therapy session, viewing video taped sessions, or observing therapist behavior in group on individual supervision. Therapist problem behavior may be observed both while the therapist interacts with a client or during a supervisory interaction. Again, the purpose of using the FASIT to identify therapist responding that is ineffective is to assist in the training of the supervisee to become more effective conducting the intervention. Larger life goals and values not impact the therapist's ability to perform the psychotherapy but that the supervisor has for the therapist are not targeted using the FASIT system.

Each *Assessment Questions* section begins with a note to help define the class for the therapist and supervisor. Both should be familiar with these specific notes and should be able to convey what the questions are asking. The supervisor cannot assume that the therapist has the same definition for the key terms being assessed (e.g., "asking for something" or "feedback"). The therapist definitions should be sufficiently broad so that the supervisor can gather as much information as possible by asking the questions.

There are two types of assessment questions that follow: (1) *Therapist Self-Assessment Questions*, and (2) *Supervisor Assessment Questions*. Following each question, a set of brackets will enclose a key word designed to redirect the reader to that section in the class just defined and discussed. For example, if [discrimination] appears, the reader is redirected to the section Contextual Cues/Discriminative Stimulus Functions. If [general repertoire] appears, this means the question is broadly about the class and is a way to begin to focus subsequent questions.

### *Therapist Self-Assessment Questions*

*Therapist Self-Assessment Questions* are asked by the therapist him or herself at the outset of and throughout supervision. These questions are designed to help determine the presence of therapist problem behaviors that may occur over the course of their training in FAP or another interpersonally-based intervention. For these questions, the therapist needs to assess the extent to which the behaviors occur in interpersonal relationships. The supervisor will use the answers given from the *Therapist Self-Assessment Questions* as well as observations from the therapist's interactions with the client to assess for target problems and improvements. The *Therapist Self-Assessment Questions* are intended to provide specific information about the extent to which instances in the response classes can or will appear in-session with the client or in supervision meetings. These questions can also be asked by others (e.g., supervision team members) who are observing the therapist.

### *Supervisor Assessment Questions*

*Supervisor Assessment Questions* are asked by the supervisor at the beginning of the supervision process and throughout the therapist's training. These questions are designed to help determine the presence of therapist problem behaviors that may occur over the course of their training. For these questions, the supervisor needs to assess the extent to which the behaviors occur in-session or in other interpersonal interactions the therapist has with the supervisor or others. The supervisor will use the answers given from the *Supervisor Assessment Questions* as well as observations from the therapist's

interactions with the client to assess for target problems and improvements. Answers to these questions can also be provided by others (e.g., supervision team members) who are observing the therapist.

Again, it is highly recommended that the supervisor and peer supervisors frequently observe the therapist conducting therapy (live or with video recording) to get a broad sample of therapist behavior to determine whether the therapist is effective in conducting the intervention. Supervisors are cautioned about relying on therapist self-report or self-assessment as the sole determiner of targets using the FASIT system.

### *Assessment Forms*

Examples of idiographic assessment forms used to assess and help develop therapist skills are included in the appendix of this manual. There is no one specific correct way to create these idiographic assessment devices; they should each be tailored to the needs of the client, the therapist, and the on-going intervention.

Examples of the idiographic forms created using the FASIT and the FIAT include the Therapist Pre-Session and Therapist Post-session questionnaire. While these are specific to the goals of Functional Analytic Psychotherapy, both include additional session questions aimed at training the therapist and can be modified in any way to help target specific therapist problem and improved behaviors.

## OVERVIEW OF CLASSES IN THIS MANUAL

<b>CLASS A</b> <b>Assertion of Needs</b>
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### Contextual Cues/Discriminative Stimulus Functions

#### ***Problems with Identification or Specification***

*Unable to identify or specify needs from supervisor*

*Unable to identify or specify what is needed from the client (being on time, homework, evoking C2s and C3s)*

*Cannot identify that a request could be made to meet therapist need from client or supervisor*

#### ***Problems with Appropriate Contextual Control***

*Problems with under-generalizing features of relationships*

*Problems with over-generalizing features of relationships*

### Response Repertoire

#### ***Escape or Avoidance Repertoire***

*Escape*

*Avoidance*

#### ***Ineffective or unclear assertion of needs***

*Disguised Request*

#### ***Rejecting that a need is present (distorted tact)***

*Excessive requests or demands for needs to be met*

*Aversive Response Style*

<b>CLASS B</b> <b>BI-DIRECTIONAL COMMUNICATION</b>
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**Contextual Cues/Discriminative Stimulus Functions**

***Problems with Identification or Specification***

*Identifying or describing impact on others, particularly as they relate to being in an interpersonal relationship*

*Identifying that feedback is being given by another person about the therapist's impact on others*

*Discriminating whether feedback from others is accurate*

*Identifying opportunities to provide feedback to others*

*Identifying that feedback given is accurate to others*

***Problems with Appropriate Contextual Control***

*Identifying appropriate persons, situations where getting feedback would be useful*

*Identifying appropriate persons, situations where giving feedback would be useful*

**Response Repertoire**

***Receiving feedback/observing impact***

***Lack of response to observed impact or feedback from others***

*not modifying repertoire*

*failing to acknowledge that feedback has been given*

***Insensitivity to Feedback***

*Rejection of feedback by others*

***Escape or Avoidance Repertoire***

*Escape Repertoire: Hypersensitivity to observed impact on others and feedback from others*

*Avoidance Repertoire: Failure to solicit feedback from others*

***Providing Feedback to Others***

*Failure to provide feedback*

*Ineffective/Over-elaborated/Unclear feedback*

*Negativistic feedback*

*Overly detailed feedback to others*

*Perseveration of feedback*

<b>CLASS C</b> <b>CONFLICT</b>
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**Contextual Cues/Discriminative Stimulus Functions**

*Problems with Identification or Specification*

*Problems with Appropriate Contextual Control*

**Response Repertoire**

*Escape or Avoidance Repertoire*

- Excessive acquiescence*
- Social withdrawal*
- Excessive appeasing or conciliatory responses*

*Indirect/Ineffective attempts to resolve conflict*

*Unwillingness to compromise in conflict*

*Conflict-Facilitating or -Escalating Repertoire*

<b>CLASS D</b> <b>DISCLOSURE AND INTERPERSONAL CLOSENESS</b>
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**Contextual Cues/Discriminative Stimulus Functions**

*Problems with Identification or Specification*

- Identifying that supervision or client has features of close relationship*
- Identifying that supervision is place for seeking support*
- Identifying that therapy is not a place for seeking support*

*Problems with Appropriate Contextual Control (in-tact repertoire)*

- Therapist engages in repertoire that is ineffective/inappropriate in session or supervision that is not appropriate stimulus control (over-disclosure)*
- Therapist engages in a restricted range with client or supervisor (given that repertoire is intact in some context) (under-disclosure)*

**Response Repertoire**

*Escape or Avoidance Repertoire: Infrequent seeking of interpersonally close interaction*

- Low Desire for Closeness*

*Unclear self-disclosure to other*

*Inaccurate self-disclosure*

*Excessive self-disclosure*

*Therapist seeks support from client/fosters dependence*

*Failure to solicit other's disclosure*

*Problems with general pro-social repertoire*

*Failure to respond to other's disclosure or requests and/or reciprocate with social support*

<b>CLASS E</b> <b>EMOTIONAL EXPERIENCE AND EXPRESSION</b>
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**Contextual Cues/Discriminative Stimulus Functions**

*Problems with Identification or Specification*

*Problems with Appropriate Contextual Control*

**Response Repertoire**

*Escape or Avoidance Repertoire (infrequent experience)*

*Escape Repertoire*

*Avoidance Repertoire*

*Inaccurate label of emotional experience*

*Ineffective or unclear description of emotional experience*

*Excessive affective expression*

<b>CLASS A</b> <b>ASSERTION OF NEEDS</b>
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Class A is defined by behaviors that function to inhibit a therapist's ability to be effective in providing FAP or interpersonally-based treatment due to problems the therapist has with identifying needs or asserting requests as they pertain to supervision or the therapy process. These needs may be directly related to the supervisory process, where the therapist has difficulty either identifying his or needs related to treatment, or he or she has difficulty asserting requests in supervision. Problems in this area can also center on the therapist's difficulties with identifying what is needed from a client during a session that would improve the client's functioning as well as difficulties the therapist has with making these requests in an effective way. These needs may be for direction from the supervisor or for emotional support during the learning process or with a difficult client. Clearly conveying these needs to the supervisor or the supervision team may be essential for the successful development of the therapist's intervention skills.

It is not common in psychotherapy to focus on the needs of the therapist; this focus is most typically placed on the client. However, aside from the needs a therapist may have from a supervisor, when conducting interpersonal interventions, the supervisee may request that the client engage in some specific response. These requests need to be made clearly and effectively to the client. Types of requests can include discussions of outside of session improvements, talking about homework, or in-session behaviors. Consider, for example, the therapist wants to shape a particular client behavior in-session related to clearly describing an emotional experience (Class E). If the client is engaging in a problem behavior in-session such as vaguely describing that emotional experience, and the therapist needs the client to describe that feeling more clearly so that the therapist can know how to respond, he or she will

request that the client try to convey that feeling differently. This request should come to the client clearly so that the client could attempt an alternative response. The client may not be able to respond effectively, but should not be due to the lack of clear assertion by the therapist.

Class A describes therapist behaviors including:

- (1) the therapist cannot identify or specify his or her needs from a supervisor,
- (2) the therapist is unable to identify or specify what is needed from the client (being on time, homework, evoking in-session problems or improvements),
- (3) the therapist cannot identify that a request could be made to meet the therapist's needs from client or supervisor
- (4) the therapist under-generalizes or over-generalizes features of the supervisory or therapeutic relationship that prevents effective treatment
- (5) The therapist does not discriminate situations where it would be appropriate to make requests that would engender a more effective supervisory or therapeutic relationship,
- (6) the therapist will not assert a complete request to the client or supervisor or avoids making or asserting a need,
- (7) the therapist is unable to directly assert his or her needs in supervision or in treatment with a client,
- (8) the therapist rejects that a need is present or a request has been made from either a supervisor or a client,
- (9) the therapist makes excessive requests in a way that is ineffective to either supervision or therapy,
- (10) the therapist engages in asserting requests in an aversive way such that the listener is not likely to comply.

### **Contextual Cues/Discriminative Stimulus Functions**

#### ***Problems with Identification or Specification***

In this instance the therapist cannot identify or specify his or her needs from a supervisor as they relate to the therapist improving his or her skills in therapy. These problems with identifying or specifying what is needed from the supervisor may or may not parallel those problems the therapist has with clients during session. If the therapist is unable to identify or specify what is needed from the client (being on time, homework, evoking in-session problem or improved behaviors), then these problems are documented in this instance. This area also defines problems the therapist has with identifying that a request could be made from a client or supervisor. For example, the therapist may be unaware that when the client engages in negativistic, rude, hostile, confrontational, or other aversive responding that the therapist can make a request for the client to try to respond in a more interpersonally effective and appropriate manner.

#### ***Problems with Appropriate Contextual Control***

Therapists who can identify or specify what is needed from a supervisor or client may still have problems discriminating the appropriate situations to ask for needs to be met. The contextual control of with whom, as well as when and where, to make requests of others or assert needs is essential to assess. If the therapist does not discriminate these features, he or she will receive feedback from a supervisor or client that will not sustain an effective response set in this domain.

*Problems with under-generalizing features of relationships.* In this case, the therapist does not effectively discriminate conditions where he or she could make a request from a supervisor or client, even though that request is a reasonable one. An example of this case includes when a therapist is feeling badly and could talk with a supervisor to feel better, but decides not to because he or she doesn't wish to "burden the supervisor" with the therapist's problems. Here, the therapist is not effectively discriminating the features of the relationship that would allow a request to be made. If the therapist can and does make

requests from others but does not do so under certain conditions where it would be inappropriate, then the therapist does not likely have a problem in this area.

*Problems with over-generalizing features of relationships.* Another problem in this instance of Class A includes those requests or demands from others that are not warranted by the nature of the relationship or exceed the boundaries of that relationship. If a therapist were to request or demand that a supervisor see him or her during off-hours, immediately or twice a day, this would likely be excessive. If a therapist requests that a supervisor or client provide him or her with a great deal of emotional support, this could potentially be considered to exceed the boundaries of the relationship.

## Response Repertoire

### *Escape or Avoidance Repertoire*

Therapists who can discriminate the appropriate context to assert a need or make a request may have difficulties engaging in these activities because they avoid or escape aversive contingencies. These individuals may have problems asserting a need when the situation is appropriate or difficulties responding to others' requests when they encroach on or oppose the therapist's own needs.

*Escape Repertoire.* Therapists who have problems with an escape repertoire will make a request or assert a need and then terminate it before it can be met due to an increase in perceived social discomfort. In this case, therapists may experience discomfort or other aversive feelings (including guilt) that he or she will seek to terminate. In this situation the therapist might have some difficulties discriminating contextual features that would support requesting a need be met. The therapist may also be hypersensitive to the feedback of others (see CLASS B) or may seek to avoid conflict (see CLASS C).

*Avoidance Repertoire.* Therapists with problems with an avoidance repertoire fail to assert a need or make a request at all due to a fear of social repercussions. In this case, the therapist will not make requests of others because he or she avoids experiencing some aversive emotion as a result of making such a request. These individuals may appear timid or shy.

*Rejecting that a need is present.* This instance is defined by a therapist's behavior serving to decrease the likelihood that his or her needs will be met due to a rejection or denial of the presence of a need. When the therapist has an opportunity to state his or her need or that a request is being made (or even could be made), the therapist states that this is not the case, that there is no need or request. For example, a therapist may be asked by a supervisor, "Are you asking me for something right now, like support?" and then respond with "No," even though the therapist does have this need.

If the therapist can detect that needs are present as well as conditions under which to make requests, but the therapist will not admit that a need exists or is being asserted, then the therapist may have problems with other instances in this class. Specifically, the therapist may have problems with an escape or avoidance repertoire where there are fewer immediate and aversive short-term consequences of denying a need than those associated with clearly making the request.

### *Ineffective or Unclear Assertion of Needs*

Therapists who can identify and specify their needs may experience difficulties with directly conveying this information so that others respond effectively to the therapist. The result of indirectly or unclearly making a request of the listener can include confusion and misunderstanding.

Indirect requests can appear as vague statements that are not clearly understood by the listener. Unclear assertions can also be surrounded by so many disqualifying or self-deprecating statements that

the listener does not understand the request being made or does not take the request seriously. If the listener misunderstands what is being requested, then the therapist likely will not get his or her needs met.

*Disguised Request.* A particular instance in this class is making a request that is disguised as an observation or a question that is not a direct request for what is needed (disguised mand; Skinner, 1957). An example of this is found in requests disguised as observations such as “It’s hard for me to get to supervision on time,” when the therapist would like the supervision time to change. Another example of this problem area is when a therapist would like to receive sympathy from another person and says, “People don’t understand how hard this therapy is to do.” Clearly asserting this need would appear as “I need you to...” Disguised requests also occur as questions such as, “Do you mean to speak to me in that tone of voice?” when the therapist would like the listener to alter his or her behavior.

Asking questions or making observations rather than directly asserting needs is frequently quite successful for many individuals. Often times listeners comply with the disguised request naturally. To be considered a problem, an individual whose need was not met with the disguised request would *not* follow with a direct request. This would result in the therapist frequently not getting his or her needs met from the supervisor or accomplish the goals of therapy when either could not interpret or respond naturally to the disguised request.

#### ***Excessive Requests or Demands for Needs to be Met***

Therapists who make excessive requests or demands of others have problematic relationships as a result of high frequencies of these behaviors. The therapist may accurately discriminate when and with whom to make requests or assert a need, and he or she may have the repertoire to assert these needs clearly. The problem in this class lies with the therapist asserting so many needs and making so many requests of the client or supervisor that the listener no longer acknowledges or meets these needs. An example of this type of therapist is one who overwhelms the listener with demands or requests. This may occur when the therapist is frustrated with the client or anxious about having the intervention be effective. It can also occur when the therapist attempts to excessively problem-solve for the client. Each of the asserted needs may be reasonable, but the quantity makes it difficult for the listener to comply. Therapists with problems in this area may also have problems with CLASS B below, inability to accurately discriminate his or her impact on others.

#### ***Aversive Response Style***

In this instance, the therapist discriminates the conditions under which a request can be made, but the style, approach, attitude, tone, or other aspects of communicating his or her need function to decrease the likelihood the need will be met. Here, the therapist may make demanding statements or express affect in such a way that listener engages in counterpliance or otherwise resists meeting the request.

### **ASSESSMENT QUESTIONS FOR CLASS A**

For questions about assertion of needs from others, “needs” is defined as anything the therapist desires. Needs from others may include requests for interpersonal closeness, support, or pragmatic or logistical needs. These needs may or may not appear as reasonable to others.

#### **Therapist Self-Assessment Questions for Class A:**

1. Do you feel like other people are able to meet needs that you have? [overview of class]
2. Are your needs met when you have them, or are they met later on? [overview of class]
3. What kinds of needs do you have from other people? [discrimination]

4. Are you able to make requests from others to meet your needs? [discrimination]
5. What types of requests do you make? [general repertoire]
6. Are you able to recognize when you need something from someone else? [discrimination]
7. Are you able to identify times or situations when it is better to ask for what you need? [discrimination]
8. Can you identify people that are more likely to meet these needs? [discrimination]
9. Do you often begin to ask for something, and then change your mind and decide not to make the request or take the assistance? [escape response]
10. Do you often decide not to ask someone for something even though it might be a reasonable request to make? [avoidance response]
11. Are you able to express these needs directly to others, or do you hint at your needs? [ineffective response]
12. Are others clear about what you need when you ask for something? [ineffective response]
13. Do you ask for something by making a statement or observation rather than making the request directly? [ineffective repertoire: disguised]
14. Has anyone ever given you feedback that you ask for too much or make requests too often? [excessive response]
15. Has anyone ever told you that the way in which you ask for something is off-putting or otherwise makes it hard to comply with what you want? [aversive response]

#### Supervisor Assessment Questions for Class A

1. Does the therapist have problems getting his or her needs met? [overview of class]
2. Are there times when the therapist has trouble getting his or her needs met in-session or from supervisor?
3. Can the therapist discriminate when he or she has needs and what those are as they occur in-session with the client or with supervisor? [discrimination]
4. Is the therapist able to make requests from a supervisor or client? [general repertoire]
5. What types of requests does the therapist make? [general repertoire]
6. Is the therapist able to discriminate that the supervisory setting is an appropriate place to make a request? [discrimination]
7. Are the therapist's requests appropriate of a supervisor or client? [discrimination]
8. Does the therapist begin to ask for something from the supervisor or client and then terminate the request or take assistance due to a perceived level of discomfort? [escape response]
9. Does the therapist fail to make requests even though they are reasonable requests to make? [avoidance response]
10. Is the therapist able to make requests of the supervisor or client in-session, or does the therapist do this indirectly, making it difficult to know what the request is? [ineffective response]
11. Does the therapist ask for something by making a statement or observation rather than making the request directly? [indirect repertoire: disguised]
12. Does the therapist make an excessive number of requests of the supervisor or client in-session? [excessive response]
13. Does the therapist make a request in such a way that the request is experienced by a supervisor or client as aversive? [aversive response]

<b>CLASS B</b> <b>BI-DIRECTIONAL COMMUNICATION</b>
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Class B is defined by behaviors that function to inhibit a therapeutic relationship between the therapist and client or an effective professional interpersonal relationship between the therapist and supervisor due to the therapist's inability to discriminate, or respond effectively to the impact he or she has on other people, or due to problems with providing feedback to others. The goal of assessing for Class B behaviors is to capture the bi-directionality of noticing the impact of others and ourselves as well as providing feedback and responding to it.

Class B is essential in interpersonal therapist, especial FAP. The mechanism of clinical change has been described as the therapist's in-session contingent responding (shaping) to client problem and improved behaviors. Discriminating and providing feedback about the impact of client behaviors is as fundamental to FAP as observing the impact of our own behavior. For many therapists this begins with deficits in discriminating impact and feedback. Providing this information to clients occurs as a complex repertoire. Supervisors and therapists should be certain that the supervisee's ability to discriminate client impact on them and their own impact on clients is well developed.

Class B describes therapist behaviors including:

- (1) the therapist cannot identify or specify the impact that he or she has on the client or supervisor,
- (2) the therapist does not discriminate situations where or when it would be more effective to notice his or her impact,
- (3) the therapist cannot identify or specify the impact that the client or supervisor has on the therapist,
- (4) the therapist does not discriminate situations where or when it would be more effective to notice the impact of the client or supervisor on the therapist,
- (5) the therapist lacks an effective response to observed impact or feedback given by others,
- (6) the therapist is insensitive to his or her impact on others (and may escalate the original response),
- (7) the therapist is hypersensitive to his or her observations about impact or to feedback from others,
- (8) the therapist has problems with effectively providing feedback to others about their impact on the client.

### **Contextual Cues/Discriminative Stimulus Functions**

#### ***Problems with Identification or Specification***

In this case, the therapist has problems

- (a) identifying or describing his or her impact on others, particularly as they relate to being in an interpersonal relationship with the supervisor or client,
- (b) identifying that feedback is being given by another person about the therapist's impact on others,
- (c) identifying or specifying the impact that the client or supervisor has on the therapist,
- (d) discriminating whether feedback is accurate,
- (e) identifying that feedback can be given.

The therapist may have problems observing or being aware that he or she has an impact on others (either effective or ineffective). Problems in this area may occur when the therapist is unaware of the stimulus functions he or she brings to a social interaction. These functions may inhibit the development or maintenance of a social relationship.

A therapist may also have problems recognizing that the impact of a client or that feedback has been given to him or her with an expectation that the behavior then be altered. In this case, the therapist may

or may not have the repertoire to alter the behavior once the discrimination is made (see *Lack of Response to Observed Impact or Feedback from Others* below). Before assessing the therapist's response repertoire, it is essential to determine whether or not the therapist has the skills to determine that feedback has been given.

Problems with identification also occur when the therapist cannot recognize whether accurate feedback about his or her behavior is being given. For therapists who reject all feedback that is critical or negative, the supervisor must assess that this is not a problem with identification that feedback has been given. One key consideration in making this distinction is if the therapist recognizes and responds to praise but rejects all critical feedback. If the therapist responds differentially like this to negative feedback, the therapist likely has the skills to make this identification, but has problems with the response repertoire instance of *Insensitivity to Feedback*, particularly, *Rejection of Feedback by Others* (see below).

Problems with identification also occur when the therapist fails to discriminate situations where he or she could provide feedback to another person about their behavior. This feedback would be useful to the other person and may engender a closer interpersonal relationship. If the therapist has problems making a request of another person for his or her needs to be met, then these problems are addressed in CLASS A.

#### ***Problems with Appropriate Contextual Control***

Therapist with problems in areas of contextual control do not discriminate appropriate times or situations (when or where or with whom) to be more or less sensitive to the impact or potential impact they are having on others or situations where it would be appropriate to provide feedback to another person. For example, if the therapist has difficulty discriminating situations where or when it would be more effective to notice the impact of the client or supervisor on the therapist; this would need to be improved.

### **Response Repertoire**

#### ***Escape or Avoidance Repertoire***

Therapist may have problems with both seeking and responding to feedback from others about their behavior. The following are specific repertoire problems that serve to decrease the likelihood that the therapist experiences or continues to experience difficult interactions surrounding feedback.

*Escape Repertoire: Hypersensitivity to Observed Impact or Feedback from Others.* In this instance, the therapist has problems with observations about his or her impact on others or receiving feedback. Here, the therapist is hypervigilant about his or her impact on others and is overly sensitive to changes in expressions from the listener. This hypersensitivity results in the therapist changing his or her behavior to escape (terminate) any aversive stimulus from the listener despite the therapist's own needs. In this case the therapist may appear overly acquiescent to the demands of others.

*Avoidance Repertoire: Failure to Solicit Feedback from Others.* This specific instance characterizes problems with the therapist's lack of asking others for feedback about his or her behavior. This avoidance of asking for feedback about the therapist's performance prevents the therapist from contacting aversive feelings during this type of interaction. However, the therapist remains unclear about his or her impact on others or about his or her performance by failing to ask. There are situations where having this repertoire intact facilitates an interpersonal relationship if the therapist would inquire about his or her impact.

***Lack of Response to Observed Impact or Feedback from Others***

Here, the therapist recognizes that his or her impact is less effective through their own observation or from feedback given by others, and the therapist can discriminate its accuracy but does not know how to respond differently. The therapist may respond to this discrimination or the direct feedback with a blank stare, stopping the interaction, or fail to express affect congruent with the feedback being given. This lack of response may be to feedback that is either positive (e.g., praise) or negative (criticism).

In the case of direct feedback being given, this lack of or ineffective therapist response results in the person giving the feedback being unaware of the therapist's understanding or that the therapist listened to the feedback. In essence, the therapist fails to respond the prompt implicit in the speaker's statements.

***Insensitivity to Feedback***

In this situation the therapist can recognize that his or her impact is ineffective or aversive (boring, hostile, etc.) or has been given direct feedback about this impact, but the therapist continues to maintain or increases the rate of response. This maintained or increased response rate appears as insensitivity to or ignoring feedback and serves to interpersonally distance the therapist from others.

*Rejection of Feedback by Others (Externalization).* One specific type of *Insensitivity to Feedback* occurs in the form of the therapist rejecting feedback despite its accuracy and stating that the source of the feedback is wrong or is at fault for giving the feedback. This type of inaccurate identification is designed to stop the feedback given by the supervisor or client. The result of the behavior by the therapist decreases the availability feedback given and possibly social interactions in general.

If the therapist escalates the response rate or engages in a different response (such as aggressing against the person for giving the feedback) that functions to or is an effort to create conflict, then the therapist likely has problems with CLASS C, Problems with Conflict (see below). In this case, the therapist's behavior should also be still assessed to determine whether he or she could discriminate the impact that he or she is actually having.

***Problems Providing Feedback to Others***

The following is a set of problems that therapists may have with providing feedback to supervisors or clients about their impact on the therapist. These problems focus on difficulties providing this feedback that would otherwise be facilitative of closer and more effective relationships. If the therapist has difficulties making requests from others to get his or her needs met or assert his or her values, then these problems are addressed in CLASS A. In the instances of *Negativistic feedback* and *Preservation of feedback* the supervisor needs to determine if these are presentations of *Problems Providing Feedback* or are better understood as CLASS C: *Conflict*.

*Avoidance Repertoire: Failure to Provide Feedback.* In this case, the therapist does not provide feedback to others in most or all situations. This may be due to the therapist's fear that others will become upset, or other reasons that create an avoidance repertoire for providing input to others about their impact on the therapist.

*Ineffective/Over-elaborated/Unclear Feedback.* If the therapist expresses problems with providing clear and concise feedback to others, then the other person will not have the opportunity to modify his or her behavior. This instance may include the use of excessive wording or making a repeated attempts at explanation that make it unclear what the therapist's response is to the client or supervisor

person. Here, a description of impact is made, but it is lost in the rest of the response so it no longer functions as feedback or a request for alternative responding.

*Negativistic Feedback.* In this instance, the therapist provides excessive or highly focused feedback about the problems of the client or supervisor without providing other response options or a context of general support. This type of feedback creates a context for the other person that makes it difficult to respond to the therapist with an improved response.

*Overly Detailed Feedback to Others.* This type of problem describes the therapist's use of excessive detail about the other person's behavior problems as they impact the therapist. This problem is similar to *Negativistic feedback* in that it does not optimize the likelihood that the other person will engage in a more effective new response following the feedback.

*Perseveration of Feedback.* This instance describes the therapist continuing to provide feedback beyond its point of being useful to the listener.

### ASSESSMENT QUESTIONS FOR CLASS B

The definitions of bi-directional communication are important to these assessment questions. For these questions, the supervisor needs to inform the therapist that *impact* simply refers to how we affect others when we interact with them. The supervisor may use examples to illustrate types of impact (e.g., "A comedian has a humorous impact on the audience," etc.).

With respect to the term *feedback*, the supervisor tells the therapist that these questions pertain to all different types of feedback or information that we get from other people about our interaction. This feedback may be subtle or more directly spoken, but it includes all types of input from others. The therapist should be clear that *feedback* is not just that information provided in more formal evaluations (i.e., in a work setting). These are the "clues" or "cues" that each of us receives from others during our interactions.

#### Therapist Self-Assessment Questions for Class B

1. Are you able to notice the impact that you have on others, that is, how others perceive you or feel about you when you are interacting? [discrimination]
2. How would you describe this impact? [discrimination]
3. Do you sometimes make remarks that could be interpreted offensively by others? [discrimination]
4. Are you aware or do you notice when other people are giving you feedback about your behavior? [discrimination]
5. Do you feel like you change what you do in a way that is consistent with the feedback that has been given to you? [discrimination]
6. Are there times or situations when you need to be more aware of your impact on others? [context control]
7. Are there times or situations where it would be better for you to respond to feedback you are given? [context control]
8. Are you able to respond when people are giving you feedback? [general repertoire]
9. When others give you feedback, are there times when you do not know how to respond to it? [lack of response]
10. Do you ever have trouble changing what you are doing when you notice or are told that you aren't having the impact you would like to be having? [lack of response]

11. Do you often ignore or decide not to respond to the feedback that others give to you? [insensitivity response]
12. When you notice your impact is less effective or are given feedback about this, do you continue to do the same thing, perhaps in an effort to make yourself better understood? [insensitivity: increased response]
13. Do you find yourself fighting with someone if he or she gives you feedback that is hard to hear? [assess CLASS C]
14. Are you very sensitive to how you affect others? [hypersensitivity reps]
15. Are there situations when you are very sensitive about feedback that has been given to you? [hypersensitivity response]

**Supervisor Assessment Questions for Class B**

1. Does the therapist have problems identifying that he or she has an interpersonal impact on the supervisor or client? [discrimination]
2. Is the therapist able to recognize when he or she has been given feedback by the supervisor or client? [discrimination]
3. Can the therapist discriminate when he or she affects the supervisor or client during session? [discrimination]
4. Does the therapist value the feedback of the supervisor or client? [discrimination]
5. Is the importance that the therapist places on the supervisor or client consistent with the nature or development of the supervisory or therapeutic relationship? [discrimination]
6. Does the therapist respond to the supervisor or client when feedback about his or her behavior is given? [general repertoire]
7. Does the therapist evidence a lack of a response repertoire to effectively respond to the supervisor or client when feedback is given? [lack of response]
8. Does the therapist adjust his or her behavior consistently with what the supervisor or client has given as feedback? [insensitivity]
9. Does the therapist differentially reject feedback that is critical, but accepts feedback that is positive? [insensitivity]
10. Does the therapist continue to engage in or increases his or her responding even though direct feedback about the response has been given? [insensitivity: increased response]
11. Does the therapist become antagonistic when feedback is given? [assess CLASS C]
12. Is the therapist overly sensitive with regard to his or her impact on the supervisor or client? [hypersensitivity response]
13. Is the therapist overly sensitive when he or she has been given feedback by the supervisor or client? [hypersensitivity response]

<p><b>CLASS C CONFLICT</b></p>
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Class C is defined by behaviors that function to inhibit an interpersonal interaction between the therapist and a supervisor or client due to the therapist’s inability to respond effectively to interpersonal conflict. These behavior problems serve to inhibit the therapist’s development or maintenance of successful interpersonal relationships.

Hostile conflict is not overwhelmingly typical in most psychotherapy settings, but it can occur. Conflict in this class must be understood as any interaction with disputing goals or needs. This may produce overt tension and may be more subtle and harder to discriminate. The essential feature of this

class is to assess for the therapist's ability to effectively identify and respond to (which may or may not include resolution) the conflict that occurs in-session with clients or in supervision meetings.

For those therapists focusing on what is often described by the common vernacular and contemporary nosological system as personality disorders. With these pervasive repertoires, clients will frequently bring conflict into session. It is important for the therapist dealing with such clients to be able to effectively discriminate and respond to this type of responding.

Class C describes therapist behaviors including the following:

- (1) problems with identifying that conflict is occurring,
- (2) problems specifying situations that require conflict responding (e.g., resolution) or the conditions appropriate for engaging in interpersonal conflict,
- (3) escape and avoidance of situations requiring effective conflict resolution or compromise including being overly acquiescent at the onset of or prior to conflict, engaging in social withdrawal, or being excessively appeasing,
- (4) indirect or ineffective attempts to decrease or resolve conflict,
- (5) an unwillingness to compromise in conflict in an effort to remain "right," or
- (6) therapist behavioral excesses that function to facilitate or increase conflict rather than resolve it.

Therapists with problems in this area may also have problems with CLASS A (assertion of needs) and CLASS B (discriminating impact on others).

### **Contextual Cues/Discriminative Stimulus Functions**

#### ***Problems with Identification or Specification***

In this case the therapist cannot recognize that conflict is occurring. Deficits in this area may be due to the therapist's avoidance of conflict or a lack of training to recognize that disagreements can and do occur in the context of close interpersonal relationships.

#### ***Problems with Appropriate Contextual Control***

In this case, the therapist has problems discriminating a situation (when, where, with whom) requiring problem resolution skills particularly as they relate to being in an interpersonal relationship. If the therapist cannot discriminate an appropriate situation where conflict or disagreement can be resolved, he or she will not engage effectively in the interpersonal interaction. The context involving both when and where conflict occurs is important for the therapist to discriminate. The therapist may also have problems discriminating with whom conflict resolution skills should be employed.

### **Response Repertoire**

#### ***Escape or Avoidance Repertoire***

Therapists may have behavioral problems dealing with interpersonal conflict and engage in escape or avoidance strategies to either terminate or decrease the future likelihood of conflict situations.

Escape or Avoidance problems can occur in the following forms:

- (1) *Escape Repertoire: Excessive Acquiescence.* Therapists with problems in this area may engage in escape strategies such as rapid or *excessive acquiescence* to the client or supervisor so that the conflict and perceived social discomfort is prevented or terminated even though the therapist has not expressed his or her needs. Conflict resolution can require acquiescence, but to qualify for problems

in this area the therapist needs to maintain this strategy frequently or in multiple contexts that result in problems effectively providing the intervention or other important interpersonal relationships such as that with the supervisor.

- (2) *Avoidance Repertoire: Social Withdrawal.* Avoidance strategies can include *social withdrawal* due to fear of conflict arising. In this case, the therapist maintains this one strategy of responding that serves to inhibit successful interpersonal relationships.
- (3) *Avoidance Repertoire: Excessive Appeasing or Conciliatory Responses.* Engaging in *excessive appeasing or conciliatory responses* functions to decrease the likelihood of engendering conflict or terminate it if conflict has begun. Therapists with problems in this area may express a hypervigilance for anticipating the needs of a supervisor or clients without the other person directly identifying or asserting that need. Here, therapists may effectively avoid conflict by anticipating and meeting a supervisor or client's needs in advance. The therapist may have a number of interpersonal relationships but the therapist reports that his or her needs are not being met, that he or she is taken advantage of by a supervisor or clients.

#### ***Indirect/Ineffective Attempts to Resolve Conflict***

In this case, the therapist can identify the conditions under which appropriate conflict resolution can occur and attempts to resolve the conflict, but the attempts to engage in respond to the conflict are at such weak behavioral strength or are so vague that the behaviors are ineffective. Therapists with problems in this area appear timid or uncertain about the conflict resolution that it is ineffective.

#### ***Unwillingness to Compromise in Conflict***

In this case, the therapist discriminates that conflict is occurring and that conflict resolution may bring about a change in the interpersonal interaction, but the therapist will not compromise or aid in conflict resolution in an effort to comply with a self-stated rule of remaining "correct." In this situation it is more advantageous for the therapist to maintain his or her position in conflict than experience the aversive contingencies that would occur if the therapist compromises or acquiesces. These aversive contingencies may occur through contact with emotional experiences related to being "incorrect" or "wrong" and can be addressed as problems with CLASS E (problems with emotional experience and expression). Aversive contingencies may occur in the form of actual or perceived punishing responses delivered by other listeners (either involved with or outside of the conflict). In this latter case, the therapist's behavior is partially under the control of another individual who evaluates the therapist's performance and delivers salient social reinforcers or punishers (here, related to being "right" or not acquiescing).

#### ***Conflict-Facilitating or -Escalating Repertoire***

Therapists with problems of a conflict-escalating repertoire recognize that conflict is occurring but engage in behaviors that engender, maintain, or escalate conflict rather than resolve it. In this case therapist (1) may not discriminate that the behaviors they engage in serve to facilitate conflict; or (2) may seek or maintain conflict in an effort to meet interpersonal needs not met elsewhere. In this second case, an oppositional or confrontative therapist may engage in behaviors that engender or maintain conflict to obtain basic social reinforcers such as attention.

Therapists with a learning history that suggests that interpersonal closeness is expressed through conflict will seek out or maintain conflict when it occurs. Therapist behavior in this case is under contingent control that may be perceived as aversive by others but meets important therapist needs. It is

important ethically that therapists not get these emotional needs met through clients, particularly with this response repertoire. Therapists may have problems discriminating appropriate conditions for conflict, may have problems with CLASS B (inability to accurately discriminate his or her impact on a supervisor or client), or may have problems with CLASS D (problems with interpersonal closeness), particularly when a therapist cannot clearly convey emotional closeness and instead escalates conflict.

### ASSESSMENT QUESTIONS FOR CLASS C

For questions about Conflict, the therapist should be informed that all relationships include conflict and that is a normal part of human interaction. The supervisor should distinguish between conflict and (physical) violence for the therapist and not normalize the violence. Escaping and avoiding violence is very important, and escaping and avoiding conflict is sometimes successful. Here, the supervisor is attempting to understand how the therapist engages or does not engage in interpersonal conflict when it arises in relationships.

#### Therapist Self-Assessment Questions for Class C

1. Is it normal for conflict to occur between you and other people in your relationships? [overview of class/discrimination]
2. Are you aware when conflict is going on between you and another person? [discrimination]
3. Are there certain times it is better to engage in conflict? [context]
4. Are there certain individuals with whom it is more acceptable to engage in conflict than others? [context]
5. Do you tend to try to stop conflict that you are in, even though there may not be a resolution or you have not stated your opinion? [escape]
6. Do you tend to give-in to others easily if there is conflict, accepting their position or view, even though you may not agree with it? [escape, over-acquiescence]
7. Do you tend to withdrawal if conflict begins or may begin with you and someone else [escape/avoidance]
8. Do you find that you try to avoid conflict at almost all cost? [avoidance]
9. Do you try to be the 'peace-maker' or try to decrease the chance that any conflict may occur between you and others, perhaps by making sure the other person is happy? [avoidance, excess conciliatory]
10. When you try to resolve conflict, are your attempts successful? [ineffective]
11. Are others clear about what you are doing when you are trying to decrease a conflict? [indirect]
12. Do you find (or have you been told) that you tend to not give in to others in conflict, even though the other person may have a good point? [unwilling to compromise]
13. When you are in conflict with someone else, do you find that you continue to fight or that the fight even gets worse? [escalating]
14. When you are having conflict with others do you deliberately attempt to increase the level or intensity of conflict? [escalating]
15. Do you feel more connected or close to someone during intense conflict? [escalating, thoroughly assess CLASS D, *Problems with interpersonal closeness*]

#### Supervisor Assessment Questions for Class C

1. Does the therapist engage in any type of conflicting interactions with the supervisor or client in-session? [overview of class]

2. Is the therapist aware that conflict is occurring when it happens with supervisor or with client during session? [discrimination]
3. Does the therapist recognize that conflict can occur between him or her and a supervisor or client? [context]
4. Does the therapist attempt to stop any conflict once it has started to arise with the supervisor or with the client in-session [avoidance]
5. Does the therapist acquiesce to a supervisor or client, without making his or her own needs or opinion known? [escape, over-acquiescence]
6. Does the therapist withdrawal if conflict occurs or may occur with the supervisor or client? [escape/avoidance]
7. Does the therapist appear over conciliatory or escape or avoidance from conflict by appeasing a supervisor or client unnecessarily? [avoidance, excess conciliatory]
8. When the therapist makes attempts to resolve conflict with a supervisor or client, are the resolution strategies clear? [indirect]
9. Is the therapist willing to compromise in conflict? [unwilling to compromise]
10. Does the therapist engage in conflict resolution strategies that inadvertently facilitate or escalate the conflict? [escalating]
11. Does the therapist deliberately attempt to escalate the conflict? [escalating]

<p><b>CLASS D</b>  <b>DISCLOSURE AND INTERPERSONAL CLOSENESS</b></p>
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Class D is defined by behaviors that function to prevent establishing or maintaining interpersonally close relationships between the therapist and supervisor or the therapist and other people. Behavior problems from the other classes already described may contribute to difficulties with this class of behaviors. This class characterizes behaviors that prevent the establishment or maintenance of social support or otherwise restrict the therapist's access to social reinforcers (i.e., that results in social withdrawal) including engaging in self-disclosure, requesting social support, and responding to needs or requests of others. Self-disclosure in the context of interpersonal closeness may include discussions about problems the therapist is having, but these discussions may also include disclosures about the therapist's life that are more pro-social or facilitative of positive interactions.

As with the other classes previously described, psychotherapy is not the context for therapists to get all of their interpersonal closeness needs met or provide considerable disclosure about the therapist that is not directly relevant to the intervention. This closeness and the process of disclosure is important in interpersonal psychotherapies but is bounded by the ethics and professional regulations of the therapist's role. In FAP, for example, disclosure to a client by a therapist is typically limited to the emotional or verbal experience the therapist is having in that moment to that client. Disclosure of the therapist's personal experiences, his or her past, and so on is not typically relevant. That said, it is important for the therapist to be able to discriminate what type of disclosure could be useful, the timing of this, and how to disclose in an effective way to the client.

A more broad definition of disclosure may be warranted in the supervision setting depending on the team or individual supervisor. Still, the caution is in place to consider the therapist's experience as directly related to their training and skill development in conducting the intervention being taught.

Class B, *Difficulties discriminating impact on other and sensitivity to feedback*, is essential to assess because it relates directly to problems with self-disclosure. The supervisor needs to be clear whether the therapist has the skills to discriminate the impact that the self-disclosure has on the listener.

Specific problems in Class D include:

- (1) an inability to discriminate situations where or persons with whom the therapist self-discloses or seeks social support, particularly with clients,
- (2) engaging in infrequent attempts to have interpersonally close interactions that would yield social reinforcers,
- (3) engaging in ineffective or unclear affective disclosures or requests for social support,
- (4) engaging in excessive disclosure or seeking social support that function to decrease the availability of future social interactions, or
- (5) failing to respond to attempts by others to establish interpersonally close interactions including not responding to requests made of the therapist from others.

### **Contextual Cues/Discriminative Stimulus Functions**

#### ***Problems with Identification or Specification***

In this area, the therapist has difficulties identifying that interpersonal closeness or support would be helpful to the therapist, particularly in supervision. This instance also describes problems the therapist has failing to recognize that he or she is engaging in self-disclosure or what the important features are of that disclosure (salience, valence, etc.) and how that impacts the client or others.

This instance also describes therapist problems with identifying or specifying what is needed from others (either requested directly or indirectly) or where a response from the therapist is expected. This failure to discriminate and corresponding lack of response prevent the therapist from effectively responding to the client or supervisor and may limit future disclosures by either.

In addition, problems with identification or specification also include difficulties discriminating times when to ask someone else about his or her experience. If the therapist can make this discrimination that he or she could ask the client about the client's experience but does not do so, the therapist has problems with the associated repertoire for this instance (see *Failure to Solicit Other's Disclosure*).

#### ***Problems with Appropriate Contextual Control***

In this case, the therapist is unable to discriminate the conditions (when, where, with whom) in which to engage in social interactions that involve interpersonally close behaviors such as self-disclosure (of emotional or affectively laden material), opportunities to seek social support, or conditions in which it would be effective to offer or reciprocate with support.

Therapists who do not identify conditions appropriate for self-disclosing or talking about their own experiences can have an aversive impact on others (particularly clients) or create inappropriate and ineffective therapeutic relationships. The therapist may also experience discomfort when he or she fails to discriminate appropriate individuals with whom to self-disclose.

If an identified listener to whom the therapist will *not* self-disclose typically does respond effectively to others' with support, then the problem lies with the therapist's lack of disclosure (e.g. see *Escape or Avoidance Repertoire*). However, if the therapist will not disclose due to a history where other listeners have responded to the therapist unsupportively, then the therapist likely has a problem with identifying the appropriate conditions for disclosure.

This problem area encompasses therapist difficulties with discriminating which interpersonal relationships would provide important supportive functions for the therapist including listening, providing

emotional support, or allowing a reasonable amount of rate self-disclosure of talk of the therapist's experiences. This latter skill would be especially important for supervision.

Specific instances in this Class include:

- (1) The therapist may have trouble *over-disclosing* in contexts where the relationship does not have a sufficient history to support such self-disclosure, talk about the therapist's own experiences, or having provided emotional support to the therapist. Again, this can create inappropriate or ineffective therapeutic relationships with clients.
- (2) The therapist may also have challenges with recognizing that a relationship does have the features where disclosure or seeking assistance would be supported (*under-disclosing*) and would provide assistance to the therapist. Therapists with problems in the area of not identifying appropriate conditions under which to disclose or seek support may appear withdrawn or socially isolated. This is especially important for the support that can be provided in some supervisory relationships or with colleagues in consultation. In the case of *social withdrawal*, the therapist can have problems with identifying appropriate conditions for closeness or problems with failing to disclose (see response repertoire problems below).
- (3) The therapist may fail to realize that therapy is not the appropriate venue to seek support for his or her own personal problems.

### Response Repertoire

#### *Escape or Avoidance Repertoire: Infrequent Seeking of Interpersonally Close Interaction*

In this instance, the therapist is able to identify the conditions in which disclosure or seeking support would be reinforced, but the therapist will avoid or immediately escape the experience. This escape or avoidance repertoire functions to prevent the therapist from engaging in an effective interaction that yields social reinforcers. The therapist may have a learning history where seeking support of disclosing was punished through social contingencies such as embarrassment, anger, etc. Therapists may also escape or avoid self-disclosure due to an unwillingness to experience the affect that arises as a result of the disclosure (see CLASS E).

It is important in this class to assess whether the therapist has specific rules about not engaging in interpersonally close relationships. These rules may need to be addressed specifically as the supervisor has the therapist engage in exposure-based strategies.

*Low Desire for Closeness.* Therapists may also express a low or lack of desire for interpersonally close relationships. This may be due to a therapist's reinforcement history for escaping or avoiding the interactions due to a history of aversive events surrounding these relationships. This instance may also be due to the therapist not finding these interactions rewarding or pleasurable. This may lead to the therapist's failure to solicit the support of a supervisor. An extensive history should be taken for any previous relationships that were interpersonally close and enjoyable for the therapist. If the therapist truly does not desire any type of interpersonal closeness, a discussion should occur about whether impersonally-based interventions (e.g., FAP) are a good match for that therapist and his or her skills and values.

In the case that the therapist has never had an interpersonally close relationship and is of sufficient age or development that this would be expected, the therapist may not find relationships reinforcing. These therapists will appear socially unskilled and withdrawn, but this lack of skill does not

bother them. These therapists may lack the basic understanding of the utility and value of interpersonal relationships. In this case, the therapist may need to be informed about the advantages of social relationships and be instructed in some basic interacting skills that would develop the therapist's ability to engage others socially.

#### *Failure to Solicit Others' Disclosure*

This instance describes a therapist's failure to engage in asking questions in an interpersonal interaction about the client's experiences. Making a pro-social response of inquiring about other's experiences can occur in a reciprocal fashion where the therapist asks another person how they are doing after having been asked (e.g., "I'm doing well, thanks for asking...How are you doing?") or by making a more facilitative response with another person. This repertoire is much more pervasive for therapist's and should be developed for successful interpersonal therapeutic interventions. This deficit can create a more one-sided conversation for the therapist that leaves the other person feeling less important to the therapist. These inquiries by the therapist can range from being general conversation questions to those asking another person for more intimate disclosure. The supervisor needs to assess whether the therapist has an intact repertoire for discriminating the context for seeking interpersonal closeness and soliciting other's disclosure.

#### *Problem with General Pro-social Repertoire*

This instance characterizes therapist skill deficits with engaging in general conversations that are more than just grossly superficial but that do not involve intimate disclosure. An intact general pro-social repertoire captures many interactions that occur in relationships that are less interpersonally close or intense but still provide social contact.

#### *Unclear Self-disclosure or Request for Social Support*

In this case, the therapist can identify the conditions under which to self-disclose or seek social support, but the therapist's repertoire is insufficiently developed to do this in a way that provides the client or supervisor with clear information about what the therapist is disclosing or requesting. This problem is parallel to therapist problems with asserting or requesting needs be met (see CLASS A) but is directly related to problems with requests for social support (not other general needs). The result of indirectly or unclearly self-disclosing or seeking support makes it difficult for the listener to provide effective responses to the therapist. This instance also describes therapist requests that contain distracting disclaimers or self-deprecating comments so that the client or supervisor is not clear what is being discussed or requested.

#### *Inaccurate Self-Disclosure*

In this case the therapist makes self-statements or descriptions of his or her experiences that are interpreted as inaccurate or overstated by the listener. To be considered a problem, behaviors in this instance of Class D must occur with relative frequency and result in a decrease in interpersonal relationships or decreased access to social interactions. Statements characterized by this instance include those that appear as bragging, grandiose, self-focused, and so on. These inaccurate statements also include excessively self-deprecating comments or statements about one's self as being without value to others in a social relationship. Overly-affected or non-genuine responding will make it difficult for the client to respond to the therapist and are also problems in this instance.

Humorous or ironic statements about one's own experiences do not qualify as problems in this instance unless they result in the decreased social interactions just described.

### *Excessive Self-disclosure or Seeking Social Support*

Therapist with problems of excessive disclosure or seeking support have problematic relationships with clients or supervisors as a result of high frequencies of engaging in self-disclosing, talking about one's own experiences, or asking for emotional or social support. As stated above, this will likely create inappropriate, unethical, and ineffective therapeutic relationships with clients.

The therapist may accurately discriminate when and with whom to make these requests of support, and he or she may have the repertoire to make these requests clearly. Problem behaviors in this instance are described by the therapist making so many requests of the listener that he or she no longer provides the social support that is requested or required, or the therapist discusses him or herself to such an extent that the listener no longer engages the therapist in social interactions.

An example of this instance includes a therapist over-burdening the supervisor or client with personal experiences or disclosing more than it is appropriate for the context, resulting in fewer or less effective interactions with the supervisor or client.

The therapist may also be seeking support from the client. In this case, the focus of the therapy session shifts from the client to the therapist. When this is not explicitly about evoking a particular client behavior in-session in the service of the client's psychotherapy and the client's goals for treatment, then it is a problem behavior for the therapist.

Therapists with problems in this area may also have problems with CLASS B above, *Inability to accurately discriminate his or her impact on others*.

### *Failure to Respond to Other's Disclosure or Requests and/or Reciprocate with Social Support*

Another instance in the class of problems with interpersonal closeness occurs when the therapist fails to or cannot respond to the client's disclosure or request for social support or requests for needs to be met. In this instance, the therapist does not recognize the opportunity to respond to another person's disclosure or request for support, or the therapist does not have the repertoire to engage in an effective response. The therapist who has problems in this area may appear to be insensitive to the disclosure or support seeking by others.

Here, the therapist has the repertoire to respond to the client or supervisor, but they perceive that response to be unsupportive. The therapist may have problems with CLASS B, specifically, an *Inability to Accurately Discriminate Impact on Others*.

<b>ASSESSMENT QUESTIONS FOR CLASS D</b>
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For questions about Disclosure and Interpersonal Closeness, the therapist should be informed that this means feeling "connected to," "close with," or "good friends with" another person. Interpersonally close relationships do not characterize acquaintances or other more superficial relationships that are a normal part of our work and social life. Interpersonally Close relationships are those that involve telling others how we feel, being understood, and appreciating others and their needs. Talking about one's self or one's own experiences simply means that the therapist engages in talk focused on what is going on for him or her as it occurs or after the fact. Seeking support refers to making requests from others for comfort, understanding, or problem solving.

**Therapist Self-Assessment Questions for Class D**

1. Have you had a best friend, or people that you would say you are close with? [overview of class]
2. Do you currently have any close relationships, people you are friends with, with whom you can talk about how you are doing? [discrimination]
3. Do you value or feel that close relationships are important to you? [discrimination/lack of desire]
4. Are there times when you feel it is important to share things about yourself with others? [discrimination]
5. Are there times when you are more sensitive to what someone else is telling you about how they are doing? [discrimination]
6. Have you ever been told that you say too much to others about how you are feeling or about your own experiences? [context]
7. Are you unsure of which people you could tell your feelings to, talk about your own experiences, or ask for support? [context]
8. Do your friends or other people ask you how you are doing, but you choose not tell them, talk about how you are doing, or ask for support from them? [context]
9. Do you ever begin to talk about how you are doing or ask for support but then decide it would be better not to do that? [escape]
10. Do you think it is better just not to talk about your feelings or yourself at all? [avoidance]
11. Do you think it's better for you to not ask for support from others even though it might be helpful? [avoidance]
12. Do you have any rules you tell yourself about when it's all right to talk about your own feelings or ask for support from others? [escape/avoidance]
13. When you talk about how you are doing, share your experiences, or ask for support from others, do the people you are talking to understand how you are doing, do they get what is going on for you or what you want? [unclear; rule out discrimination above]
14. Do people often tell you that the way you talk about yourself in a way that others feel like you aren't giving yourself enough credit? [inaccurate]
15. Do people ever give you the feedback that you tend to brag or talk about yourself in a way that exaggerates your skills or qualities? [inaccurate]
16. Do people ever tell you that you talk about yourself too much, or talk too much about what you are feeling or what you have done? [excessive]
17. Do others tell you that you ask for support too much or that they can't meet your needs as often as it feels like you would like them to? [excessive]
18. Do you listen to others and offer support when they are seeking it from you? [failure to response]
19. Have you ever been told that you take more than you given in a relationship? [failure to response]

**Supervisor Assessment Questions for Class D**

1. Does the therapist evidence a desire or need for a close supervisory relationship? [overview of class/low desire]
2. Does the therapist self-disclose or seek support from the supervisor in supervision? [discrimination]
3. Does the therapist seek support from the client during the therapy session? [discrimination]
4. Does the therapist recognize that the supervisor or client is a participating member in the interaction? [discrimination] {NB: The therapist is not in training to meet the supervisor's needs or provide social support to the supervisor. This question is assessing the sensitivity of the therapist to the supervisor or client as another person with feelings in the supervisory or therapeutic relationship.

5. Does the therapist self-disclose with the supervisor or client at appropriate times in meetings or in session or given the development of the supervisory or therapeutic relationship? [context]
6. Does the therapist recognize the supervisor as a person to whom the therapist can self-disclose or ask for social support? [context]
7. Does the therapist engage in self-disclosure or other interpersonally close behaviors and then terminate them? [escape]
8. Does the therapist fail to self-disclose or seek support in the context of supervision even when it would be beneficial for the therapist to do so? [avoidance]
9. Is it unclear what the therapist is disclosing or that the therapist is seeking support when he or she engages in these tasks with the supervisor? [unclear response]
10. Does the therapist engage in a high number of self-deprecating comments that are not consistent with the supervisor's perceptions or experiences of the therapist? [inaccurate]
11. Does the therapist engage in grandiose or exaggerating self-talk with the supervisor or client? [inaccurate]
12. Does the therapist engage in a talk about his or her own experiences at a high frequency so that the result is off-putting to the supervisor or client? [excessive]

<p><b>CLASS E</b> <b>EMOTIONAL EXPERIENCE AND EXPRESSION</b></p>
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Class E is defined by behaviors that function to inhibit an interpersonal interaction between the therapist and a supervisor or client because the therapist has no or very low tolerance of experiencing emotional responses. This Class can also include the somatization of psychological conflicts in an effort to not directly talk about or express an aversive emotional experience.

Because interpersonal interventions can be difficult, it is important for the therapist to recognize and respond to his or her own emotional responses. For example, when commenting on the ineffective response of a client in-session during a FAP intervention, the therapist might state, "you know, I think I know what you are trying to do here, but that really isn't it. I still don't know what you need, and I want to help. Can you try again?" This requires that the therapist first notice that he or she would like to help and then, when the client tries again, and likely still does not do it effectively, the therapist be able to recognize the mounting anxiety her or she may feel, and continue with the intervention in a compassionate and effective way. If the therapist is unable to tolerate his or her own aversive affective experience (e.g., anxiety), he or she may escape from that emotion, leaving the intervention incomplete. If the emotion is aversive enough, the therapist may not engage in strategies that evoke that feeling at all.

Class E describes therapist behaviors including:

- (1) the therapist cannot identify or specify their emotional experience (either that it has occurred or what it is),
- (2) the therapist does not discriminate situations where or when it would appropriate to express (disclose) an emotional experience,
- (3) escaping or avoiding an emotional experience when it occurs,
- (4) inaccurately labeling of emotional experiences,
- (5) ineffectively or unclearly describing emotional experiences, or
- (6) excessively expressing emotions.

## Contextual Cues/Discriminative Stimulus Functions

### *Problems with Identification or Specification*

In this case, the therapist has problems identifying or specifying that an emotional experiences has occurred or is occurring (either in the present or the past), particularly as they relate to being in an interpersonal relationship with the supervisor or a therapeutic relationship with the client. This instance describes problems the therapist has with being unable to identify that an emotional experience is occurring. Problems with responding to this stimulus and labeling the experience are described under the Response Repertoire section that follows (see for example, *Inaccurate Label of Emotional Experience*).

### *Problems with Appropriate Contextual Control*

Therapists with problems in areas of contextual control do not discriminate appropriate times (when or where or with whom) to either (1) recognize that an emotional experience would be expected in that context, or (2) discriminate when to report or express a feeling. The contextual control of with whom, as well as when and where, to express an emotional response is essential to assess. If the therapist does not discriminate these features, he or she will receive feedback from a supervisor or client that will not sustain an effective response set in this domain.

## Response Repertoire

### *Escape or Avoidance Repertoire*

Therapist who can discriminate that an emotional experience is occurring may have difficulties experiencing the response and will engage in strategies to avoid or escape the aversive stimulation. Many of the other classes include problems with emotional experience, particularly in opportunities to experience interpersonal closeness or eliminate conflict. This instance describes individuals who will escape or avoid opportunities to experience any set of responses that would be appropriate and expected for that individual given his or her learning history.

These emotional experiences may be either “positive” feelings (joy, happiness, pride) or they may be “negative” or “hard” (e.g., sadness, anxiety), but the individual experiences the emotional responses in this class as *aversive*. The escape and avoidance responses are especially relevant as the impact the therapist’s ability to interact with others.

The reader is cautioned that escape and avoidance strategies are only ineffective for the therapist when they prevent him or her from accomplishing the goals of the intervention or effectively engage in supervision. All therapists choose when to engage in emotionally difficult situations. Escape and avoidance repertoires should be described and assessed for intervention when they are sufficiently pervasive to interfere with therapist skill development.

*Escape Repertoire.* Therapists with problems with an escape repertoire will engage in strategies to terminate the emotional experience after it has begun. The onset of the emotional experience may or may not be easily observed by others, but the escape response will be observable as a direct response or a collateral response.

*Avoidance Repertoire.* Therapists with problems with an avoidance repertoire will engage in activities to prevent the experience of the targeted emotional response. In this case, the therapist has very

little contact with the emotional experience that is avoided. therapists in this instance may have problems with social withdrawal or engage in activities that prevent the emotional experience.

For escape and avoidance behaviors, the therapist may develop rules (either explicit or implicit) that help to prevent the therapist from experiencing the emotional response. The supervisor should address these behaviors as they function on other interpersonal relationships.

### *Inaccurate Expression/restricted Repertoire of Emotional Experience*

In this case the therapist is unable to accurately label the emotional experience that he or she is having, either inaccurately expressing it or not having a broad enough repertoire to express an emotion appropriate to the context. Problems with inaccurate expressions of emotional experience prevent the listener from effectively responding to the therapist. This inaccuracy may be evidenced by an expression of affect that is incongruent between the therapist's verbal report (or content of discussion) and the therapist's affective state. The inaccuracy may occur as a consistent lack of correspondence between the therapist's affective expression and more commonly observed affective responses given the content of the therapist's discussion. If the therapist does not have a broad enough repertoire to label the variety of emotions that occur in different situations, then this expression may also appear inaccurate.

A therapist with deficits in this area may also inaccurately identify an emotional response as a bodily state or physical experience (i.e., somatization). For example, the therapist may state, 'I feel tired' when 'I feel sad' is more accurate given the context. This may be very difficult for clients to understand and respond to and will likely not model effect client behavior in this area.

The distinction between an inability to label an emotional experience and escape and avoidance behaviors is subtle but important to make. Therapists who engage in escape or avoidance strategies can state the behavior they are working to terminate or prevent. This labeling process will be difficult for the therapist to engage in, because the process will likely have the therapist contact the emotion that is being avoided. For example a therapist saying, "I feel sad hearing that" will make available the emotional functions of sad. In this case, the supervisor can attempt to help the therapist label the experience and then observe whether he or she is capable or will engage in the labeling process. Here, the supervisor could say, "Other people in this situation might feel sad." If the therapist states this is not accurate, but expresses some other, unnamed affect, then the therapist may have a problem with labeling. If the therapist states this is not the case, the supervisor can ask, "If that were how you are feeling, would that be OK with you, or would you try to not feel sad?" In both situations, the therapist may appear uncertain or lack an emotional expression. The supervisor should try to differentiate these response sets, as the treatment should be different for each instance.

### *Ineffective or Unclear Description of Emotional Experience*

Therapists who can identify and label their affective experience can experience difficulties with directly conveying this information so that others may respond effectively to the therapist. The result of indirectly or unclearly conveying an affective experience to the listener can include confusion and misunderstanding. If a client or supervisor misunderstands or is confused by the therapist's expression or report of affect, that person may discount or ignore the affective expression. The listener may also respond ineffectively to the therapist and interact with the therapist based on an understanding of an emotional experience different from what the therapist was trying to convey.

*Excessive Affective Expression*

Therapists with problems of excessive expression of affective experiences may have problematic relationships with others as a result of high frequency or intensity of emotional expression. In this case the therapist may accurately identify his or her emotional experience, but engage in an expression of that emotion that exceeds what is appropriate to the situation. In this case, therapists may exhibit an inability to modulate an affective response. Therapists with problems in this area may also have problems with Class B above, inability to accurately discriminate his or her impact on others. This is an important repertoire to assess and address as the therapist may bring this into session and provide more than some clients can manage. Worse, the therapist could create ineffective and potentially inappropriate therapeutic relationships where the focus of therapy is on the needs of the therapist rather than the client.

## ASSESSMENT QUESTIONS FOR CLASS E

For questions about Emotional Experience and Expression, the therapist needs to understand that emotional experience means all types of emotions, not just the “negative” feelings like sadness, anxiety, loneliness, etc. These feelings also include love, pride, joy, humor, etc. The therapist must also understand that responses to these feelings can occur in “real time” while the emotion is occurring, or responses and affective expression can occur later, to memories about events. All of these are understood as emotional responses.

**Therapist Self-Assessment Questions for Class E**

1. Are you able to notice that you have emotional experiences as they are happening? [discrimination]
2. Are you able to notice that you had a feeling after it occurred, but were not able to notice it when it was going on for you? [discrimination]
3. Can you distinguish different types of emotional experiences from each other? [discrimination]
4. Are you able to identify situations when it is appropriate to express your emotions as you have them? [context]
5. Do you feel like there are times when you decide not to show an emotional experience you are having? [context]
6. Has anyone ever let you know that they feel like you should be more expressive about what you are feeling? [escape or avoidance/infrequent response]
7. Do you have any rules for yourself about feelings you won't have or spend time experiencing? [escape & avoidance]
8. Do you frequently begin to have a (strong) emotional experience and then engage in activities to get rid of the feeling after it starts? [escape]
9. Do you frequently do things that will keep you from having particular feelings at all? [avoidance] (which ones?)
10. When you tell people how you are feeling, do they respond in a way that makes sense to you? [inaccurate response OR ineffective response]
11. Are you able to accurately label feelings you have as you are experiencing them so that others understand what you are feeling? [inaccurate response]
12. Do you feel like you are able to communicate your emotional experiences clearly so that other people can understand what you are feeling? [ineffective response]
13. Do you hint to people about what you are feeling when you are experiencing an emotion? [ineffective response]
14. Has anyone ever let you know that they were overwhelmed by how you express your feelings? [excessive response]

## Supervisor Assessment Questions for Class E

1. Does the therapist have problems expressing his or her emotions? [overview of class]
2. Is the therapist able to identify when he or she has emotional experiences? [discrimination]
3. Does the therapist make this discrimination in vivo (during the emotional experience)? [discrimination]
4. Is the therapist able to discriminate the different emotional experiences he or she has? [discrimination]
5. Does the therapist identify the supervisor or client as someone she can share his or her emotions with? [context]
6. Does the therapist show emotions infrequently relative to the topics of therapy or training/supervision? [escape or avoidance/infrequent response]
7. Does the therapist evidence rules for not experiencing emotions as they occur? [escape or avoidance]
8. Does the therapist escape or terminate an emotional response after it has started? [escape]
9. Does the therapist engage in avoidance strategies to prevent the onset of an emotional response? [avoidance]
10. Does the therapist accurately label his or her emotional experiences as they occur? [inaccurate]
11. Does the therapist communicate his or her emotional experiences in a way that is clear and relatively easy to respond to? [ineffective]
12. Does the therapist hint around his or her feelings or express them directly? [ineffective]
13. Does the therapist engage in excessive or overly intense expression of emotional experiences? [excessive]

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**Appendix:**  
**Examples of FIAT Instruments**  
**For use by therapists**

FASIT-T (Pre)  
Sample pre-session assessment form for therapist for Class [X]

FASIT-T (Post)  
Sample post-session assessment form for therapist for Class [X]

**FASIT-T (Pre)**  
**Therapist Pre-session Questionnaire**  
**CLASS [X]**

*These questions refer to the session you are about to have with your client. Please answer the questions based on what you would like to occur in therapy in the session you are planning.*

The following is a list of ongoing goals for treatment for this client:

Is there a change in the case conceptualization that needs to be added or dropped from this list? **Y or N**  
**IF SO, PLEASE SPECIFY:**

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**For CLASS [X]:**

- 1. Has this been a focus of therapy recently? **Y or N**
- 2. Is this talked about as events that happen **outside of therapy**? **Y or N**
- 3. Have you responded to both outside session problems and improvements as they occur? **Y or N**

4. Is this problem brought into therapy as an issue between you and the client **in-session**? Y or N
  5. How will you attempt to evoke an **in-session** problem or improved behavior in this class today?
  
6. Based on your FASIT-T (Post) [Post Session Questionnaire] answers from last week, what would you do differently in response to these **in-session** problem or improved behaviors that might be more effective?
  
7. What specific areas are you working on related to responding to **in-session** problem or improved behavior that might arise in this class?
  
8. What might the client do that would evoke an **in-session** problem behavior of yours?
  
9. What can you do to engage in an **in-session** improved behavior of yours in this situation?

**FASIT-T (Post)**  
**Therapist Post-session Questionnaire**  
**CLASS [X]**

*These questions refer to the session you just had with your client. Please answer the questions based on what occurred in therapy in the session you just finished.*

The following is a list of ongoing goals for treatment for this client in this Class:

1. Did this issue come up during therapy today? Y or N → If “N” Go to next section
  
2. Was this talked about as events that happened **outside of therapy**? Y or N → If “N” Go to question 6
  3. Did the client talk about problems in this area occurring outside of session? Y or N
  4. Did the client talk about improvements in this area occurring outside of session? Y or N
  5. Did you discuss controlling variables for the outside problem or improvement? Y or N
  
6. Did this issue occur between you and the client **in-session** today? Y or N → If “N” Go to question 17
  7. Did you attempt to evoke **in-session** problem or improved behavior in this class today? Y or N
  8. What did your evoking response look like?
  


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9. Did the client engage in an **in-session** improved behavior? Y or N

10. Did you respond to this **in-session** improved behavior when it occurred? **Y or N**

11. Provide a brief exemplar of how you responded

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12. Did the client engage in an **in-session** problem behavior? **Y or N**

13. Did you respond to this **in-session** problem behavior when it occurred? **Y or N**

14. If you did **not** respond, what prevented you from doing so?

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15. Provide a brief exemplar of how you responded?

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16. What can you do differently in response to these **in-session** problem or improved behavior to be more effective?

17. On a scale of 1 to 10, rate how much **progress** has the client made working on «PROBLEM\_1A» **Outside** in other relationships (circle the number that best describes the client’s progress):

1	2	3	4	5	6	7	8	9	10
This is not a problem		This is a small problem		This is a moderate problem		This is quite a bit of a problem		This is an extremely large problem	

18. On a scale of 1 to 10, rate how much **progress** has the client made working on «PROBLEM\_1A» **in-session** with you over the course of therapy (circle the number that best describes the client’s progress):

1	2	3	4	5	6	7	8	9	10
This is not a problem		This is a small problem		This is a moderate problem		This is quite a bit of a problem		This is an extremely large problem	