

Donna M. Sudak • R. Trent Codd, III

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Teaching and Supervising COGNITIVE BEHAVIORAL THERAPY



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FOREWORD

*T*eaching and Supervising Cognitive Behavioral Therapy is the first comprehensive text to provide empirically validated, effective training and supervisory approaches to teachers and supervisors from a variety of disciplines that use a cognitive behavior therapy (CBT) approach. Despite the substantial interest in the practice of cognitive behavioral therapy, until recently there has not been a corresponding pursuit of evidence-informed training and dissemination methods. For example, it took more than twenty years from the publication of *Cognitive Therapy of Depression* in 1979 for CBT training to be required in psychiatry residencies. Likewise, dissemination of CBT remains poor in other disciplines, including psychology. In addition to broader uptake, there is a need for the field to develop more effective training programs and to deepen CBT's impact across multiple disciplines of caregivers, which will be assisted by effective supervision.

The authors of this book are expert CBT practitioners, supervisors, and teachers whose experiences enrich their review of the available evidence on effective training and supervision. In addition, this book provides an approachable framework for using technological aids to teaching and supervision in an accessible manner. The learning exercises and practical understanding of different trainee groups, along with the online resources provided with this book, will undoubtedly contribute to the effort to develop more robust CBT training. As such, I believe this book will be an excellent tool for individual trainers and educational programs alike.

—A. T. Beck, MD,
University Professor of Psychiatry
Emeritus
and author of *Cognitive Therapy
and the Emotional Disorders*

ABOUT THE AUTHORS

Donna M. Sudak, MD, is professor, senior associate training director, and director of psychotherapy training in the Department of Psychiatry at the Drexel University College of Medicine. She is a clinician-educator with a wealth of national and international experience in teaching and patient care, and she has received numerous teaching awards. She has made a number of significant contributions to the literature in CBT education and has played a major role in developing suggested curricula and guidelines for resident competency in cognitive behavior therapy. She also has authored multiple publications regarding combining treatment with medication and CBT.

In addition to her teaching responsibilities at Drexel University College of Medicine, Dr. Sudak is an adjunct faculty member at the Beck Institute for Cognitive Therapy and Research. She is past president of the Academy of Cognitive Therapy, the editor of the PIPE examination, and serves on multiple national committees in Association of Behavioral and Cognitive Therapies and American Association of Directors of Psychiatric Residency Training (AADPRT), including having been named the incoming program chair for the 2016 Annual Meeting at AADPRT.

R. Trent Codd III, EdS, is the president and founder of the Cognitive-Behavioral Therapy Center of WNC, P.A., an interdisciplinary group practice located in Asheville, North Carolina. In addition to rendering clinical services at the center, he provides clinical consultation and training in CBT locally and nationally. He codirects an intensive training program in CBT each year and is on the clinical faculty of Lenoir-Rhyne University. Additionally, he is a licensed professional counselor as well as a fellow, certified trainer/consultant, and credentialing committee member of the Academy of Cognitive Therapy.

John Ludgate, PhD, is a licensed psychologist who has worked as a psychotherapist for nearly thirty years. He currently works at the Cognitive-Behavioral Therapy Center of Western North Carolina. In addition to having an active clinical practice, he is involved extensively in training and supervision in CBT,

locally and nationally. He trained at the Center for Cognitive Therapy in Philadelphia, obtaining a postdoctoral fellowship in cognitive therapy from the University of Pennsylvania. He subsequently became assistant director of training at the center. In the early 1990s he was a research clinical psychologist at the University of Oxford in England and served as a protocol therapist in several outcome studies of panic disorder, agoraphobia, social phobia, and hypochondriasis. He has written a number of books on CBT, including *Heal Yourself: A CBT Approach to Reducing Therapist Distress and Increasing Therapeutic Effectiveness* (2012), *Cognitive Behavior Therapy and Relapse Prevention in Depression and Anxiety* (2009), and *Maximizing Psychotherapeutic Gains and Preventing Relapse in Emotionally Distressed Clients* (1990). He cowrote *Overcoming Compassion Fatigue: A Practical Resilience Workbook* (2014) with Martha Teater and was coeditor with Jesse Wright, Michael Thase, and Aaron T. Beck of *Cognitive Therapy with Inpatients: Developing a Cognitive Milieu* (1992). He is a founding fellow of the Academy of Cognitive Therapy and serves on the credentialing committee of the academy.

Leslie Sokol, PhD, is a licensed psychologist, expert in cognitive behavior therapy, internationally recognized speaker, and coauthor of *Think Confident, Be Confident* (2009). She is a distinguished founding fellow, past president, and credentialing chair of the Academy of Cognitive Therapy. She was the director of education at the Beck Institute for Cognitive Behavior Therapy for nearly fifteen years. Her private practice is in the Philadelphia suburbs.

Marci G. Fox, PhD, is a licensed psychologist and has been in private practice for nearly twenty years. She has worked closely with Dr. Sokol, Dr. Judith Beck, and Dr. Aaron T. Beck at the Beck Institute for Cognitive Behavior Therapy in Philadelphia for almost the same amount of time. As an Academy of Cognitive Therapy certified trainer/consultant and former adjunct Faculty Member at the Beck Institute, she trains individuals in cognitive therapy both nationally and internationally, and helps mental health professionals to improve their clinical skills and pinpoint specific areas of remediation. Dr. Fox has a founding fellow distinction as well as an invited placement on the board of examiners and credentials committee of the Academy of Cognitive Therapy. Dr. Fox has lectured for years on cognitive therapy as well as confidence and self-esteem. She has coauthored the books *Think Confident, Be Confident: A Four-Step Program to Eliminate Doubt and Achieve Lifelong Self-Esteem* (2009) and *Think Confident, Be Confident for Teens: A Cognitive Therapy Guide to Overcoming Self-Doubt and Creating Unshakable Self-Esteem* (2011). Dr. Fox has published in peer-reviewed journals and diverse publications in the area of cognitive behavior therapy.

Robert Reiser, PhD, is a licensed psychologist and a fellow of the Academy of Cognitive Therapy. Since 2006, he has collaborated with Derek Milne on a series

of research projects involving the development of an instrument (*SAGE*) to assess competence in supervision. He has written and coauthored journal articles and has contributed book chapters with Derek Milne focusing on evidence-based approaches to clinical supervision, including the *International Handbook of Clinical Supervision* (edited by Ed Watkins and Derek Milne, 2014). After ten years of teaching a graduate-level CBT course, he is now actively engaged in supervision and training in a CBT for psychosis implementation and dissemination project. Over several years he has served as a consulting supervisor for the CBT-D national training program with the Veterans Administration.

Derek L. Milne is a clinical psychologist and a fellow of the British Psychological Society, with extensive experience as a supervisor, supervisor trainer, and supervision researcher. Since 1996, he has led the first ever systematic R&D program on clinical supervision, developing our understanding and seeking to enhance practice within the field of mental health (especially CBT supervision). This research program has followed the evidence-based practice rationale and has included extensive collaboration within the National Health Service. This started with theory-building work (systematic reviews), then involved a series of $n = 1$ studies (including the development of an instrument to assess competence in supervision), and related efforts to foster an evidence-based practice (for example, a national pilot study of a supervisor training manual). This program is summarized in *Evidence-Based Clinical Supervision* (2009). In 2010 he retired as director of The Doctorate in Clinical Psychology at Newcastle University, but he continues to teach and research supervision. His latest work is *The International Handbook of Clinical Supervision* (2014), coedited with Ed Watkins.

Chapter 1

CBT TRAINING AND SUPERVISION

An Overview

John Ludgate

To help readers understand the current recommendations for cognitive behavioral therapy (CBT) training and supervision, this chapter begins with a review of the historical roots and subsequent development of CBT training and supervision worldwide. In addition, the chapter describes the advantages and disadvantages of existing formats for training and briefly reviews the literature on the effectiveness and benefits of CBT training. Last, future directions regarding research and practice in the field of CBT training and supervision are outlined.

HISTORICAL ROOTS OF CT TRAINING AND SUPERVISION

The evolution of a cognitive model and the development of Beck's cognitive therapy has been described in several texts (Weishaar, 1993; Wills, 2009). The development of training in cognitive therapy (CT) is closely linked with the history of cognitive therapy itself. In the 1960s Aaron Beck, a psychiatrist in Philadelphia, now widely regarded as the father of cognitive behavioral therapy, became interested in determining the factors involved in the development and maintenance of depression. He formulated his initial cognitive model of depression in papers in 1963 and 1964 (Beck, 1963, 1964). The theory was elaborated in his book *Depression: Clinical, Experimental, and Theoretical Aspects* (1967).

The author expresses gratitude to Aaron T. Beck, Judith Beck, Bob Berchick, Barbara Marinelli, Ruth Greenberg, Frank Datillio, Paul Merrick, and Leslie Sokol for providing information on the historical aspects and current status of CBT training.

Thereafter, along with the subsequent publication of Beck's *Cognitive Therapy and the Emotional Disorders* (1976), a number of case studies were conducted in single-case design in which therapy derived from the model was applied to depressed outpatients (Rush, Khatami, & Beck, 1975; Shaw, 1977).

John Rush, a psychiatry resident at University of Pennsylvania from 1972 to 1975, and other residents became interested in both the clinical and research applications of cognitive therapy for depression. Beck provided supervision to the residents at the Mood Clinic at Philadelphia General Hospital and, as well, taught a psychotherapy course (Weishaar, 1993). After the successful clinical outcome achieved in the single-case studies previously mentioned, a study was designed to test cognitive therapy in a randomized controlled trial compared with antidepressant medication, at that time considered the gold standard for treating depression. Beck and Rush were joined by Gary Emery, Marika Kovacs, and Steve Hollon in planning and conducting this study, which, according to Weishaar (1993), resulted in notes on each patient's progress and details on the effectiveness of techniques being used compiled initially into a twelve-page manual on conducting cognitive therapy. This manual eventually grew to two-hundred pages and evolved into the book *Cognitive Therapy for Depression* (Beck, Shaw, Rush, & Emery, 1979).

The earlier brief manual was used to guide research therapists; recruited subjects were randomly assigned to cognitive therapy or pharmacotherapy. The therapists were psychiatry residents who received weekly supervision from Beck based on audio recordings of actual therapy sessions, a highly influential, and unusual for the time, model of supervision that has continued to date. Beck's emphasis on supervision and feedback on actual therapy practice to ensure skill development, and experiential, active learning as part of initial training, are key contributions to psychotherapy education.

The subsequent paper (Rush, Beck, Kovacs, & Hollon, 1977) was the first to show the efficacy of cognitive therapy, and a follow-up study of this patient cohort (Kovacs, Rush, Beck, & Hollon, 1981) showed that cognitive therapy was as effective as medication in the short term and fared better at one-year follow-up, findings that have been confirmed in numerous subsequent studies. As well as the training and supervision of therapists for this outcome study, another seminal event was the development of the Cognitive Therapy Rating Scale (CTS; Young & Beck, 1980) to ensure fidelity, which has become a key measure of competence for training and supervision, and, in addition, an Index of Cognitive Therapy Fidelity in outcome studies. Chapter 4 illustrates the use of the rating scale and other methods of evaluating competency in trainees.

In 1979 the National Institute of Mental Health (NIMH) elected to conduct a multicenter outcome study comparing cognitive therapy, interpersonal psychotherapy (Klerman, Weisman, Rounsaville, & Chevron, 1984), and medication for unipolar depression. Cognitive therapists were trained by the Philadelphia group at a number of sites to participate in the study. By the study design, only three

months of training was provided to these novice therapists because the NIMH stipulated that it should represent the therapy provided by the “average practitioner,” who presumably would have received only short-term training.

According to Weishaar (1993), therapists’ ratings indicated that the majority failed to reach the established competency criteria for cognitive therapists. Beck, apparently, strongly suggested that it would take one year of training and supervision to produce adequately trained cognitive therapists. The somewhat poorer outcome for cognitive therapy with severe depression found in this study (Elkin et al., 1989) relative to interpersonal psychotherapy and medication may have been due to inadequate training. Even in these early days in the evolution of cognitive therapy and CT training, an essential for effective training was thought to be an adequate dosage of training and the provision of supervision over a significant time period, which has been validated by subsequent research. This idea is discussed in greater detail in chapter 10.

Another important contribution to training and dissemination in cognitive therapy was the development of a one-year postdoctoral fellowship in cognitive therapy at the University of Pennsylvania in 1979. The objective was to provide intensive training and supervision in CT. Trainees also provided therapy to a range of clients at the Center for Cognitive Therapy, an outpatient clinic under the University of Pennsylvania’s Department of Psychiatry. As the program grew, approximately six to seven full-time fellows were accepted into this program per year, including some key figures in the development of CBT.

Although this program is no longer in existence in its original form, the model of training has endured, and fellowships in CBT are currently offered at several centers, including the Beck Institute for Cognitive Behavior Therapy, the Cognitive-Behavioral Institute of Albuquerque, Harbor-UCLA, and the Depression and Anxiety Specialty Clinic in Chicago. An extramural training program started at the Center for Cognitive Therapy in Philadelphia to allow clinicians who were employed to travel to the center for didactic training several times a year and to also receive case supervision, often by telephone, when geographical location made this more feasible than face-to-face supervision, a model that has been continued by the Beck Institute for Cognitive Behavior Therapy.

As CBT training evolved, the Center for Cognitive Therapy and the Beck Institute offered visiting professionals brief or longer trainings customized and designed for their particular needs. Individuals who had spent time training in Philadelphia returned to their home countries or home locations within the United States and started training, therapy, or research programs in the field of CBT.

For example, several training courses were set up in Oxford, London, and Newcastle in the United Kingdom as a result of training directors at these locations receiving training from Beck and colleagues in Philadelphia. Thus, CBT education spread worldwide.

In the late 1970s and early 1980s there were still few trainings opportunities for professional development available in the United States outside of Philadelphia,

except for a small number of workshops at the Association for the Advancement of Behavior Therapy (AABT) conferences (now ABCT—the Association for Behavioral and Cognitive Therapies) and other events offered by continuing education groups. In Europe there were some one-time workshops usually organized during annual conferences of organizations such as the British Association for Behavioural and Cognitive Psychotherapy (BABCP) and the European Association for Behavioral and Cognitive Therapy (EABCT). Similarly, in other parts of the world, brief training was usually the sole vehicle for dissemination, most often associated with events like the World Congress of Cognitive Therapy.

Following the Rush et al. (1977) study, several centers, such as at Washington University in St. Louis and, later, Vanderbilt University in Nashville, provided CBT training for therapists to conduct research utilizing a small group of established, proficient, and experienced therapist trainers. Such training is described in several early articles (Shaw & Dobson, 1988; Shaw & Wilson-Smith 1988), and the many studies carried out subsequently evaluating training provided as part of research trials have recently been reviewed (Rakovshik & McManus, 2010). This literature provides significant help in designing therapist training.

The first postgraduate intensive training for professionals outside Philadelphia was offered at the Cleveland Center for Cognitive Therapy in 1982 under the direction of Jim Pretzer and Barbara Fleming, two former fellows at the Center for Cognitive Therapy in Philadelphia. This ten-month systematic training in the theory and applications of CBT, involving once-monthly one-day training workshops, has been offered from 1982 to the present and can now be completed online. In 1985 the Atlanta Center for Cognitive Therapy began to offer a nine-month, one-day-a-month CBT training with supervision. Their didactic program included guest trainers such as David Burns, Edna Foa, and Art Freeman. Subsequently other agencies and organizations in the United States, usually clinical practice CBT centers, started to offer this intensive type of training.

Training in the United States during the 1980s and 1990s lagged behind that of the United Kingdom. Windy Dryden in 1982–1983 at Goldsmith College at University of London offered the first time-intensive CBT training in Britain, which led to a diploma in Cognitive Approaches to Counseling and Psychotherapy. By the mid-1990s, postgraduate diploma courses for professionals in the field existed at the Institute of Psychiatry in London, at Oxford, and at Newcastle. These were usually one year in duration and involved didactic instruction and supervision, often with rating of audio recordings included to assess and monitor competency and guide supervision.

Other countries, including Japan, Turkey, Hong Kong, Saudi Arabia, Brazil, Australia, and New Zealand, have developed comprehensive home-based training programs, often with the initial assistance of US- or UK-based CBT trainers.

Several initiatives by US states (for example, Michigan and Texas) have instituted statewide evidence-based therapy training, which includes CBT. In Britain, the publication of the National Institute of Health and Clinical

Excellence (NICE) guidelines on creating access to evidence-based psychological interventions in 2004 and the subsequent provision of funding by the British government in 2007 for this initiative (see chapter 2 for further descriptions of this initiative) have resulted in a major CBT training effort and a large number of mental health workers, often from nontraditional groups as regards therapy and counseling, have been, and are being, trained to deliver low-intensity CBT (Bennett-Levy, Richards, et al., 2010) to depressed and anxious patients in the community. Training approaches for maximally effective training in CBT for nontraditional trainees are described in chapter 11.

Public health policy clearly will continue to greatly affect the growth of CBT training and dissemination. A welcome development in many countries has been the provision of public funding for CBT trainings. Several European countries have been funded for this through the European Union and the World Health Organization. Some Scandinavian countries receive government assistance with such training, and in South Africa an educational council helps with the training process.

Such efforts have a major focus in the CBT community on the issue of dissemination from a theoretical and research perspective, including practical guidelines (McHugh & Barlow, 2012).

Although supervision was a recommended part of the training for cognitive therapists, no systematic descriptions of CBT supervision practice appeared in the literature until the mid- to late 1990s (Liese & Alford, 1998; Liese & Beck, 1997; Newman, 1998; Padesky, 1996; Perris, 1994). Subsequently, Milne and James (2000) provided a very systematic review of effective cognitive behavioral supervision. These practical resources (the seminal articles mentioned previously), along with the advent of training workshops for CBT supervisors offered at national and international CBT conferences, and through other forums in the past decade, have resulted in a much more elaborate, comprehensive, evidence-based approach to supervision in the field of CBT.

Recommendations concerning “good” CBT supervision practice, which includes agenda setting, provision of feedback, concrete goal setting, practice opportunities, a focus on both core skills (conceptualization and intervention) and the client-therapist relationship, attention to the supervisory process, and the use of different learning modalities for the supervisee (Liese & Beck, 1997; Padesky, 1996) have emerged. Currently, in addition to those just mentioned, many resources now exist for supervisors attempting to develop CBT supervisory skills, including two books (Milne, 2009; Scott, 2013) and a number of recent book chapters and articles (Gordon, 2012; Kennerley & Clohessy, 2010; Milne & Dunkerley, 2010). This is a part of the field that has grown rapidly and holds rich promise, as does the important work on measuring supervision adherence and competency (Kennerley & Clohessy, 2010; Milne, 2009) and attempts to describe and operationalize core competencies for CBT trainees and supervisees (Newman, 2012; Roth & Pillings, 2008). In this volume, chapters are devoted

to evidence-based supervisory practices in CBT (chapter 12) and to training CBT supervisors (chapter 13).

CURRENT TRAINING OPPORTUNITIES

Currently, individuals can receive training in CBT in a number of different ways.

CBT Training within Existing Professional Training

Professional training programs often provide opportunities for initial CBT exposure.

Clinical Psychology and Counseling Psychology Training Programs

Many psychology programs have a strong CBT component. Klepac et al. (2012) offered guidelines for CBT teaching based on the findings of an ABCCT task force created to examine cognitive and behavioral psychology doctoral education. This report gives detailed recommendations on competencies expected from such training, but actual practice may not yet reflect these recommendations. Clinical psychology training in other countries, such as England, may well include a greater focus on CBT because this model of treatment is more widely espoused there. Weissman et al. (2006) reported that 100 percent of PhD programs in the United States offered CBT didactic training, while only 89 percent required this training. An examination of PsyD courses showed that CBT didactic training was offered in 100 percent of courses and required in 96 percent, but “gold standard” training, which includes both didactic and supervision components, was included in only 20 percent of PsyD, and PhD courses were only somewhat better in this regard. CBT training at graduate level for psychologists is fully discussed in chapter 8.

Residency Training in Psychiatry An initiative taken by the Accreditation Council for Graduate Medical Education and the Residency Review Committee for Psychiatry in 2001 required competence in CBT for graduating psychiatry residents as defined by each individual program. Weissman et al. (2006) found that the vast majority of residency programs reported compliance with this. In addition, in a survey comparing training courses for different professionals, psychiatry had a higher percentage of programs meeting the “gold standard”. This training is described in a number of articles (Sudak, 2009) and is fully discussed in chapter 9.

Social Work Training Many training programs available in the field of social work include a major CBT didactic training component. Weissman et al. (2006) reported that 93 percent offered CBT training and 80 percent required this. However, only 21 percent of these courses involved supervision as well as didactic instruction.

Postgraduate Training for Professionals Postgraduate training may lie on a spectrum of training intensity from stand-alone seminars and workshops available at conferences or continuing education groups through intensive training often leading to certification (such as the Cleveland or Atlanta programs) to, at the most intensive level, postgraduate degree or diploma courses such as those offered in the United Kingdom and other countries, and postdoctoral fellowships in CBT offered at several centers in the United States.

Another avenue to obtaining CBT training is to serve as a therapist in a randomized controlled CBT outcome study, which usually involves training to a designated criterion of competency. Currently, a practicing professional wishing to receive training in CBT has a number of specific options.

- General CBT workshops or CBT for Specific Disorder workshops at conferences held by groups such as ABCT, BABCP, and IACP (International Association of Cognitive Psychotherapy), or through continuing education groups such as PESI (Provider Education System Incorporated) Education or Cross Country Education.
- On-site trainings organized by agencies, which are usually of brief duration and may involve a heterogeneous professional group (counselors, in-home workers, case managers).
- Weekend or multiple-day workshops and training on specific CBT topics, for example, depression, anxiety, or personality disorders, such as those organized by the American Institute of Cognitive Therapy or the Beck Institute. These can be sequential, with beginner-level and advanced workshops offered. Supervision may be offered. In some cases general certification is provided. In addition to this, professionals may receive certification in specific applications of CBT (for example, trauma-focused CBT; Cohen, Mannarino, & Deblinger, 2006) or CBT-based extended models (Schema therapy; Young, Klosko, & Weishaar, 2003).
- Intensive nine-month to one-year trainings (which often involve supervision) such as those in Cleveland, Atlanta, San Diego, Chicago, and Asheville, among others.
- Postdoctoral fellowships that involve full-time training and work in a dedicated CBT center for one or two years, such as those offered in the Depression and Anxiety Specialty Clinic in Chicago, the Cognitive Behavioral Institute in Albuquerque, and Harbor-UCLA in Los Angeles.

Training through participation as a therapist in research trials of CBT in which therapists are trained to a predesignated level of competency. This training is quite intensive but may be focused only on the treatment of a particular problem or disorder. Candidates selected usually have backgrounds in general CBT skills.

In the United Kingdom, thirty-seven universities offer CBT postgraduate training courses. It is now possible in Britain to obtain both master's and doctor

of philosophy degrees in the field of CBT, which is not yet possible in the United States.

Although the Academy of Cognitive Therapy (ACT) (www.academyofct.org) provides excellent information on training courses, there is no body in the United States that accredits training, although ACT and several other organizations provide certification to individuals, which is further described in chapter 4.

The British Association for Behavioural and Cognitive Psychotherapies approves trainings and provides different levels of credentialing for British and Irish courses. Other countries have robust local postgraduate training and credentialing initiatives.

Appendix VI, Training Opportunities (www.wiley.com/go/sudak), contains information on training opportunities available in the United States and overseas for individuals and agencies considering training or supervision in CBT.

CLASSIFICATION AND REVIEW OF TRAINING PROGRAMS

Recent literature is helpful when considering the type of training to pursue, as there are pros and cons to each. Rakovshik and McManus (2010), in a comprehensive review of evidence-based training in CBT, describe training programs as (1) brief (60 hours or less of CBT training), (2) intermediate (61–137 hours of CBT training), and (3) extensive (137 hours or more of CBT Training). They did not make a distinction between courses offering supervision as well as didactic training but noted in their review that almost all the studies they examined included supervision. They reported that supervision plus an adequate dosage of didactic training appeared to be the important component in training that results in favorable outcomes. Using this classification, it is likely that most trainings available throughout the world for practitioners are in the brief category, some in the intermediate category when ongoing supervision hours are included, and only a few in the extensive category.

Using a number of different criteria (duration, presence or absence of a systematic step-up approach, presence or absence of supervision), CBT training programs might be classified as follows.

Limited-Exposure CBT Training

These are usually of brief duration (no more than one day) and may offer a general introduction to CBT, more advanced applications of CBT, or CBT for specific disorders. Such training is often delivered to mixed and heterogeneous audiences or, in some cases, may be presented to an entire agency.

Advantages Such trainings are offered frequently, do not involve a significant financial or time commitment, and for practitioners familiar with the model may provide a “tune-up” or extension of their skills and knowledge.

Disadvantages Brief training of this sort usually is largely didactic and, though there may be some experiential components, without practice or supervision components. Real-life skill development beyond an increase in knowledge is limited. The quality of training or trainer in fidelity to the model can be extremely variable and hard for trainees to assess in advance.

More Systematic CBT Training Programs of Longer Duration

This type of training is often offered for several days, over a weekend or in a series, with a more systematic approach to knowledge (of theory, research, and practice) and skill acquisition.

Advantages Compared with limited-exposure training, this type of training is longer, more in-depth, and may have built-in opportunities for practice within the training. Also, a number of areas of application of CBT or one application (for example, depression) can be focused on in greater detail with more trainee involvement.

Disadvantages Again, such training is unlikely to involve supervision of actual practice and, subsequently, changes in actual therapy behavior may not ensue following such training. Similarly, the quality of training may be more variable than the next two types of training described.

More Intensive CBT Training Involving Supervision or Case Consultation

This form of training usually is geared toward therapists in practice who attend part time for six months to one year with a significant number of hours (forty or greater) of didactic instruction. The training is usually progressive and systematic in nature. Supervision is usually provided on an individual or group basis either during or after the training.

Advantages The range and time spent in didactic instruction gives a good grounding in the theory and application of CBT. Trainers are more likely to be adequately credentialed and trained. This type of training may be particularly helpful for CBT “novices” who have opportunities for practice, both within the training and in supervised patient care between training sessions. Such trainings usually have built-in assessment of skills and competence (CTS ratings, for example), and supervision also provides a check on skill development. This form of training may provide internal certification when a defined level of competence is achieved and may meet the requirements for external and peer-reviewed credentialing, as described in chapter 4.

Disadvantages For economic and practical reasons, the amount of supervision provided may not be sufficient to ensure continued best practice of CBT. Rating samples of trainees' therapy sessions may not occur. In addition, although the CBT trainers conducting such trainings may encourage this, trainees may not pursue credentialing. Last, such training may be costly and involve a time commitment that may be difficult or impossible to sustain when trainees are employed full time.

Intensive CBT Training Leading to Certification or a Diploma or Degree

This type of CBT training involves either a part-time master's or doctoral degree program associated with a university department, such as those in existence in the United Kingdom, or a full-time postdoctoral fellowship organized through a university department, or a clinic, or center with links to a university who award the fellowship, which is possible in the United States. This training may be of significant duration, usually from one to two years.

Advantages This is the most extensive form of CBT training, both in teaching input and supervised practice. Trainees are evaluated in many different ways to ensure competency (CTS plus other methods) and have numerous opportunities to deliver CBT in a practice setting under supervision to be evaluated on their skill level and receive corrective feedback, often from a number of different supervisors over the duration of the training. Individuals completing such training receive an award (diploma, degree, fellowship) from an institution with credentialing authority and are, in this way, set apart in terms of training and expertise.

Disadvantages Such training is very time intensive and can be expensive. As a result it involves a self-selected, favorably disposed group of trainees who possibly do not represent the providers who most need intensive evidence-based training. In addition, such training, as pointed out by Muse and McManus (2013), is very labor intensive for trainers and supervisors and may not be the optimal use of resources for dissemination of CBT.

A detailed description of different training routes for continued education for therapists in practice can be found in chapter 10, in the section titled "Current CBT Training Options."

Table 1.1 summarizes training options and their advantages and disadvantages, as described previously.

For a professional considering training options, some important questions to be asked include:

- What is the length of training?
- How is the training organized (time blocks, consistency with job requirements)?

Table 1.1 Summary of Alternatives for CBT Training

Type of Training	Characteristics	Training Methods	Positives/Negatives
Limited-exposure workshops	Brief (1 day or less). Usually sponsored by agencies or associations. Introductory or specialized.	Usually didactic and demonstration only. Little or no experiential focus. No supervision or practice components.	High availability. Online versions readily available. Inexpensive. Brief time commitment. Trainer and training quality variable. No practice or supervision. Behavior change as a practitioner unlikely.
Brief CBT programs	Several-day programs or spaced over time. Progressive approach and more in-depth focus possible. Sponsored by agencies or associations.	Can include experiential, practice, and consultative components, as well as didactic and demonstration.	More in-depth. More nondidactic components. Quality of training and trainer variable. No supervision. No assessment of competency. Behavior change may not occur.
Intensive programs	Usually 6 months to 1 year duration. Part-time program. Systematic progressive training for professional practice. Sponsored often by CBT centers.	Includes comprehensive didactic and demonstration component. Opportunities for experiential and self-reflective elements. Supervised clinical practice encouraged. Case consultation or supervision usually provided.	More likely to result in behavior change as well as knowledge acquisition. Competence often assessed. May provide certification and often meets criteria for credentialing. Trainers more likely to be credentialed. Costly.
Intensive programs culminating in a diploma,	Duration of one to two years. Diploma.	All training methods are utilized. Supervision (individual or	Likely to result in behavior change. Competence assessed.

(continued)

Table 1.1 (Continued)

degree, or fellowship award	Master's, doctorate, and fellowship awards. The most comprehensive, both in time involved and content of training. Sponsored by CBT center in association with universities or through university clinics.	group) is a major component of training. Use of CBT in actual patient care targeted, monitored, and fine-tuned through supervision. Competency assessed often at several intervals during training.	Trainers usually credentialed. Training itself can be credentialed through organizations. Results in the award of degree, diploma, or fellowship acknowledging training and competence. Often costly and involves a significant time commitment. May mean giving up current employ- ment, if full time.
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- What is the content of training?
- What is the supervision or practice component?
- What training methods are employed (didactic, experiential, online)?
- What is the trainer's background and expertise?
- Is certification and credentialing part of training?
- What is the cost and time commitment?

Most systematic CBT training programs offer certification from the agency providing the training and may also offer continuing education credits. In addition some assist in the process of credentialing through the Academy of Cognitive Therapy or other credentialing bodies.

Currently in the United States there are three routes toward certification:

1. *The Academy of Cognitive Therapy* offers different forms of membership. Becoming a diplomate entails peer credentialing based on CBT experience, CBT training hours accumulated, and ratings of work samples. The academy also credentials individuals in training and consultation, who receive the designation ACT Trainer/Consultant. These individuals have reached a desired level of competence as CBT trainers, CBT supervisors, or CBT consultants; this can assist individuals and agencies in setting up good-quality training and supervision.
2. *The American Board of Professional Psychology (ABPP)*, which is affiliated with the American Psychological Association, provides certification in

cognitive behavioral psychology that involves an exam, professional experience, and an evaluation of work samples. Unlike the Academy of Cognitive Therapy, which is open to all professionals, this is restricted to psychologists.

3. *The National Association of Cognitive-Behavioral Therapy (NACBT)* certifies members at two levels: Diplomate in Cognitive-Behavioral Therapy and Certified Cognitive Behavior Therapist. Both are based on training and length of experience. There are no requirements regarding work samples or evaluation of skills or practice for certification with this organization.

In the United Kingdom, the British Association for Cognitive and Behavioural Psychotherapy has certification at the level of Cognitive Behavioral Psychotherapist (Full), Cognitive Behavioral Psychotherapist (Provisional), and Supervisor and Trainer and Psychological Wellbeing Practitioner (linked to receiving training through the Improving Access to Psychological Therapies Courses). Accreditation procedures are also reviewed in chapter 4. See “Accreditation as a CBT Provider.”

Individuals or agencies considering instituting training or supervision should seek out CBT trainers and supervisors accredited by some of the listed organizations.

EFFECTIVENESS OF TRAINING

Not a great deal of research has been conducted about CBT training to allow us to provide training based on evidence for effectiveness. As Milne (2009) argues, it is important that we establish a good evidence base and have research support for CBT supervisory and training practice. This is emerging with increasing vigor. Very little evaluative research on the effects of training therapists for practice, as distinct from studies evaluating training for research trials, has been conducted in the United States. Most of the existing literature on the effects of training and supervision originates from the United Kingdom and other countries. The existing research is reviewed in Tables 10.1 and 10.2 in chapter 10.

A recent review article by Rakovshik and McManus (2010) located forty-one published studies up to the year 2009 that evaluated CBT training and met criteria for inclusion in the review. Of these, only seven studies were *not* linked to a research trial of CBT. Nineteen studies (approximately 46 percent) showed clear competence enhancement, measured in an acceptable fashion, thirteen studies (approximately 32 percent) showed positive effects of training but not necessarily meeting the criteria of competence, and five (approximately 12 percent) showed no significant effects of training. However, a more general systematic review of training for evidence-based practice (many studies of CBT training were included) carried out by Beidas and Kendall (2010) concluded that “perceived and declarative knowledge increased following training in evidence-based

practice” but cautioned that “generally speaking, therapists trained in the current format (workshop, manual, and brief supervision) do not reach proficiency in treatment adherence, competence and skill” (p. 25). The authors went on to outline methods of maximizing training through active learning. Empirically supported educational methods that maximize learning in CBT training are described in chapter 3 of this volume.

It is difficult to draw definitive conclusions across studies because of the very different outcome measures and indices of competency. The problem of differing outcome measures in CBT training research has been noted by several commentators (Beidas & Kendall, 2010; Fairburn & Cooper, 2011; Muse & McManus, 2013). These and other authors have suggested ways to remedy this situation.

Many existing training studies have used multiple measures and, most important, included the Cognitive Therapy Rating Scale (CTS) or a revision of this (CTS-R; Blackburn et al., 2001) with ratings made (often by independent observers) on recorded work samples. Some writers (Fairburn & Cooper, 2011) favor a measure of therapist skill in real-life settings, a trainee conducting therapy with a standardized “patient” (an actor), a method of evaluation used in medical training, while others favor role plays and behavioral rehearsal as a way to assess competency (Beidas, Cross, & Dorsey, 2014). Most training studies used measures of knowledge and self-perceived skill without any measure of observed skill.

Unfortunately, self-reported behavior change does not match actual behavior change (Beidas & Kendall, 2010). Some studies include patient outcome as a measure of the effectiveness of training, but this may be less than ideal because other factors, in addition to therapist competency, may be instrumental in determining therapeutic outcome. Muse and McManus (2013) provide an excellent review and evaluation of measures of competency for CBT training. In addition, chapter 4 describes different methods of evaluating trainee competency. Chapter 10 also includes a more detailed analysis of the research on the effectiveness of CBT training.

However, a brief summary of the findings of the training research indicates that

- Dosage is predictive of outcome. More extensive training leads to greater competence and better patient outcomes (Ravoshik & McManus, 2010).
- Supervision added to didactic instruction is more effective than didactic instruction alone (Sholomskas et al., 2005).
- Relatively inexperienced therapists (CBT “novices”) can be successfully trained, especially when the training is lengthier and more extensive and includes a supervision component (Barnfield, Mathison, & Beaumont, 2007; Keen & Freeston, 2008).
- Nontraditional providers such as nurses, occupational therapists, case managers, and palliative care workers can be trained to competence in CBT (Westbrook, Sedgewick-Taylor, Bennett-Levy, Butler, & McManus, 2008).

- Employing different training modes, including experiential learning, clinical practice (including self-practice), self-reflection, and supervision is important to attain competence in CBT (Beidas & Kendall, 2010; Bennett-Levy, Lee, Travers, Pohlman, & Hamernik, 2003).

BEST PRACTICES FOR TRAINING

Later chapters (8, 9, 10, and 11) elaborate on best training practices from both a review of existing research and the experience of trainers. At this point, several suggestions and guidelines are briefly outlined:

- Training should be tailored to the specific needs of those being trained.
- Training should include different modalities of learning, including experiential components that foster active learning and skill development rather than the acquisition of knowledge alone.
- Online versions of training are needed for maximum dissemination of training.
- Brief training, including some supervisory or consultative component, should be made easily available to those who are providing low-intensity CBT.
- Follow-up or ongoing practice of skills with supervision is critical.
- Assessment of core competencies and skills, not only knowledge, is essential.
- Trainers must receive training in best training practices.

BEST PRACTICES FOR SUPERVISION

Evidence-based supervision in CBT is described in later chapters (12 and 13). The following is a summary from the existing literature (Milne, 2009; Milne & James, 2000) regarding best practices in optimizing CBT supervision:

- Use of different training modes in a targeted and conceptually driven way (didactic, observational, experiential)
- Use of training manuals and disorder-specific evidence-based protocols
- Structuring supervision in a manner that mirrors cognitive behavioral therapy practice (agenda setting, problem definition, use of feedback and homework)
- Developing a good supervisory alliance that involves collaborative empiricism
- Providing corrective feedback to supervisees and eliciting and responding to trainee feedback regarding supervision (see chapter 5)
- Use of self-practice and self-reflection to foster learning
- Focus on the supervisory process

- Ensuring supervisors have ongoing supervision and training to fine-tune their supervisory skills (see chapter 13)

WATCH. Go to www.wiley.com/go/sudak, *Appendix VII, Video Library*, and View Videos:

- Goal Setting for Supervisors
- Frustration

SOME DISTINCTIVE FEATURES OF CBT TRAINING AND SUPERVISION

Key features in the development of CBT training and supervision include:

Range of professionals trained CBT training has been notably inclusive of professional groups trained. Beck supervised, trained, and collaborated with psychiatrists, psychologists, and social workers in the early development of CBT. Training courses currently offered are open to professionals from all disciplines. Professional organizations representing cognitive behavior therapists in the United States (ABCT, Academy of Cognitive Therapy) and internationally are solidly multidisciplinary. Studies describing and evaluating training for a wide range of mental health, nursing, medical, and other professional groups exist in the literature. CBT has been more widely disseminated as a result. Behavior therapists need to be given great credit for implementing this ecumenical training stance. Isaac Marks implemented behavior therapy training for nurses in the 1970s and clearly demonstrated that this group could produce outcomes comparable to other professionals (Marks, 1985). Multidisciplinary teamwork related to the delivery of CBT is unique among psychotherapies. Such open-mindedness to maximizing services to clients by widespread training of many disciplines is well represented in the low-intensity CBT movement, which has gained tremendous support (Bennett-Levy et al., 2010) and has considerable potential to help a larger number of suffering patients.

Range of applications of CBT training A hallmark of the evolution of CBT has been the continuous momentum and progression of new applications to clinical problems and populations. In the 1980s and 1990s, CBT was largely a treatment for mood and anxiety disorders; now evidence-based CBT protocols exist for a wide variety of conditions ranging from medical conditions such as irritable bowel syndrome (Toner, Segal, Emmott, & Myran, 2000) and Tourette's Syndrome (Woods et al., 2008) to psychiatric symptoms previously thought to be untreatable by psychotherapy, such as hallucinations and delusions (Chadwick, Birchwood, & Trower, 1996).

Very specialized training in CBT exists for such specific areas of interest as trauma-focused CBT (Cohen et al., 2006) or CBT-I for insomnia (Perlis, Jungquist, Smith, & Posner, 2005).

Reflexivity One of the hallmarks of the CBT approach is that key elements of therapy (structure, collaboration, feedback) are reproduced in training and supervision, which is unique among psychotherapies. These similarities are described in Table 1.2. In CBT, this practice models the key components of the therapy by implementing them in supervision and training (Liese & Beck, 1997; Padesky, 1996). In addition Bennett-Levy, Thwaites, Haahrhoff, and Perry (2015) describe how CBT can be practiced “from the inside out”; that is, by trainees using CBT methods on themselves utilizing self-reflection and self-practice to improve skill development.

Regarding supervisory practice, Milne (2008) has noted this “reflexivity” and its advantages but has also pointed out that (1) it is not always adhered to and (2) it may not be sufficient. Milne recommends a more specialized approach with the inclusion of other elements from the wider field of supervision and also from the applied psychology of learning. This practice is described in chapter 12.

Table 1.2 Commonalities between CBT Therapy and CBT Supervision and Training

Therapy Elements	Present in Supervision	Present in Training
Structure	Yes	Yes
Agenda setting	Yes	Trainer directed but can include trainees’s needs
Prioritizing agenda	Yes	Most often trainer determined
Collaboration	Yes	In more active learning modules and in seeking feedback
Guided discovery	Yes	In more active learning
Interpersonal effectiveness	Yes	Yes
Efficient use of time/ pacing	Yes	Yes
Problem definition/ goal setting	Yes (for patient and supervisee)	Yes, in stated training objectives
Problem solving	Yes (for patient and supervisee)	Yes, in meeting training objectives
Capsule summaries	Yes	Yes
Homework	Yes	Usually present in ongoing training, not in one-time training
Feedback	Yes (to and from supervisee)	Yes, on clarity of and reactions to the material presented

Face validity of the CBT model The CBT model has a coherence, clarity, and commonsense quality that can be easily explained and demonstrated. Trainees and clients resonate with the high face validity of the model. Its universality is represented in proverbs (“One man’s trash is another man’s treasure”), widely read quotations (Shakespeare noted, “There is nothing either bad or good but thinking makes it so”), and Oscar Wilde concluded, “We are all in the gutter but some of us are looking at the stars”), and in the commonsense analysis of day-to-day situations (It is not the noise in your house during the night that makes you anxious but your assumption about what is causing it).

The emergence of models for training and supervision The development of models for training and supervision in CBT in general (Bennett-Levy, 2006; Bennett-Levy et al., 2015) and for training in specific skills such as case conceptualization (Kuyken, Padesky, & Dudley, 2009) may guide trainers in a manner quite different from the earlier “train and hope” approach (Stokes & Baer, 1977). Similarly, the development of evidence-based supervision approaches with a clear guiding model (Milne, 2008) ensures more effective supervision. See chapter 12 for more information.

Delineating core competencies and improved measurement of competency The general move toward delineating the competencies required for psychotherapy and other areas of professional practice (Kaslow, 2004) has extended to CBT. Of great value to trainers and supervisors, trainees, and therapists alike has been the defining CBT competencies (Newman, 2012; Roth & Pilling 2008). Just as therapy is generally more successful when clear goals and targets are established, operationalizing clear competencies and skill sets expected of a therapist delivering CBT with fidelity is likely to make CBT training and supervision maximally effective. Chapter 2 describes core competencies in CBT training. As mentioned previously, research regarding training outcomes has been hampered by the use of differing measures of competency (Muse & McManus, 2013). There are encouraging signs of improved measures of competency of trainees, supervisees, and supervisors. Chapter 4 reviews methods of evaluating competency in trainees, and chapter 12 describes practical ways of measuring elements of supervision.

Training for supervisors and trainers Ongoing supervision and consultation for supervisors and trainers is widely recommended. It ensures that the cycle of training and supervision is optimized with and optimizes both continued professional development and faithful, skillful patient care improving the probability of positive clinical outcomes. This is described in detail in chapter 13.

FUTURE DIRECTIONS FOR CBT TRAINING AND SUPERVISION

There is a significant need for greater availability of effective training programs (intensive with a strong didactic, experiential, practice-and-supervision component) both at the graduate and postgraduate levels. The quality and content of training should be assessed by credentialing bodies. CBT national and international organizations could devote attention to this issue to ensure that training programs offered meet adequate standards.

Clearer and more specific descriptions of training and supervision are needed. Such needs inspired this text. Access to training in CBT supervision and training should be improved and more continual education and supervision for trainers and supervisors required. The initiative by the Academy of Cognitive Therapy to credential individuals with the required competence to be “consultant trainers” will, we hope, lead to a continuing improvement in the quality of supervision. The effort to prevent “drift” from the model ultimately affects patient outcomes.

As Clark (2004) points out, there is a need for a theory to guide training research to inform the practice of CBT training and supervision. At the present time, despite some advances in this field we are still not sure, based on empirical data, what works best and for whom in training and supervision. Unfortunately, in reality training that is currently available is often a “one size fits all” approach.

Consensus is needed about the goals of training and how we define competence or desired outcomes so that we may design training in a systematic way. Setting benchmarks regarding competencies at different stages of a therapist’s development may help this (Newman, 2012). Sharpless and Barber (2009) have suggested that therapists may pass through five developmental stages:

1. Novice
2. Advanced beginner
3. Competent
4. Proficient
5. Expert (paralleling the Dreyfus competency model; see Sudak, chapter 5)

A formulation of expectations for each stage is required rather than a one-time definition of competence (a specific cut-off score on the Cognitive Therapy Scale, for example). We also need unanimity on what defines competency, which makes comparison of training studies possible. Muse and McManus (2013) identified ten methods of assessing competence in a review of studies that measure different skills on Miller’s Pyramid (Miller, 1990), such as knowledge (“knows”), practical understanding (“knows how”), practical application of knowledge and skill (“shows how”), and clinical practice (“does”). Chapter 4 discusses the different methods of evaluating competency.

Well-designed evaluative research must answer some of the following questions:

- What is the optimal length, content, and form of training for different trainee groups (for example, low-intensity providers, individuals with little knowledge of counseling in general, therapists working with highly complex and challenging cases)?
- Which mode or modes of training (didactic, experiential, observational, self-reflective) produce the best outcomes? Effective training may involve a two-stage process in which first theoretical knowledge is acquired via didactic presentations, guided reading and the use of Internet and Web-based resources followed by continuing skills development via practice cases, experiential work, observation of sessions, and supervision (Rakovshik & McManus, 2010). (Different teaching methods applicable to CBT are discussed in chapter 3.)
- How much CBT training can be done online without the expense of providing trainers and supervisors? Fairburn and Cooper (2011) argue that all aspects of training should be done through the Internet and other technologies since traditional training is both cost-ineffective and unlikely to lead to the degree of dissemination required given the public health needs.
- How much can training use nontraditional methods such as computer programs (similar to those designed to assist patients), CBT “apps,” research-based manuals, and self-help materials? (The use of technology in training is discussed in chapter 7.) Such research needs to be a priority to ensure that we train and supervise in the most effective way (Milne, 2009).

Several writers have emphasized the importance of organizational factors in maximizing the effectiveness of CBT training and supervision. Beidas and Kendall (2010) have proposed a systems-contextual model to optimize training stressing the role and interaction of therapist factors, client variables, and organizational support. They argue that each factor needs to be addressed to create effective training. Stirman et al. (2013) offer guidelines to facilitate training looking at the role of organizational factors. Chapter 11 provides suggestions for motivating organizations to support initiating and maintaining CBT training and supervision efforts.

More training courses for supervisors and trainers should be developed. Professional organizations and individuals in the training and supervision community must provide such opportunities and stress the importance of continued training and supervision.

SUMMARY

Significant progress has been made to refine and optimize the dissemination of CBT. This is an exciting time for trainers and supervisors. Subsequent chapters in

this volume provide guidelines to optimize the practice of CBT training and supervision from the existing knowledge base and on the extensive practical experience of the contributors.

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Chapter 2

CORE COMPETENCIES IN COGNITIVE BEHAVIORAL THERAPY TRAINING

Donna M. Sudak

Efforts to develop robust training programs in cognitive behavioral therapy (CBT) require specification of the knowledge, skills, and attitudes necessary to implement the therapy. A variety of organizations have attempted to specify these competencies with varying degrees of detail and complexity. Trainers must become familiar themselves with the content of the competencies and specify methods by which competencies will be taught when building curricula, in addition to employing instruments to measure educational outcomes.

This chapter aims to provide trainers with an overview of competencies in CBT in the following ways:

- Review existing competency frameworks
- Describe essential competencies for training in CBT, and
- Provide examples of methods of teaching competencies to trainees of varying levels of professional knowledge and sophistication

A full description of each essential competency and examples of how to teach them would constitute an entire text. The reader is directed to basic CBT textbooks (Beck, 2011; Newman, 2013; Sudak, 2006; Wright, Basco, & Thase, 2006; Wright, Sudak, Turkington, & Thase, 2010; Wright, Turkington, Kingdon, & Basco, 2009) to obtain such information. This chapter describes the essentials and explains how to approach teaching them in beginner, intermediate, and advanced groups.

WHAT ARE COMPETENCIES?

Lists and texts notwithstanding, general agreement is lacking regarding the definition and content of a *competency*. Generally, competency implies a measurable behavior, skill, knowledge base, or attitude that leads to successful implementation of CBT. Albanese, Mejicano, Mullan, Kokotailo, and Gruppen (2008) provide a useful definition of what competencies do:

- Competencies “focus on the performance of the end product of . . . instruction.”
- Competencies “reflect expectations that are an application of what is learned.”
- Competencies are “expressed in terms of measurable behaviors.”
- Competencies provide standards for judging adequate performance that are “not dependent on the performance of others.” And
- Competencies “inform learners . . . about what is expected of them.”

In an effort to synthesize recommendations from a task force on competency education in psychology, Kaslow et al. (2004) noted specific assumptions often made regarding competency, including that

- We can identify what competencies are for an individual therapy.
- Individuals can be trained to develop competencies. And
- Competencies can be assessed.

The processes that train therapists to deliver competent CBT are less well defined and researched than the processes of therapy. Research about effective educational processes is just beginning. There is a wide variety of trainee experience, and the patient populations treated are diverse, further adding complexity. We need better measures of competence and more efficient ways of disseminating treatments. A particular challenge in defining and measuring therapeutic competencies is that we teach therapy in a predictable and “closed” environment, but it is practiced in an unpredictable context in which responsiveness is key. Training and measurement of goal attainment, therefore, are complex (see the open versus closed skill development discussion on page 32).

EXISTING COMPETENCY FRAMEWORKS

CBT training is rapidly expanding throughout the world. Many national health systems (for example, United Kingdom, Japan, Denmark) and health care systems (for example, the Veterans Administration in the United States) (Karlin et al., 2012) have recognized the considerable medical, societal, and personal costs that are the result of untreated or poorly treated mental illness and have hence developed and funded programs to increase the availability of CBT. In October 2007, the government of the United Kingdom inaugurated an effort

called Improving Access to Psychological Therapies (IAPT). This initiative resulted in the investment of approximately US\$260 million to train and deploy at least 3,600 (mostly CBT) therapists (Clark et al., 2009) and was accomplished by an increased number of postgraduate courses in CBT (McManus, Westbrook, Vazquez-Montes, Fennell, & Kennerley, 2010). This initiative also led to the specification of competencies for the treatment of particular disorders and for the development of trainee skills. Because of the scale of the IAPT initiative and the unprecedented amount of attention to therapist training, much can be gleaned from this effort.

In 2007 the British Department of Health released “The Competences Required to Deliver Effective Cognitive and Behavioural Therapy for People with Depression and with Anxiety Disorders” (Roth & Pilling, 2007). This publication was the result of a project commissioned by the IAPT program in order to ensure the availability of competent practitioners who could offer effective, evidence-based psychotherapy. Roth and Pilling determined what activities characterized effective CBT interventions, then mapped and described the competencies. The map can be downloaded from the website of the Centre for Outcomes, Research & Effectiveness, University College London (CORE), <https://iris.ucl.ac.uk/iris/browse/researchGroup/1316>. To delineate these competencies Roth and Pilling reviewed the literature regarding empirically supported CBT treatments for depression and anxiety, extracted the competencies needed, and then confirmed these with the authors of the treatment protocols, finally generating an overall model with expert input (Roth & Pilling, 2008). Sbulati, Schniering, Lynham, and Rapee (2011) used a similar process to generate a model for therapist competencies in working with children with anxiety and depression. Educators can use these resources to assess training programs for completeness. Self-assessment tools are available for the use of individual practitioners to gauge their particular skill acquisition to provide CBT. The competency maps can be used by a supervisor–trainee pair to help identify specific needs for further study and self-practice.

The Roth and Pilling (2007) framework consists of generic, basic, and specific competency subsets, then problem-specific competencies (phobias, panic disorder, obsessive-compulsive disorder, generalized anxiety disorder, posttraumatic stress disorder, and depression), and meta-competencies. These subsets are useful for planning training. The first set, *generic therapeutic competencies*, delineates basic psychotherapy competencies that are needed for all practitioners irrespective of theoretical orientation regarding knowledge of mental health problems and professional and ethical guidelines. It specifies skills needed to engage and build a therapeutic alliance with the patient to assess problems, to use supervision, and to terminate care. This baseline level of skills describes the person who is ready to obtain more specific training in CBT.

The second set, *basic CBT competencies*, includes skills required to implement CBT collaboratively and indicates the critical importance of the therapeutic

relationship in CBT. Therapists must be capable of implementing the structure of therapy in a fashion that is flexible and highly attuned to the patient's needs.

The third competency group, *basic cognitive and behavioral competencies*, involves foundational knowledge regarding the basic principles of CBT (cognitive biases and the role of safety seeking) and then specifies the skill sets needed for the implementation of CBT, including explaining the rationale to the patient, structuring sessions, using measures for self-reporting symptoms, developing hypotheses about the maintenance of problems, problem solving, and termination.

Specific cognitive and behavioral techniques constitute the next group of competencies, including guided discovery, Socratic questioning, thought recording, case conceptualization, and treatment planning.

Last, *problem-specific competencies* are the fifth set of competencies comprising specific aspects needed to provide treatment for each of the specific diagnostic areas. Roth and Pilling also detail *meta-competencies* that are more abstract, relating to the capacity to use judgment, self-reflect, and formulate custom-tailored strategies for patients while using appropriate pacing and managing obstacles. Although quite extensive, this framework is a useful road map to detail and develop competencies for training therapists.

THE BRITISH ASSOCIATION OF BEHAVIOURAL AND COGNITIVE PSYCHOTHERAPIES (BABCP) CORE CURRICULUM

The British Association of Behavioural and Cognitive Psychotherapies (BABCP) core curriculum closely parallels Roth and Pilling's 2007 competencies. This curriculum is designed to be used over the course of one hundred hours of directed study. It is designed to provide an understanding of the scientific and theoretical foundation of CBT for a spectrum of mental health disorders and to help the trainee master the clinical competencies essential to practicing CBT. Table 2.1 summarizes the content of the BABCP core curriculum (Hool, 2010). The curriculum is extremely inclusive and incorporates the generic Roth and Pilling competencies. Generally one would not include phenomenology and diagnosis as part of a CBT curriculum; educators generally assume that their trainees have grounding in such knowledge. Assessing whether this assumption is accurate is of critical importance when developing educational programs. Also significant is the BABCP's emphasis on the theoretical framework of CBT, on the empirical support for behavioral and cognitive theories of common mental disorders, and on the research regarding the effectiveness of CBT, because these topics are less frequently included in therapist training. Briefer training (that is, workshops) in CBT is often about the "how to" in the absence of the "why" regarding critical interventions. Therapists who have had such skill-focused training in the absence of theory may be less skillful and less flexible when they employ the therapy in real-world settings.

Table 2.1 The British Association of Behavioural and Cognitive Psychotherapies Core Curriculum

Scientific and theoretical underpinnings	CBT Core Competencies	
• Phenomenology • Behavioural theories • Cognitive theories • Efficacy research • The scientist–practitioner	• Competency measurement • Professional and therapeutic competencies • Assessment competencies • Intervention competencies • Treatment process competencies	• Another distinguishing feature of the BABCP curriculum is that trainees are taught the identification and measurement of clinical competence before learning the specific skills of CBT. This order of operations is fully in the spirit of producing lifelong learners and inculcates the importance of continually using measures to improve patient care. General psychotherapy skills, such as interpersonal competencies, using supervision effectively, assessment, and diagnosis are integrated into the curriculum. A key distinction of the BABCP curriculum is that it provides two pathways to attain competency in working with cognitions and in providing treatment for anxiety. Therapists can attain mastery with either cognitive restructuring or considering cognition in context, and in work with anxiety by either the use of exposure or by recontextualizing cognition and using behavioral experiments. As in the Roth and Pilling (2007) framework, individual skills are developed first, and then protocols for specific disorders are taught. • The BABCP framework of competencies acknowledges that supervisor training is a separate competency (Milne & James, 2002). CBT educators increasingly recognize that supervisors also need to develop their skills. This approach is unlike the “See one, do one, teach one” method by which many of us became teachers and supervisors.

Source: Hool (2010).

ESSENTIAL COMPETENCIES IN CBT TRAINING

Essential CBT competencies can be broadly divided into therapeutic process skills, generic competencies, and CBT-specific skills (Table 2.2). In all the existing competency frameworks, the processes common to CBT for all disorders include collaboration, Socratic questioning, guided discovery, conceptualization, structure, and tailoring of treatment and of the alliance to the individual patient.

Table 2.2 Essential CBT Competencies

Therapeutic Process Skills	Generic CBT Competencies	CBT-Specific Competencies
Develops a therapeutic alliance specific to CBT	Has capacity to self-reflect	Performs guided discovery
Can perform a diagnostic assessment	Engages in self-care in the service of providing good treatment	Collaborates with the patient
Understands and embodies the principles of professionalism and ethical practice	Uses routine progress monitoring to enhance care	Structures the session in a collaborative and efficient manner
Practices cultural competency	Identifies problems both cross-sectionally and longitudinally	Uses Socratic questioning
Sets appropriate goals (SMARTER goals: <u>S</u> pecific, <u>M</u> easurable, <u>A</u> chievable, <u>R</u> elevant, <u>T</u> imely, <u>E</u> thical, <u>R</u> esources)	Trains patient in skills	Uses conceptualization throughout to inform treatment planning
Manages “stuck” points in therapy	Engages in behavioral and functional analysis	Provides behavioral activation
Prepares patient for termination	Uses supervision wisely	Engages patient in cognitive restructuring, including thought records and techniques to change intermediate and core beliefs
		Provides exposure and response prevention
		Understands the theoretical foundations for interventions
		Assigns appropriate out-of-session practice (for example, homework)

Source: Rector and Cassin (2010).

Numerous authors have noted that problem identification (and specifying the mechanisms by which problems are maintained) is an area in which many trainees lack proficiency (Beidas & Kendall, 2010). Rector and Cassin (2010) provide a review of competency frameworks and link these to best practices in training.

TEACHING METHODS

Once competencies are defined, trainers and supervisors must have efficient and effective methods of teaching core knowledge and skills to trainees.

Methods of Skill Acquisition

- Multiple authors have emphasized that coaching and feedback are essential to acquiring new skills (Bearman et al., 2013; Beidas and Kendall, 2010; Miller, Yahne, Moters, Martinez, & Pirritano, 2004). Chapter 5 provides a framework for training skills that can be used to help trainees acquire essential CBT competencies. Modeling and role playing are the most effective ways to encourage therapists to change behaviors and incorporate new approaches (Bearman et al., 2013). Padesky (1997) published an elegant description of the parallel processes of teaching skills to patients in CBT and teaching skills to therapists who wish to learn CBT. Such a synergy occurs naturally because CBT incorporates principles of learning theory. Therefore, trainers use Socratic questioning, behavioral experiments, feedback, and focused practice just as therapists use these tools with patients because they are important ingredients of both processes. Theoretically, skilled CBT practitioners already possess a number of the tools optimally used by CBT trainers—they just need to apply these skills in both venues.
- Rakovshik and McManus (2010) emphasize the importance of timing in training as well. Adults need to have time to apply new skills and to reflect upon what occurs in training in order to consolidate their learning. Bennett-Levy (2006) echoes this principle in his classic paper on the acquisition of therapy skills. All of the competencies we teach include the components of knowing facts, knowing how to apply the facts, and utilizing a mechanism to meaningfully evaluate what occurs following the application.
- Teaching adult learners is referenced in many places in this book. The most important “take-home” message to educators is “Think active.” Experiential learning is unquestionably the most potent dissemination method for adults. Engagement is essential. Find ways to make learning come alive for trainees; demonstrations, role plays, exercises, and personal examples invigorate adult learners. Don’t leave your Socratic principles at the door when transitioning from therapist to teacher. *It is the same process!*

Examples

One way to approach teaching core competencies is to develop modular education, which raises the level of sophistication and challenge across trainee groups. For example, role-play practice must be tailored to the level of proficiency in a training group. Applying CBT skillfully with patients requires self-reflection and flexibility to adapt to changing circumstances. In physical therapy and sports, skills are sometimes classified as either “open” or “closed” (Gentile, 2000). This concept may be useful in training CBT, or for that matter, any psychotherapy. When using a closed skill, the performer initiates the action and the environment is stable. For example, gymnastics or bowling involve closed skills in sports—the activity is self-directed and self-paced, and conditions do not vary to any large extent. When using an open skill, the performer acts in accordance with the context in which the skill is deployed, and the environment is unstable. Skiing is a perfect example of an open skill in sports—conditions are highly variable and affect performance. Training someone to use an open skill, whereby the environment shifts and a number of variables can impinge on the skill, certainly describes training in psychotherapy. In the physical therapy and sports science model, self-reflection is also key to learning open skills while gaining experience from applying the skill under different conditions.

Skills in CBT, often learned in isolation and during role play, are far more complex when employed with patients. Patients present with a wide variety of conditions, and their responses to therapy vary. The therapist, too, makes a contribution to the dyad. Applying the concept of open skills training can guide our efforts to educate new therapists. Open skill sets are best taught by assigning graded tasks that gradually increase in challenge and variability. One might begin with very specific, almost scripted interactions, which the therapist learns and practices and then gradually employs at more challenging and variable levels of difficulty. For example, the trainer might first develop a script for a new therapist to rehearse agenda setting. The trainee then implements an agenda in role play using a script. At the next level of training the trainee must practice agenda setting in role play with no prompts; the exercise is then repeated with role-play patients whose conditions gradually increase in complexity. Finally, the trainee practices agenda setting with patients with varying conditions and later listens to tapes of the sessions while reflecting on his or her performance and the outcome of the intervention. Role play is significantly improved as a training device when the therapist takes time to observe and self-reflect. Watching tapes or using triads (with one person as an observer) and providing a list of specific questions to each participant in the role play to use in debriefing facilitates self-reflection.

Trainee practice should also be varied based on the trainee’s level of professional sophistication and should help the trainee develop the flexibility needed to take the next learning step. For example, as illustrated in Table 2.3, practicing automatic thought records, an assignment for a very new trainee, might include a

Table 2.3 Graded Exercises for Role Play

Situation	Emotion	Automatic Thought	Alternative Thought	Emotion
Beginner				
Forgot cupcakes for school event	Sad	I am a terrible mother.		
Intermediate				
Forgot cupcakes for school event	Frustrated	Why am I such an idiot?		
Got a flat tire	Angry	This always happens to me.		
Advanced				
Had a fight with my mother	Sad	She is always so mean. I hate her.		
Failed a geometry test	Hopeless	There is no use in trying.		
Watching TV	Angry	My boyfriend is a jerk.		

role play involving helping a patient restructure a single well-articulated thought. For intermediate-level trainees, thoughts that are in the form of questions or that are difficult to restructure might be used in the role play so that the trainee needs to respond to a common clinical challenge. Finally, advanced-level trainees might discuss a thought record that has several inconsistencies in it that must be resolved before cognitive restructuring can be used. Table 2.4 provides role-play suggestions for learning the skills that facilitate forming the therapeutic alliance and employing behavioral activation. Hands-on teaching methods are always

Table 2.4 Role-Play Suggestions for Teaching Behavioral Activation and Forming a Therapeutic Alliance

Therapeutic Alliance by Trainee Level	
Beginning	Role-play for 20 minutes the basic structure of a CBT session for a patient with uncomplicated panic disorder
Intermediate	Role-play for 20 minutes the basic structure of a CBT session for a patient with panic disorder who has significant issues with trusting the therapist
Advanced	Role-play for 20 minutes the basic structure of a CBT session for a patient with panic disorder, comorbid substance abuse, and significant issues with trusting the therapist
Behavioral Activation by Trainee Level	
Beginning	Role-play explaining the rationale and collaboratively choose a single assigned task for a patient with moderate depression
Intermediate	Role-play troubleshooting assignments that did not go well for a patient with significant psychomotor retardation and low interest
Advanced	Role-play managing chronic depression complicated by rumination and avoidance

preferable to didactic instruction and should incorporate corrective and confirming feedback to increase skill development.

Role play with intermediate or advanced trainees can also be enhanced by asking them to provide material from their own most challenging cases and then role playing the situation in triads for observation and feedback. “Real play” is also a good strategy. In this intervention, trainees bring material from their personal lives to role play. Thought records about learning CBT are less threatening for this purpose; tasks that the student has found difficult to initiate (such as thesis writing, a task often associated with procrastination) are often useful illustrations. These self-practice exercises can be used to augment practice that involves role playing about clinical situations and greatly increase engagement. An exercise that can be used with beginning trainees, “The Change Project,” is included in *Appendix II, Forms and Tools* online at www.wiley.com/go/sudak. In it beginning trainees are tasked with choosing a habit or situation in their own lives that they want to change and must then research and implement a behavior change effort over a period of weeks. This assignment illustrates the difficulty inherent in trying to change behavior and also the challenges that occur in self-observation.

Always keep in mind that CBT is performed by a *person*. This variable influences implementation and requires the therapy trainee not only to self-reflect but also to understand what engaging in this profession means for his or her personal life. Therapists often neglect their responsibility to gauge their own fatigue and to monitor their own stresses so that their “instrument” is in the best possible condition when they work with patients. This is itself an important competency. Self-reflection and assessment cannot be overemphasized and should be taught as a competency as well as discussed in supervision.

SUMMARY

A key element for trainers and supervisors in CBT education is to identify the specific competencies to train and then employ effective methods to ensure that trainees have the knowledge and skill to treat patients. A number of frameworks exist to assist trainers in compiling the essential elements to be taught and practiced.

LEARNING EXERCISES

- Review the Roth and Pilling (2007) competency map (downloadable from <https://iris.ucl.ac.uk/iris/browse/researchGroup/1316>). Identify core competencies you believe are a solid part of your psychotherapy repertoire. Develop a plan to increase your skill level in those competencies you believe are less well developed.
- Choose one core competency. Develop three exercises to teach it: one beginner, one intermediate, one advanced in sophistication.

- Make a series of handouts for use in role-play practice, for the trainee who portrays the patient, the therapist, and the observer. List items for reflection and to promote good feedback.

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Chapter 3

EMPIRICALLY SUPPORTED EDUCATIONAL METHODS

R. Trent Codd III

Cognitive behavioral therapy (CBT) educators teach empirically supported clinical methods whose efficacy is well documented in the literature. However, the literature in CBT outlets pertaining to empirically supported instructional methods that can be used to effectively deliver CBT training is sparse. Cognitive and behavioral therapists generally declare an allegiance to evidence-based practice, involving the reliance on scientific methods to guide their selection of clinical procedures. However, it's less clear that those who instruct others in these treatments similarly rely on scientific methods to guide their instructional design and delivery when training others in these therapies. There is precious little empirical data available on both the knowledge and frequency of use of empirically supported instructional methods by the cognitive and behavioral therapy educator. This absence of data is itself evidence of the dearth of attention paid to empirically supported methods in this educational context. This is concerning because possessing a fluent repertoire in the subject matter of instruction does not guarantee one also possesses an effective instructional repertoire (Bransford, Brown, & Cocking, 2000). This repertoire must be developed separately.

Empirically supported instructional methods, most of which were developed by the applied behavior analytic educational community, are available. This literature is extensive and was undertaken in both the mainstream and special education populations and in elementary through high school cohorts. However, several investigators extended evaluation of these methods to typically developed

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adult populations (especially college and university students), finding support for these well-known methods with this cohort (for example, Clayton & Woodard, 2007; Kellum, Carr, & Dozier, 2001; Malanga & Sweeney, 2008; Marmolejo, Wilder, & Bradley, 2004; Musti-Rao, Kroeger, & Schumacher-Dyke, 2008; Shabani & Carr, 2004; Williams, Weil, & Porter, 2012).

In this chapter, the primary findings from the empirical educational literature are reviewed. The purpose of the review is to have an *applied impact* rather than to facilitate the reader's command of the research findings supporting these methods. Specifically, the primary intent is to prompt the use of these methods by the cognitive and behavioral therapy educator. Toward this end, the basic findings are noted and described, and then followed by concrete examples illustrative of their application to training and supervision in the cognitive and behavioral therapies. Further, although these methods are robust and well supported by a vast literature, and although the academic content is generally tangential to the effectiveness of these methods, another purpose of this chapter is to ignite interest in empirical examination of these methods specifically in the cognitive and behavioral training context, and in both university- and workshop-based delivery formats. Much empirical work is left to be done on extending these methods to cognitive and behavioral training and supervision. Finally, methods that have not yet developed a robust empirical base, but with promise for doing so, are introduced and described.

PRIMARY FINDINGS

Eight instructional tactics derived from the evidence-based educational literature are offered below. These comprise (1) use active student responding, (2) train relevant behavior, (3) attend to student motivation, (4) measure instructional results, (5) understand the role of feedback in instruction, (6) target behavioral fluency, (7) attend to learning efficiency, and (8) target expert performance.

Finding 1: Use Active Student Responding

The single most robust finding in the empirical educational literature is that students who have many opportunities to respond to instruction greatly outperform those who have few if any opportunities to respond (Austin, 2000; Barbetta & Skaruppa, 1995; Heward, 1994; Kellum et al., 2001; Malanga & Sweeney, 2008). The behavior-analytic educational literature refers to the method of providing students with many opportunities to respond to instruction as active student responding (ASR).¹ More specifically, ASR involves trainees generating responses that are detectable to the trainer and that are related to the content of the instruction. The emphasis on ASR differs from much existing instruction that emphasizes trainee engagement through passive attention. Passive attention occurs when students are attending to instruction without emitting instructionally

important responses. Some examples of passive attention of this kind include trainees physically orienting toward the instructor and refraining from texting during instruction. Passive attention also occurs when trainees provide some tangentially related-to-instruction response such as body language suggestive of interest, emitting a vocal “yes” when an instructor asks, “Does that make sense?” and providing vocal feedback indicating interest in the subject matter. However, the ASR literature is clear that although learning may occur with the use of passive attention methods, they are not optimal procedures for producing learning.

Additionally, the instructor is not able to institute real-time changes in instruction based on real-time feedback regarding student learning. Although asking students directly about the presence of learning can be useful, it is inherently unreliable. Some students are fearful of acknowledging that they don’t understand something or they may simply fail to appreciate that they do not know (that is, they do not know what they do not know). Most important, the passive recipient model does not require the student to emit behavior that can then be reinforced. Learning involves behavior change that occurs from before to after instruction. Behavior is developed through extensive reinforced practice so procedures that provide higher rates of practice opportunities produce more behavior change per time spent implementing the procedure, on valid measures of the behavior(s) collected before and after the teaching procedure was implemented (Bruce, 1999).

In many educational settings, a method is used that appears to meet the definition of active student responding, but is in fact only a slightly more active variant of a passive instructional practice. The method highlighted here occurs when instructors ask a question, require students to raise their hands if they know the answer, and then call on one of these students to respond with the answer. This is an active method, but only for the student who is raising his or her hand and who subsequently gets called on by the instructor. The other students, in contrast, remain passive during this process, reducing opportunities for responding and denying the instructor real-time feedback about the impact of the instructional procedures (Narayan, Heward, Gardner, Courson, & Omness, 1990). An important caveat regarding feedback during instruction is that measurement during instruction does not provide a measure of learning, but rather of procedural impact on behavior (Bruce, 1999). Accurate feedback about student learning requires at least two valid measures of behavior, one of which must be taken prior to implementing the procedure and the second taken after the procedure. Behavioral practice during the procedure is necessary to produce learning, but it is not a good measure of learning because the practice conditions differ from the test conditions (for example, practice usually includes prompting or other assistance from the instructor that is not available during test conditions).

ASR Break #1 Throughout this chapter you are provided with opportunities to actively respond. The general format involves a small section with information

delivery, an ASR section, another informational section, and so on. You should respond by speaking aloud, by writing your response in the spaces provided, or by responding covertly (that is, in your head).

- The most robust educational finding is that students who have many opportunities to _____ outperform those who have few if any opportunities to _____.
- ASR stands for _____.
- ASR is a _____-based procedure.

Review of specific methods of active student responding follow. Prior to initiating this review, it is useful to touch briefly on the issue of “knowing.” Instructors instruct so that trainees may learn something. That is, they instruct so that at the end of instruction the trainees will “know” something. It is important to discriminate knowing of two kinds: “knowing that” and “knowing how” (Baum, 2005). “Knowing that” refers to a trainee’s ability to recite facts about a subject matter. For example, a trainee who can vocalize several methods for eliciting² automatic thoughts (ATs), who can vocalize the exact sequence of a cognitive restructuring procedure, and who can summarize the research literature on a particular intervention or population can be said to “know that” with respect to CBT. This is an important aspect of knowing, but it differs from “knowing how,” which occurs when a trainee can successfully emit the behaviors of eliciting automatic thoughts and delivering cognitive restructuring (Beck, 2011) with respect to the thoughts elicited. Both types of knowing are important to the trainer of cognitive and behavioral therapists, and, it should be noted, competence in one area does not suggest competence in the other (for trainer or trainee). Making the distinction between these two types of knowing is important because the trainer must consciously attend to one or both depending on the objectives of the instructional sessions, and because each responds optimally to different instructional methods.

Many types of active trainee responses are possible to program into instruction. The following types of group-based ASR are reviewed (Heward, 1994): choral responding, response cards, and guided notes. Each method provides many opportunities for all students to respond.

Choral responding. Choral responding (Heward, 1994) occurs when all trainees in a group respond vocally, in unison, to opportunities to respond provided by an instructor. For example, a CBT trainer might query a group of trainees with the following prompt: “Which level of thought occurs at the stream-of-consciousness level and is the most immediate determinate of your emotional responding?” The group would then simultaneously respond orally with “Automatic thoughts.” Many responding opportunities of this type would be delivered in rapid succession in order to achieve many choral responding trials.

Several criteria determine whether choral responding is an appropriate ASR method, all of which can be noted in the example just provided. Specifically there

must only be one correct answer to the question, and that answer must be of a form that can be delivered briefly for the purpose of delivering rapid instruction. In examining the preceding example, we can see the criteria were satisfied. There is only one correct answer to the question (that is, “automatic thoughts”), and trainees can emit that response quickly, allowing the instructor to move quickly to the provision of the next trainee opportunity to respond. Satisfying these criteria allows for a procedure that produces many opportunities for reinforced practice (the procedure must, of course, also include reinforcer delivery).

The choral responding procedure contains a number of crucial elements. First, it is important to introduce the procedure to trainees by providing a brief description of the nature of the procedure as well as its purpose. Ideally, this should involve describing the types of responses desired and the modeling of one or two trials. Also important is the introduction of a signal that indicates instruction is stopping and that ASR is about to begin. This can be as simple as “Okay, it’s time for some ASR, ready, [present question].” Second, reinforcement delivery must be part of the procedure. Reinforcement can take the form of contingent praise³ for correct vocal responses and for active participation, but other reinforcers for individuals or for the group as a whole should be considered.⁴ There are many possibilities, but, for example, tickets can be handed out contingent on performance and then later used in a raffle for a book (a CBT one, of course!) or cashed in for other desired items. Additional fun can be added to this process by constructing a friendly competition between trainees. For example, trainees can be placed into teams or departments (for example, the crisis team versus the in-home team versus the outpatient team) who can compete with each other. Choral responding can occur one team at a time (provided there aren’t too many teams, because that will significantly reduce the overall opportunities to respond) with a drawing held at the end of the training event so the winning team can cash in their tokens. If the training is occurring in a hospital or agency setting, the employer can be consulted on the provision of incentives for this purpose (having a half-day on a Friday, say, or one extra vacation day for the winning team). The more opportunities there are for delivering reinforcement, the more that learning will generally occur.

Third, correct and incorrect responding require different responses from the instructor. If the entire group provides a correct response, the instructor acknowledges the correct responses, provides brief praise, and then moves quickly to the next trial. If only a small number of trainees provide incorrect responses, the instructor states the correct answer (“Yes, automatic thoughts are thought to be most responsible for our emotional responses and are the most surface-level types of cognition”) and then re-presents the same question a few trials later. If there are many trainees who are incorrect, the instructor should state the correct answer, provide a brief explanation, immediately repeat the same question, and then re-present the same question again a few trials later.

Fourth, when designing instruction, one should plan where one will embed choral responding trials. Some of the logical places these trials may occur are (1) as a

“warm-up/review” of a previous instructional period, (2) periodically throughout the instructional period (for example, after completion of certain material, or at certain time points regardless of where one is with the material), or by randomly stopping instruction and implementing these trials. If the latter is selected it is recommended that some timing device be used, because without a prompt that is used faithfully it is all too easy for one to omit these important exercises, reducing trainee learning, (3) at the completion of the training event, or (4) during transition periods (for example, immediately after a break). The most important factor is to plan where one will implement these learning trials and to adhere to one’s plan faithfully.

Of the ASR methods reviewed in this chapter, this is the most difficult method to implement properly because a high degree of instructor training is required for effective implementation. The difficulty can be seen when examining typical learner behavior during choral responding procedures. Learners frequently engage in “skating,” which involves pausing slightly and waiting until their peers begin their responses before they jump in. An instructor must be skillful if he or she is to distinguish which trainees are and are not responding exactly on cue. Considerable skill is also required to provide the correct verbal stimuli and to provide enough think time for students to respond correctly.

A final consideration when selecting choral responding is recalling that it is primarily used for repetition of what an instructor has presented rather than seeking the performance of more complex discriminations, when discerning actual discrepancies are found to produce real learning.

Despite these challenges, choral responding can be an effective ASR method in the hands of a properly trained and skillful instructor.

ASR Break #2

- There are two types of knowing. Knowing _____ and knowing _____.
- _____ is when all trainees in a group respond vocally, in unison, to instructor-provided opportunities for responding.
- For choral responding to be an appropriate ASR method, there must only be _____ correct answer.
- Of the ASR methods reviewed in this chapter, choral responding is the _____ difficult one to implement properly.

Response cards. Whereas choral responding involves group oral responding, response cards (Heward, 1994) involve trainees responding with the aid of a card. Each trainee gets a card or set of cards. There are two types of response cards: preprinted and write-in. On the preprinted card a trainee can point to indicate her or his response. For example, a card can be constructed with the heading “Levels of Cognition,” and with a list of three items underneath this heading: “Schemas,” “Intermediate Beliefs,” and “Automatic Thoughts.” During this type of ASR the instructor can ask, “This level of cognition can often be stated in if-then form,” and

students are expected to hold up their cards and point to the item on the list that is their answer (in this case the correct answer is “Intermediate Beliefs”), or they can place a clothespin or other marker on their answer. Alternatively, several cards, perhaps on a key ring, can be constructed (in this example, each one would list a type of cognition); the trainee is to select and hold up the correct card on the ring. Another example of preprinted cards is True/False cards. The color of the cards can indicate the response, such as a green card standing for “True” and a red card standing for “False” (Bruce, personal communication, 2014). The write-in response cards are blank and require the trainee to write in a response. Most often these response cards are small whiteboards accompanied with dry erase markers. So, in response to the same query from the instructor, the trainee would write in “Intermediate Beliefs” on the dry erase response card and then hold it up for the instructor to see.

Each type of response card confers its own set of advantages and disadvantages. Preprinted cards allow higher rates of responding than the write-in type because less time is required for emitting a response. They are also less challenging than write-in cards because they only require recognition rather than recall. Thus, they should be used for newer and more complex material and later replaced with a write-in type response card. Preprinted cards also allow students to learn by observing the responses of their peers. However, preprinted cards aren’t practical for material involving a large number of concepts. Finally, write-in cards afford flexibility by allowing for more than one correct answer and also for creative answers.

The procedure for using response cards is essentially the same as the one described for choral responding in replying to correct and incorrect answers from the group as well as the method for introducing the procedure. The most important considerations when constructing response cards is to make sure they are large enough for the instructor to see and that they are easy for the trainee to manipulate (so that valuable time is not wasted with trainees “fumbling” for the correct card or to place the marker correctly).

There are many technologies that may be used for the response card approach to ASR (see chapter 7 for more information). Generally, the technological applications of this ASR method are superior because they afford various kinds of data collection that the instructor may use to guide her or his instruction. For example, data on who is and is not responding as well as the number of correct and incorrect responses emitted by each student can be collected and then examined by the instructor.

Guided notes. Guided notes (Heward, 1994) are handouts that guide students through an instructional presentation by the use of prompts around key pieces of information and have been found effective in multiple settings, including higher education (Austin, Lee, Thibeault, Carr, & Bailey 2002; Williams et al., 2012). Many students are ineffective at note taking or disinterested in the material. Guided notes address this problem by prompting the incompetent note taker to record important information and by requiring the attention of the student. In

essence they help train observing behavior on the part of the student. Over time the student learns what the instructor considers important. When students review their notes after the formal instructional period, they can be confident they are reviewing accurate and important material. Student guided notes can afford the student with immediate feedback regarding the accuracy of his or her answers if the instructor displays the correct completion and asks the student to check what the student wrote against what the instructor has written. Ideally, guided notes are faded out over time so that students begin to engage in effective note taking without the dependency on instructor-provided prompts.

Finally, guided notes also keep the instructor in check. They do so by ensuring that the instructor does not go off on irrelevant tangents and by increasing the likelihood that the instructor is prepared for the instruction.

PowerPoint slides. A common means of conveying material in higher-educational circumstances involves lectures supported by software such as PowerPoint. There is a method for building ASR into these slides. For example, several slides can be dedicated to the content of instruction, as is typically the case, but at the completion of small units of instruction several slides can be dedicated to ASR. At the completion of the ASR, another unit of instruction starts, with the cycle repeated throughout the instructional event. When transitioning from instructional content to ASR a sole slide can signal that an ASR period is about to begin. This can be as simple as a slide containing the words “Active Student Responding.” The actual ASR slides can involve multiple-choice questions with each question containing two slides. The first slide contains a multiple-choice question, as is typically seen. The instructor reads the question and all response options before asking students to respond with the answer they believe to be correct. The second slide contains the same content except that the correct answer now appears in boldface type. This is one example of how ASR may be incorporated into PowerPoint and how a consequence can be added to ASR (see www.wiley.com/go/sudak: *PowerPoints Slides*, Chapter 3: *Empirically Supported Educational Methods* with ASR for an example).

Interactive whiteboards. An interactive whiteboard is a display that projects from a computer to a board typically mounted on a wall. Students interact with the board using a finger, stylus, or similar device. Many ASR methods are possible with this technology. For example, these boards allow for reveals based on student responding, student interactivity, team play, games, and collaboration. Also, many boards automatically link to devices that many students already possess (for example, smartphones) that allow for active student responding to material in the interactive whiteboard.

ASR Break #3

- Response cards, guided notes, and choral responding are methods of _____.
- Ideally, guided notes are _____ over time.

- Preprinted response cards allow for _____ of responding than write-in type response cards.
- Guided notes can afford the student _____ regarding the accuracy of their notes.

Finding 2: Train Relevant Behavior

Many instructors provide instruction on material that a trainee will not need to make use of at a later time. Others provide instruction on relevant material but provide practice opportunities that do not reflect the behavior that is required of the trainee. The most common example of this is providing training relevant to a “know that” repertoire when what is desired is the development of a “know how” repertoire. For example, if the trainee is expected to elicit negative automatic thoughts with clientele, she or he must practice doing so. Solely delivering lectures at which the trainee is a passive listener or an active oral responder does not lead to fluency with the clinical behavior of eliciting client negative automatic thoughts. Training the behavior of describing clinical procedures does not effectively train the behavior of delivering those procedures. It is certainly useful to provide oral instruction, and oral or written trainee responses describing the procedure of eliciting automatic thoughts, but it is crucial to provide many opportunities to actively emit automatic thought-eliciting behavior when developing that repertoire is the objective of instruction. Further, the ratio of vocal and written responding to actual clinical behavioral practice should favor the latter. Without such a bias, valuable learning time is lost.

Another example can be found with instructional methods involving a lot of “processing.” *Processing* can mean a wide range of things, although I am generally referring here to trainee talk about the use of certain interventions. These discussions may involve noting how the implementation of the intervention affected them emotionally, stating areas they found difficult to implement or understand, or to respond to open-ended questions such as, “What was that like?” “What did you notice?” and so forth. Unless the instructional objective is for participants to describe their private experience, then this method should be abandoned. Increasing this class of behavior is unlikely to result in increases in clinical behavior (unless that clinical behavior involves describing their private events as found in mindfulness-type clinical interventions). This process reduces valuable opportunities for trainees to receive reinforced practice of clinically relevant behavior tied to meaningful learning objectives.

Relatedly, it is not always a simple matter to determine what content is and is not relevant to instructional objectives; instructional procedures vary based on the type of performance being trained. For example, different methods are required for providing training on an algorithm or a process relative to provide training in concepts or principles. Thus, familiarity with the instructional design literature is necessary for the instructor to escape these two particular pitfalls. A full discussion

is beyond the scope of this chapter, but the reader is referred to Tiemann and Markle (1985) for an excellent treatment of these issues.

The reader is also referred to chapter 2 in this volume for a detailed discussion of core competencies in CBT training and to chapter 6 for a discussion of disorder-specific CBT instruction.

Finding 3: Attend to Student Motivation

In his classic book, *How to Turn Learners On—Without Turning Them Off: Ways to Ignite Interest in Learning*, Roger Mager (1997) details a behavioral approach to increasing student motivation. He develops this approach by reinterpreting the colloquial notion of motivation⁵ in simple behavioral terms. According to Mager, a motivated student is one who is accessing high rates of reinforcement in the learning environment and from the instruction. The instructor accomplishes this by engineering many opportunities to access reinforcement during the instruction. A motivated student is also one who experiences as little aversive stimulation as possible. This is accomplished by the instructor identifying possible aversive events and removing them from the environment to the extent possible. Viewing motivation through this behavioral lens provides the instructor with a concrete workable method for increasing the class of behaviors we colloquially refer to as “motivation”: frequent attendance at class sessions, on-time arrival for instructional sessions, routine and timely completion of homework, active participation in class sessions, persistence with learning even in the face of frustration, and pursuit of learning activities beyond what is required by the instructional environment.

In essence, Mager (1997) suggests we attend to antecedent and consequent events to locate workable ways of increasing motivation. With respect to consequent events, one of the most important factors is designing many opportunities to reinforce student behavior during instruction. Routine use of ASR methods facilitates reinforcement because it sets the occasion for access to reinforcing consequences. Some consequences that may function as reinforcers are contingent praise, incentives, and accessing knowledge of correct answers. It is essential that trainers ascertain whether consequences have reinforcing value. It is not sufficient to simply deliver consequences with the presumption they have reinforcing value. Consequences function as reinforcers if they are immediate, certain, and valuable (Bruce, 1999). A systematic approach, involving the measurement of rate of reinforcement delivery, is more desirable than a loose “off the cuff” approach wherein the trainer delivers reinforcement intuitively. The only way one knows how much contingent praise, for example, one has delivered is to measure it. If poor student “motivation” is observed, then precise measurement of reinforcement delivery will suggest target rates of reinforcement that can be programmed across subsequent instructional sessions. In addition, instructors should also determine whether the conditional probabilities of reinforcement are

higher for off-task than for on-task behavior. If they are, then the instructor must increase the relative rate of reinforcement for the target behaviors so that it is higher than the rate for other behavior. This shift will increase target behaviors (Bruce, personal communication, 2014).

In attending to antecedent events, one may attend to the instructional environment by examining such features as the size and space of the room, the comfort of the chairs and tables or desks, and the temperature of the learning environment. One should also attend to the frequency and duration of breaks from instruction as well as the pacing of instructional delivery. Attention to the difficulty level of instructional content is important. If the material is too easily mastered, or already mastered by the learner, he or she is likely to experience “boredom.” Similarly, if the material is too difficult it can be aversive. Finally, designing instruction so that the material is connected to what trainees do in their natural work environment, and helping them see the connection between the two, will likely increase learner motivation. This principle is violated when instructors teach psychotherapists who work in community mental health settings, perhaps who primarily operate in the in-home environment, with the use of examples derived from the traditional private practice psychotherapy setting. Trainees in this context are likely to see such training as irrelevant to their routine clinical work and thus turn away from instruction.⁶

ASR Break #4

- It is important for instructors to train only _____.
- According to Mager, an instructor increases student motivation through the delivery of _____.

Finding 4: Measure Instructional Results

Measuring the effects of instruction is essential for several reasons. First, measurement allows educators to evaluate their instructional design and delivery as to the amount of behavior change it produces. Unfortunately, many educators fail to measure instructional efforts, and when they do they typically measure for the purposes of evaluating the learner. For example, a brief quiz is delivered and learners are evaluated on the expected criterion for the quiz. Ogden Lindsley, the developer of the robust empirically supported educational approach Precision Teaching, coined the phrase “The learner is always right”⁷ (Lindsley, 1972). If a learner is not meeting a desired performance criterion, the fault resides with the instructional design selection, the instructional design, or the delivery of instruction, but not with the learner. The instructor must consider the learner’s entry repertoire when constructing or selecting an instructional design. For example, if a learner has not yet acquired the component repertoires necessary for success in an instructional program, the failure in subsequent student performance in the instructional program

resides in the instructor either failing to assess for the presence of prerequisite component repertoires or allowing the learner to receive the instruction despite the known inept component repertoires. Second, it allows the instructor to increase learner performance through the use of real-time data to guide instructional delivery, maintaining course when the learner is mastering material, changing course when they are not. Third, this is the only way to ascertain whether learners are reaching specified criteria. During the course of instruction, the trainee must master foundational material before receiving instruction in more complex content if the foundational knowledge is truly a component of a more complex repertoire. Commonly, educators identify a body of material that will be covered during a specified instructional period and then proceed to deliver that information. For example, an educator might deliver a lecture on certain content areas with the implicit assumption that as the lecture progresses from the basic to the more complex that acquisition is occurring in parallel. This is not necessarily the case, and level of acquisition can be known only through sound measurement procedures.

A number of factors are important to consider when selecting measurement procedures. First, measurement systems that are frequent, sensitive, meaningful, and relatively unobtrusive should be used. Such an approach differs significantly from the all-too-common post-test-only method, which is often present because of the requirements imposed by continuing education authorities, often presented in multiple-choice or true/false format, and often based on a percent correct measurement method. This approach is inadequate. It lacks the appropriate frequency necessary for real-time instructional decision making, is not sensitive to whether change is occurring during instruction, and does not adequately ascertain whether targeted repertoires have been acquired. Important information that may be used by the instructor remains hidden. Similar difficulties occur in university classrooms too. Although there may be multiple methods of assessment (for example, quizzes, exams, papers), they may not be frequent enough or used for the purposes of making real-time changes in instruction.

Percent correct, the most commonly used measure of performance, measures accuracy, but it is not sensitive because it does not include a time dimension. A more sensitive and robust measure is *count per minute*, which involves both accuracy and speed. This measure is known in the behavioral community as both “frequency” and “rate,” and is thought to produce the outcome known as fluency. Fluency is well established as a best-practice targeted outcome (Vargas, 2013) and is discussed more fully later in the chapter.

ASR Break #5

- The learner is always _____.
- _____ is a best-practice targeted outcome and involves a combination of speed and accuracy.

- Measurement during instruction allows the instructor to make _____ in instruction.

Finding 5: Understand the Role of Feedback in Instruction

The importance of providing immediate feedback during instruction is well established in the empirical educational literature (Vargas, 2013). However, *feedback* is a term for a combination of components—instructions and consequences—each of which, if it has the right features, will accelerate learning, or if it does not, will not (Bruce, personal communication, 2014).⁸ Some components of effective feedback include establishing the connection between the feedback and the performance (Vargas, 2013), delivering feedback largely on the behavior(s) you wish to accelerate (rather than those you wish to decelerate), delivering feedback immediately after the response and before the learner proceeds to the next attempt, and delivering feedback that is precise. Layng (personal communication, 2014) makes a distinction between confirmatory and instructional feedback. Confirmatory feedback is a consequence that essentially says, “Yes, you just met criterion” to the learner, but does not accomplish what instructional feedback accomplishes, which is to instruct the learner what she or he must do next. Both types of feedback are important to use during instructional delivery. When delivering instructional feedback it is essential that it be delivered prior to the next occurrence of the behavior. For example, if the behavior will not occur again for another day then it is best *not* to provide immediate feedback. It is best to wait until just before that performance is to occur again before specifying correctional instructions. To bridge the gap, the instructor may say things to the student like, “I liked how eager you were at delivering that intervention, I’ll have more to say to you the next time you deliver it,” or “I have some observations for you, remind me to give them to you at our next meeting.” In essence, one can pick out something that they want to increase in frequency (for example, eagerness) and reinforce it with confirmatory feedback, subsequently correcting it with instructional feedback just prior to the next performance of the behavior. Delaying instructional feedback to the next performance is supported by Bruce (1991), who investigated the impact of the timing of instructions by separating them from the delivery of consequences. When instructions were delivered at the same time as consequences (that is, when students were informed whether their answer was correct or incorrect and provided with the correct answer, both immediately following their response), learning efficiencies were lower than when instructional feedback was provided at the next practice opportunity. Also, his finding provides a solid example of why the term *feedback* is not always useful. It is problematic because it contains two components, and failure to isolate them reduces instructional effectiveness. Therefore, a more useful approach is to disentangle the two components—consequences and instructions—and address them separately, because there are different interventions for improving the efficiency of each.

Finally, feedback that informs the learner of his or her general progress is considered a best practice (Vargas, 2013). This is often accomplished through visual displays of the data collected during instruction.

Finding 6: Target Behavioral Fluency

Fluency is an outcome target involving a combination of speed and accuracy. Rate is a measure of fluency, but fluency involves more than just rate. The identified individual components of fluency have progressed over time (for example, Binder, 1993, 1996; Johnson & Layng, 1992, 1994, 1996) with the current literature (Johnson & Street, 2013) summarizing the components with this acronym: MESAG/PS (PS stands for **P**erformance **S**tandards). Briefly, the definitions for each of these components are (Johnson & Street, 2013)

- ***Maintenance:*** The ability to emit the behavior in the future without additional practice. The longer the time horizon, the greater the maintenance.
- ***Endurance:*** The ability to emit behavior as required in real conditions for as long as those conditions require.
- ***Stability:*** The ability to continue emitting behavior in the face of many distractors.
- ***Application:*** The ability to emit behavior in a functional way as required by real-world conditions.
- ***Generativity:*** The emergence of complex behavioral repertoires without explicit training.

Most commonly, fluency data consist of the number of correct responses and the number of errors per unit of time. Typically, both rates are measured simultaneously and easily assessed at several points during an instructional period.

An example of a procedure for developing fluency is a practice period referred to as a “timing.” A basic timing procedure simply involves having learners emit as many facts as they can while counting errors and corrects and while timing the measurement period. They may emit facts orally or in writing (or by typing in a word processing program). At the end of the timing they take the number of errors and the number of correct responses and divide those counts by the elapsed time to arrive at facts or errors per minute. The derived rate is then plotted graphically by the learners, and during each subsequent timing they attempt to increase their correct rate and decrease their error rate.

WATCH: Go to www.wiley.com/go/sudak: *Appendix VII, Video Library* and View Video:

- Fluency Training Procedure

Another example involves establishing an aim for expert fluent performance and attempting to train participants to that fluency aim. One way the aim may be derived is by asking learners, as a group, to emit facts about themselves. The instructor may ask them to emit three facts about themselves while he or she records the amount of time it takes to go from the first learner to the last. The instructor presumes that each learner is an expert on herself and that the calculated fluency is reflective of an expert fluency level. This becomes the fluency aim for the subject matter. That is, if students can become as fluent in the facts about cognitive and behavioral therapies as they can about themselves, then they will have achieved “expert” status, at least with respect to “know that” skills. To achieve learner fluency, multiple timings are implemented over the course of instruction (for example, over the course of a semester), plotting the data graphically after each timing so that students can observe their progress over time. Several other methods for setting fluency goals exist (see Johnson & Layng, 1996), but the most useful rule of thumb is to set the criterion that produces useful performance. Typically, this involves a count per minute at the frequency that equals a nonhesitant, accurate, and stable performance.

ASR Break #6

- Feedback is a term for a combination of components: _____ and _____.
- The current acronym that summarizes the components of fluency is _____.

Finding 7: Attend to Learning Efficiency

Bruce (1991) demonstrated that an error-less procedure (progressive delayed prompting) produced higher learning efficiencies than an error-filled procedure (correction). His data suggest that collecting frequent, accurate, and sensitive measures of learning efficiency is an essential component of effective instruction. Learning efficiency is a measure of the ratio of behavior change per amount of learner interaction time. Unlike fluency, learning is a measure, not just a goal (for a detailed description of an approach to learning efficiency with undergraduates see Bruce, 2004).

Finding 8: Target Expert Performance

The expert performance literature identifies and describes the critical differences between experts and novices in virtually every learning domain. One of the primary findings is that experts are readily able to recognize meaningful patterns. For example, expert chess players can “see” several pieces simultaneously while visualizing many strategic patterns (Chi, Feltovich, & Glaser, 1981).⁹ Researchers

have discovered that world-class chess players can rely on as many as 50,000 recognized chess patterns (Chase & Simon, 1973; Simon & Chase, 1973), an ability they acquired through thousands of hours of practice. Similar findings with respect to experts' skill with pattern recognition achieved through extensive time dedicated to deliberate practice have been noted across a wide range of learning domains (Bransford et al., 2000). Ericsson, Krampe, and Tesch-Römer (1993) suggested that a minimum of 10,000 hours of deliberate practice is generally necessary to acquire expertise in most domains.¹⁰ The implications of these findings for instruction are clear. When designing instruction one should specifically program procedures that facilitate the learning of important pattern recognition and strategic responses. For example, when learning to elicit automatic thoughts it would be important to train learners to see and respond to the following: (1) clients who cannot identify automatic thoughts, (2) clients who confuse thoughts with emotions, (3) clients who report a large pool of automatic thoughts, (4) clients who report automatic thoughts in forms that are not falsifiable, (5) clients who respond to elicitation by becoming extremely emotionally dysregulated, (6) clients who report automatic thoughts unlikely to be related to their emotional responding—that is, an incomplete pool of ATs are reported, (7) clients who respond to elicitation by changing the subject or seeming disinterested, and so on. This must be accomplished through many deliberate practice trials targeted to pattern recognition. This can be facilitated through the use of many case studies in which various patterns are strategically embedded. In essence, discrimination and generalization training procedures that include practice with examples, both close-in nonexamples and far-out examples, are essential. An additional important procedure is to provide instructions that facilitate appropriate stimulus control, because instructions are a primary component of efficient training procedures (Bruce, personal communication, 2014).¹¹

Finally, fact learning is an important component skill of the behavior of pattern recognition and must be trained to fluency before proceeding to the more complex repertoire of pattern recognition and strategic response training.

OTHER IMPORTANT CONSIDERATIONS

In this section the following additional instructional practices are discussed: (1) seminar-style instruction, (2) the myth of learning styles, (3) targeting “on-task” behavior versus active student responding, and (4) interteaching.

Seminar-Style Instruction

Graduate education in CBT often involves instructional delivery via a seminar format. Less data are available to guide effective seminar-style instruction. However, known behavioral educational principles highlight the importance of instructors examining their individual students' entry repertoires because there likely is variability across students. One should not assume that a student, even an

advanced graduate student at an institution with rigorous academic standards, possesses a robust entry repertoire. There are likely at least two fundamental repertoires necessary for effective seminar performance: problem solving and active listening (Layng, personal communication, 2014).¹² Appropriately developed repertoires in this regard are necessary for optimal student learning in a seminar environment. Repertoire assessment and training should occur separately from the course content.

When assessing student preparedness for a seminar, one should emphasize entry repertoires rather than emphasizing previous learning experiences. Previous learning experiences such as courses completed do not ensure that students possess the necessary component repertoires for successful performance.

Given the frequency with which this instructional method is used in graduate-level CBT education, more research attention should be directed to the conditions that optimize learning in seminar-based instruction.

The Myth of Learning Styles

An idea that pervades the field of education is that of student learning styles, a term first introduced in 1954 by Thelen. Currently, this notion refers to a collection of theories that share the belief in individual differences in how students learn. This belief gives rise to the idea that instruction should be matched to an individual's learning style. The most well-known, yet the least sophisticated of these theories, is that of the visual, auditory, and kinesthetic learning modalities (VAK; Fleming, 2006; Fleming & Mills, 1992). Proponents of this and related theories believe instructors should assess individual student's learning styles along these dimensions and then design and deliver instruction specific to the student's identified style. For example, if a student were identified as possessing a kinesthetic learning style, optimal instruction would entail the use of kinesthetic or tactile methods. In the context of CBT training, this might involve the use of writing or drawing methods (for example, drawing algorithms), more emphasis on role plays and using visualization methods, with attention directed to physical movements and sensations ("Visualize how it feels to lean forward in your chair toward your client as you . . .").

As noted previously, there are more sophisticated learning style models. However, they, along with the VAK model, are all lacking in empirical support. Much has been written on this topic, and a nice, succinct (just under seven minutes), and easy-to-comprehend lecture on the learning styles literature can be found in a video produced by the cognitive psychologist Daniel Willingham, PhD, in 2008 (www.youtube.com/watch?v=slv9rz2NTUk).

Despite the lack of empirical support for learning style theories, the notion remains prevalent in educational circles. This is likely due to a number of factors. First, there are indeed differences in student *preferences* regarding how they would like to receive instruction, but tailoring instruction to these differences does not lead to differences in learning outcome (Pashler, McDaniel, Rhorer, & Bjork, 2008). It can appear that preferences are related to learning outcome, but

empirical examination disconfirms this perception. Second, the confirmation bias likely operates for instructors with preexisting beliefs in these models. An example scenario is instructive. Imagine instructors who endorse the notion of learning styles and who have difficulty assisting students in learning some academic material after many trials of instruction. Then, further imagine that they switch instructional strategies to a method that they presume more closely matches the student's learning style, and that following this instructional intervention the student reaches criterion. Concluding that the learning style intervention was responsible for the observed learning would be an easy one to derive in this circumstance. However, there are rival explanations. It could have been the case that the student just needed one more example or one more trial to reach criterion. Furthermore, it is easy to recall circumstances where the presumed matching of instruction to learning style appeared related to improved learning outcome, and to fail to recall or notice those circumstances when learning outcome was not affected by such instruction.

The primary conclusion from this literature: Abandon focus on learning styles assessment and instructional design. There is, however, research that supports testing the effectiveness of different types of prompts with an individual student, then using that type of prompt with that student (Steege, Wacker, & McMahon, 1987). This work was conducted with students with learning difficulties, like many of the empirically supported approaches discussed in this chapter. However, although the approaches are efficacious with those learners, they are also generally more efficacious with regular learners. Another approach is training and testing to ensure that instructions are effective in facilitating appropriate stimulus control and that consequences function as reinforcers, plus training and testing of the prerequisite skills that are necessary to learn the target behaviors.

ASR Break #7

- Learning style theories _____ empirical support.
- When assessing student preparedness for a seminar, one should emphasize _____ rather than emphasizing previous learning experiences.
- Persons who've developed expertise in a domain are skilled at recognizing _____.
- _____ is a measure of the ratio of behavior change per amount of learner interaction time.

"On-Task" Behavior versus ASR

Most educators set their sights on facilitating student on-task behavior because they believe this is conducive to learning. When this idea is endorsed by an instructor, they seek to arrange conditions in the learning environment that are

conducive to students being on task, such as removing distractions (“Please turn off cell phones”), requiring student performance to a specified criterion on a post-test to earn continuing education units (CEUs) or academic grades (that is, they announce this requirement prior to the onset of instruction to increase student motivation to attend to instruction), limiting class sizes, and so on. Although these interventions may increase on-task behavior, and although there are other reasons for using these interventions, these measures do not ensure that learning is occurring. It is possible that learning is occurring, but the instructor is not able to assess this during the instructional period, and he or she is unable to ensure that optimal learning is occurring. Rather than pursuing on-task behavior in the service of optimizing learning, the instructor should instead utilize active student responding as discussed at length previously. Active student responding optimizes learning and it automatically entails on-task behavior.

Interteaching

In 2002 Boyce and Hineline introduced a method of instruction—interteaching—based on behavioral principles. Subsequent studies have shown it to be effective and superior to traditional college lectures in undergraduate and graduate courses (Saville, Zinn, & Elliott, 2005; Saville et al., 2006).

Interteaching is a peer-based instructional method that involves several components:

- *Preparation guides.* Prior to each class meeting instructors distribute guides that focus students’ reading of assigned material.
- *Peer discussions.* During class meeting peers are placed into dyads and instructed to discuss their pre-class preparation guides and, preferably, to do so without referring to their notes. The instructor circulates between the dyads during this time to facilitate their discussions and to answer any questions that might arise.
- *Incentives.* Points are earned for each dyadic discussion completed.
- *Record sheets.* At the completion of dyadic discussion, each student completes a form on which they note a number of things, including course content they found difficult to understand as well as general comments or questions.
- *Lectures.* Instructors use the record sheets to construct lectures for the next class meeting. The lectures are confined to the material students noted as difficult to comprehend or that they wanted to learn more about.
- *Exams.* Exams are derived from the preparation guides and contain objective and essay-type questions. Exams are given frequently throughout a course.
- *Quality points.* If an individual student’s preparation guide question(s) appears on an exam, they have the opportunity to earn points if they perform

well on that exam item. These points are labeled “quality points” because they are meant to incentivize high-quality discussion in their dyads. One study examined the quality points component and did not find that it contributed to the learning effects of interteaching (Saville & Zinn, 2009).

Readers interested in learning more about interteaching should consult the materials listed at the end of this chapter.

Adult Learning Theory

The purpose of this section is modest and therefore intentionally brief. Its purposes are to make the reader aware of this literature, its general make-up, and to briefly highlight two of the most well-known models within this literature. Because these models are popular in many circles, a final purpose of this section is to note the weak empirical support related to both.

In the 1920s the adult education literature, which seeks to answer questions pertaining to how adults learn, was born (Merriam, 2001). Since its birth many theories and guidelines have been articulated, rendering a comprehensive review unfeasible within the confines of this chapter. Because of their notoriety, two models are worthy of discussion.

Andragogy The first, developed by Malcolm Knowles (1968), is known as *Andragogy*, which he defined as “the art and science of helping adults learn” and which he contrasted with pedagogy, “the art and science of helping children learn” (Knowles, 1980, 43). Several assumptions regarding adult learning were articulated by Knowles: (1) adults can direct their own learning, (2) adults have life experiences that may assist them with learning, (3) readiness to learn occurs when they acquire new social or life roles, (4) adults focus on problem application and desire the ability to apply new learning immediately, and (5) adults are internally motivated (1980). From these assumptions he derived a model of instructional design and delivery that included specific implications for adult instruction. These included (1) setting a cooperative climate for learning in the classroom, (2) assessing the learner’s specific needs and interests, (3) developing learning objectives based on the learner’s needs, interests, and skill level, (4) designing sequential activities to achieve the designated objectives, (5) working collaboratively with the learner to select methods, materials, and resources for instruction, and (6) evaluating the quality of the learning experience and making adjustments as needed while assessing needs for further learning (Knowles, 1984).

A number of criticisms of his model have been articulated in the literature, which include questioning whether these assumptions constitute a theory or whether they are more accurately described as general guidelines, whether these assumptions are confined to adult learners, and whether these assumptions are applicable to *all* adult learners (Merriam, 2001). Ultimately Knowles revised his

thinking and acknowledged that learning exists on a continuum from teacher-directed to student-directed learning that is largely dictated by the situation (Knowles, 1984). Knowles's mentor, Cyril Houle, summarized his position on Andragogy in the mid-1990s this way: "Education is fundamentally the same wherever and whenever it occurs. It deals with such basic concerns as the nature of the learner, the goals sought, the social and physical milieu in which instruction occurs, and the techniques of learning or teaching used. These and other components may be combined in infinite ways . . . Andragogy remains as the most learner-centered of all patterns of adult educational programming" (1996, 29–30). Although Knowles's view of Andragogy evolved over time, he retained the humanistic psychological elements. As such, he failed to take into account the very important impact of operant learning on individual learners. This is problematic when one reviews the operant-based instructional procedures reviewed earlier, because these procedures derive from the assumption that the environment plays the critical role in student learning. Additionally, although some of his assumptions may have a strong commonsense appeal, they lack precision as well as the strong empirical base maintained by the principles articulated earlier (for example, ASR). There are instructional approaches that bear some relation to his assumptions and that have a strong empirical base. For example, the assumption that adults can direct their own learning is borne out in the frequently studied, and strongly empirically supported, Personalized System of Instruction (Keller, 1968; see Fox, 2004, for a review of PSI). PSI does not derive from an Andragogical perspective, however, but rather from an operant perspective. PSI and other approaches that derive from an operant perspective offer the advantages of strong theoretical and philosophical underpinnings, more precise instructional procedures, and a stronger scientific base than does Andragogy.

Experiential Learning Model The second model worthy of discussion is Kolb and Fry's (1975) Experiential Learning Model. Their model contains the four primary components of experience, observation, reflection, and planning, and each is thought to interact with the others to produce learning. Additionally, the authors theorize that all four elements are necessary for learning to occur, that the learning process can be initiated by any one of the four, and that a correct view of these elements is one of a continuous spiral as the learning process unfolds. These four elements have been famously diagrammed in circular fashion to emphasize the spiraling action thought to induce learning and is known as Kolb's Learning Circle. A description of the basic process includes the learner completing a concrete action (and thus acquiring experience surrounding the action and its consequences), engaging in purposeful matter-of-fact observation of what occurred during the experience, participating in a reflective process that allows abstraction of general principles from their observation, and then finishing with a planning process wherein the learner determines how to be actionable in a new context with the abstracted principle.

The Experiential Learning Model is well known to many educators, but it is not without criticism. Providing a comprehensive critical analysis of the model is not important to the goals of the present discussion. However, expressly noting that it possesses weak empirical support is immediately relevant, and the interested reader is referred to Jarvis (2004) and Tennant (2006) for useful critical analyses of the model.

INTERVENTIONS PENDING FURTHER STUDY

Two interventions that are likely of value to the cognitive behavioral therapy educator or supervisor, but require further empirical investigation in this regard, are presented next. Finally, a novel technology, Swivl, is introduced.

Chicken Camps

Applied animal training is one of the many applications of behavior analysis. In the 1980s a unique training experience involving behavioral principles was initiated by Terry Ryan: the Chicken Camp. These camps are still in operation and maintain a high degree of popularity in the behavior analytic community. They are popular because they involve intense practice with the basic principles of the science of behavior in conditions that are conducive to mastering these principles. Over a two- to five-day period, depending on the specific camp program, participants learn to train a live chicken to emit various behaviors. Chickens were chosen because they aren't as complex as humans and because they are not a forgiving species. They are quick to freeze or fly away, and they emit their actions quickly. These factors provide the trainee with immediate feedback on her performance and also pull for high levels of skill acquisition.

Initially, chicken camps were designed for dog trainers because they offered the advantages noted (for example, they provide more immediate feedback than a dog) and because they would come with less "baggage" than a trainer's dog. Although dog trainers are still frequent attendees in these camps, many attendees are clinicians who work with humans who are developmentally delayed and typically developing or developed. Although there are no empirical data available to suggest that participation in these camps improves instructional performance, there is ample anecdotal evidence that participants become more adept at key behavioral skills that are known to be effective in instructional environments. In some sense, the Chicken Camp can be thought of as a learning lab, much like a chemistry or biology lab. Some examples of behavioral skills trained intensely in Chicken Camp include shaping, reinforcement, prompting, task analysis, and chaining. One learns many other lessons, including the importance of providing brief but intense learning periods, how to problem-solve through instructional difficulties, and to provide appropriate recovery periods for the learner. Participating in a Chicken Camp provides these and many other lessons that are

invaluable to the CBT educator, and attendance is highly recommended. Bob Bailey, another famous animal trainer, also conducts Chicken Camps. Contact information for Terry Ryan's and Bob Bailey's Chicken Camps is provided in the resources section of this chapter.

The impact of these camp experiences on instructional performance should be the focus of future empirical examination.

Teaching with Acoustical Guidance

Training cognitive and behavioral therapists involves the training of "knowing-how" behavioral repertoires. One of the most difficult classes of "knowing-how" behaviors to teach is the "style" or topography of the clinician's behavior. Most trainers who have supervised trainees or who have viewed psychotherapy recordings have observed clinicians who were adherent to the CBT model, perhaps perfectly adherent, but just didn't come across as "warm" or "effective" in how they delivered their interventions. This is a style-of-delivery problem.

A number of factors contribute to the difficulty in training this class of behavior. First, the typical method of feedback delivery in training and supervision is vocal. Unfortunately, this method renders immediate and specific feedback (that is, noting which behavior is being selected for reinforcement with extreme precision) impossible. This is largely a function of language. It cannot be as precise or as immediate as is optimal for operant shaping and reinforcement. To produce the types of behavioral responses a trainer or supervisor desires in a supervisee, she must be able to capture and reinforce the behaviors of interest immediately and crisply.

Fortunately, there is a training method available that is largely unknown to the cognitive-behavioral training and supervision literatures. This method is known as Teaching with Acoustical Guidance or TAGteach.

TAGteach makes use of an audible conditioned reinforcer. An audible conditioned reinforcer ("tagger" in TAGteach parlance) provides very specific feedback, about one specific response, that has been selected for increase at a time. That is, an audible mark means, "Yeah, that's it, do more of that." The audible sound is so brief and crisp that it allows for extreme precision (delivery immediately following the targeted response).

In contrast to the TAGteach method, most supervision feedback relies on vocal instruction, modeling, and feedback that very often focuses on what to do less of (that is, what was performed incorrectly), focuses on more than one behavior to change simultaneously, and, as noted, suffers from imprecision because of the imprecise nature of language (it cannot be delivered immediately following a targeted response).

Skinner (1951) noted that effective reinforcement is provided as soon as a behavior occurs and that delayed reinforcement, even by seconds, diminishes the effects of reinforcement. Verbal feedback is not as immediate as an audible

marker. This may undermine the effects of reinforcement on the desired behavior and may actually reinforce behavioral responses other than that which was targeted (Fogel, Weil, & Burris, 2010).

A useful example involves the attempt to train a supervisee in the use of a certain tone of voice when delivering feedback to a client. Perhaps a different tone of voice is suspected to be more effective to the client, or the supervisee's tone at baseline is experienced as aversive to many patients. A typical procedure would involve the supervisor describing and perhaps modeling a suggested tone of voice. Perhaps role plays with the supervisee occur in which he or she practices delivering feedback with various intonations all the while receiving verbal feedback from the supervisor ("Yes, that's it" or "Not quite, try a sharper inflection"). These methods are likely helpful, but they still retain the core difficulties of (1) imprecise feedback, (2) feedback that is delayed, and (3) failure to reduce the client's focus to one behavior at a time. A TAGteach approach does not contain these difficulties and provides a useful set of tools for the supervisor.

TAGteach methods have been evaluated empirically with a range of "knowing-how" behaviors, including many athletic behaviors (gymnastics, swimming, golf swings, and so on). There is no existing research on the use of this method in the context of psychotherapy supervision and training. However, extending the findings from these other "knowing-how" behaviors to psychotherapy behavior is not unreasonable. The effects of positive reinforcement, including conditioned reinforcement, have been known for decades. Using TAG as suggested here simply involves using well-known procedures in a context novel to TAG (psychotherapy training). Nonetheless, empirical examination is of great importance, and the CBT training and supervision literatures would benefit from an evaluation of TAGteach methods that include evaluation of its efficacy and its social validity in this context.

Psychotherapy trainers have used "bug in the ear" technology for many years. This method may be enhanced through the use of TAGteach via the "ear bud" technology because of the many advantages it affords. During live supervision, immediate auditory feedback can be delivered when requirements are met, as can prompts with subsequent feedback.

Swivl

A new technology known as Swivl (www.swivl.com) has uses for the provision of CBT training and supervision (see chapter 7 for a full treatment of technology in training and supervision). This technology allows one to place a smartphone in a receptacle contained by the device. The device then "follows" the trainee, allowing the smartphone video camera to capture the trainee regardless of how much he moves about in the psychotherapy environment. Psychotherapy sessions can be streamed live or can be recorded for viewing at a later time. The primary advantage is that it is impossible for the trainee to go out of view of the

recording device when using this technology. This advantage is not available with a standard video camera and tripod unless it is being operated by someone. Thus, Swivl requires less personnel and captures more data. This is also useful for capturing training behavior of an instructor in training (for example, lectures and other instructional procedures).

ASR Break #8

- Interteaching is a _____-_____ instructional method.
- TAGteach involves the use of _____ markers.
- Peer discussions, quality points, and record sheets are components of _____.

SUMMARY

A sizeable body of literature on empirically supported educational methods is available for the cognitive and/or behavioral therapy educator to use (see Resources for Further Study for a few core references). By developing competence in, and subsequently adopting these methods in their instructional programs, CBT educators may increase the learning outcomes of their students and trainees while simultaneously modeling evidence-based practice.

LEARNING EXERCISES

- Choose a lecture that you will deliver in the near future. Select one of the active student responding methods discussed in this chapter (choral responding, response cards, guided notes) and construct the materials necessary for the use of this method when you deliver this lecture.
- Contribute to the research literature on instructional methods with higher education and CBT training. Plan to evaluate your instruction in workshop, supervision, and graduate classroom formats. Make an appointment on your calendar to dedicate time to planning research in this regard.
- Consider attending a Chicken Camp. Visit the Terry Ryan and Bob Bailey Chicken Camp websites to become familiar with these programs.

NOTES

1. Other educational literatures have a similar concept designated “academic learning time.” ALT is a time-based procedure, whereas ASR is a frequency-based procedure. The reasons for preferring a frequency-based procedure relative to a time-based one are discussed later in the chapter.
2. The term *elicit* is used here because that is the term used in the cognitive therapy literature in which this procedure was developed (Beck, 2011). Behavioral theorists reject this usage because *elicit* is the scientific term used when referencing respondent

behavior; *evoke* is the scientific term used when referencing operant behavior, such as thinking. *Elicit* is used consistent with the cognitive therapy meaning rather than the scientific usage.

3. The trainer must assess whether contingent praise functions as a reinforcer for his or her individual trainees.
4. Groups cannot be reinforced. Only the behavior of individuals can be reinforced. Every individual within a particular group can have his or her behavior reinforced simultaneously.
5. Behaviorally, this is not the definition of motivation. Scientifically, motivation is the set of environmental events that increase the effectiveness of consequences as reinforcers or punishers, and evoke behaviors that have been followed by reinforcers or evoke behaviors that have been followed by punishers.
6. Technically, this relates to motivating operations or antecedent events that alter the reinforcing effectiveness of consequences, and evoke previously reinforced behavior.
7. This is a variant of a well-known experimental analysis of behavior maxim, introduced by Skinner, that “the rat is always right.”
8. As a result, studies of the effect of feedback on learning will not show clear effects on learning.
9. In behavioral terms, these are known as “discriminated operants.”
10. Deliberate practice is not enough. What is practiced and the type of feedback delivered are very important components of deliberate practice that leads to expertise.
11. See the prompting literature.
12. Reading, writing, study, and study management skills are also important entry repertoires.

RESOURCES FOR FURTHER STUDY

Instructional Design and Empirically Supported Educational Methods

- Bruce, G. S. (1999). *Instructional design made easy*. Atlanta, GA: Performance Management Publications.

An outstanding book that presents best practices in instructional design and is very practical and user-friendly. It's in a workbook format with many exercises that will facilitate the reader's learning of this body of material.

- Roger F. Mager's “The Mager six-pack” consisting of the following six titles:
 - *Analyzing Performance Problems*
 - *Preparing Instructional Objectives*
 - *Measuring Instructional Results*
 - *How to Turn Learners On—Without Turning Them Off*
 - *Goal Analysis*
 - *Making Instruction Work*

These books are classics. They provide a nice foundation for educators and are accessible to the neophyte (yet useful to the experienced educator). All are recommended, but if only one book were chosen from this list, *Measuring Instructional Results* should be it. Here Mager provides an

easy-to-grasp systematic approach to measuring learning without appealing to classical test theory. Highly recommended.

- Bransford, J. D., Brown, A. L., & Cocking, R. R. (2000). *How people learn*. Washington, DC: National Academies Press.

These authors present a fairly comprehensive summation of educational research. They present more of a hard cognitive perspective that differs from the behavioral one presented in this chapter. However, most of the findings summarized closely parallel the findings presented here and are worthy of the reader's attention.

- Moran, D. J., & Malott, R. W. (Eds.). (2004). *Evidence-based educational methods*. San Diego, CA: Elsevier Academic Press.

This edited volume presents a fairly comprehensive overview of empirically supported educational methods based on behavior analysis.

- Tiemann, P. W., & Markle, S. M. (1985). *Analyzing instructional content: A guide to instruction and evaluation*. Champaign, IL: Stipes.

This outstanding book should be on the shelves of every instructional designer. Designing instruction can be a complicated endeavor. It's not always easy to determine what is and is not relevant for instruction, and different instructional designs and methods are required for different bodies of material. For example, teaching students an algorithm or process requires significantly different procedures from teaching concepts and principles. Tiemann and Markle provide readers with a solid foundation with which to address these complexities.

Interteaching Resources

- Saville, B. K. (2011). Interteaching: A behavior-analytic approach to promoting student engagement. In R. L. Miller, E. Amsel, B. M. Kowalewski, B. C. Beins, K. D. Keith, & B. F. Peden (Eds.), *Promoting student engagement: Volume 1: Programs, techniques, and opportunities*. Society for the Teaching of Psychology. <http://teachpsych.org/ebooks/pse2011/vol1/index.php>
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- Zinn, T. E., & Saville, B. K. (2007). Interteaching: A new approach to peer-based instruction. *Psychology Teachers Network*, 17(2), 19–20, 22.

Reviewed Interventions with Promise Resources

- TAGteach International (www.tagteach.com)
- Terry Ryan Chicken Camps (www.legacycanine.com)
- Bob Bailey Chicken Camps (www.behaviormatters.com)

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Chapter 4

MEASURES OF COMPETENCE IN COGNITIVE BEHAVIORAL THERAPY

Donna M. Sudak

Why should we use measures of competence in cognitive behavioral therapy (CBT) training? Aside from the available empirical evidence indicating that such measures are beneficial in predicting therapeutic outcomes, significant benefits accrue to trainers who make routine use of such measures.

Training is significantly enhanced when trainees use measures of competence to evaluate progress and learn key elements of the therapy Without using such measures, therapists cannot evaluate their own progress and determine whether they are employing optimal CBT, or even whether they are employing CBT at all. Therapists learning CBT who review the essential elements of the treatment as defined by competence measures reinforce their own didactic and procedural knowledge.

Training programs may use data obtained from the routine use of competence measures to evaluate what patterns of strengths and weaknesses exist in the program. This can serve as a springboard for improvement in training effectiveness Resources are frequently scarce in psychotherapy training. Careful attention to what modifications would be most helpful to produce competent therapists enhances training efficiency.

Training efficiency should be enhanced if such measures help the field determine what duration of training produced therapists who are capable of conducting competent CBT. We still are uncertain how much training, for which type of trainee, is needed to produce a workforce of therapists who are able to serve the mental health needs of the public. Competence measures may serve as a needs assessment for trainees to help define and understand a rationale for the content of training.

Therapists may continue to employ measures of competence over a lifetime of practice to avoid “drift” in implementation of CBT (or of any particular therapy). We know that there is a tendency to gradually “revert” to prior therapy practices after a new form of treatment is adopted (Waller, 2009). Continual improvement and refinement of skills requires feedback. Measures of competence may help practicing clinicians observe and refine their therapeutic skills.

Therapists who attain competence in delivering a form of treatment could be identified to individuals seeking treatment, as data suggest that outcomes are superior when therapists deliver treatment with fidelity to the model (Elliott & Mihalic, 2004). As consumers become more sophisticated regarding access to quality care, and outcomes are more routinely measured, competence may become a key element in how individuals seeking treatment make choices regarding practitioners.

The goals of this chapter are to

- Describe existing measures of competence in CBT
- Illustrate the use of such measures in training, and describe obstacles and confidentiality issues to address
- Explain the scoring of the Cognitive Therapy Scale (CTS)
- Describe the “next steps” in our need for development of competence measures, and
- Describe how several organizations certify competence in CBT therapists

MEASURES OF EVALUATION OF COMPETENCE IN CBT AND EVIDENCE FOR THEIR RELIABILITY AND VALIDITY

The following is a summary of the most common methods of competency assessment in CBT.

History and Current Status of Assessment Instruments

Cognitive behavioral therapy was founded on the basis of a fundamental tradition of empirical inquiry for its efficacy. This principle meant that developing measures of competence was critical to ensure both that the therapy that a

therapist is implementing is CBT, and that he or she is delivering the therapy competently. Recently, dissemination and training have emerged as critical research issues in CBT. We continue to face a shortage of competent therapists and a lack of availability of evidence-based treatments. Depression, anxiety, and other mental health disorders constitute a tremendous mental health burden (Fairburn & Cooper, 2011) in the world. The trend toward examining issues of research and training has produced several recent reviews regarding existing measures of competence and the use of such measures in training.

Measures of Declarative and Procedural Knowledge

Although the existing literature evaluating current measures of competence in CBT is sparse, it points to notable shortcomings in the tools available. Current measures of evaluation generally target broad skills in CBT rather than skills that relate to employing CBT for divergent disorders (that is, specific skills that would be useful in panic disorder rather than depression). Because we do not know which skills relate most closely to the efficacy of CBT, measures that provide a global score may not always target those aspects of the treatment that are most important to its outcome. Two recent reviews (Muse & McManus, 2013; Simons, Rozek, & Serrano, 2013) have systematically identified and described measures of therapist competence and specified the limits of use of these measures. Both reviews identified a scant few measures for assessing a therapist's "declarative knowledge" and ten to twenty-two measures for assessing "procedural knowledge"; for many (six) of the measures identified, no psychometric properties have been reported. Many measures of patient declarative and procedural knowledge that exist are an indirect reflection of a therapist's skills. (The reader is directed to both references for a full list of such measures.) Muse and McManus (2013) describe the strengths and weaknesses of the assessments they reviewed and sort them into a framework based on Miller's (1990) clinical skill hierarchy. They also note that variability in *how* measures are administered increases the lack of standardization. Studies differ in terms of who rates the therapist (self-administered, supervisor, independent rater), whether the scale is diagnosis specific, and what session of treatment is rated. A new measure of procedural knowledge, the Assessment of Core CBT Skills (ACCS), has been developed by Muse and McManus (2013) and is currently being evaluated. See www.wiley.com/go/sudak: *Appendix III, Manuals*, for the Assessment of Core CBT Skills ACCS User's Manual; and *Appendix II, Forms and Tools* for the ACCS Submission Cover Sheet and Feedback Form. This instrument has rating forms for self-evaluation and independent evaluation.

Few measures exist that assess therapists' general knowledge about CBT as well as their knowledge about its application in specific disorders. Standardized measures in this area would significantly benefit the field. Myles and Milne (2004) describe a twelve-item multiple-choice evaluation of therapist knowledge

(see www.wiley.com/go/sudak: *Appendix II, Forms and Tools* for the Cognitive-Behavioral Therapy Knowledge Quiz and Score Sheet), and they have developed a video assessment task for evaluating trainee progress. Both have good psychometric properties. Dissemination of such tools among trainers could be extremely helpful to the field.

Current standards of assessment have limited reliability. Keen and Freeston (2008) examined the reliability of measures of competence in a group of trainees and found a significant lack of reliability, even using expert independent raters. Obtaining ratings from expert raters is expensive and time consuming. Novice raters can reliably assess adherence but not competence (Weck, Hilling, Schermelleh-Engel, Rudari, & Stangier, 2011). With newer measures that have been developed to assess fidelity (Hepner et al., 2011), it remains easier to obtain interrater reliability regarding adherence than regarding competence, even when coders undergo extensive training and practice in groups to increase their reliability. At least one study (Weck, Grikscheit, Hoffing, & Stangier, 2014) indicates that raters could use twenty-minute middle-of-session segments of therapy rather than full sessions to reliably evaluate for competence and adherence. Further replication of this work could provide a critically needed more cost-effective alternative to listening to full sessions.

ASSESSMENT OF CASE CONCEPTUALIZATIONS

Formal methods exist for evaluating cognitive case conceptualizations (Eells, Lombart, Kendjelic, Turner, & Lucas, 2005; Kuyken, Fothergill, Musa, & Chadwick, 2005). Kuyken, Padesky, and Dudley (2009) provide general criteria for assessment that can serve as models for training: namely, conceptualizations should be comprehensive, parsimonious, coherent, precisely worded, and meaningful. These authors are preparing an article for publication regarding the psychometric properties of a rating scale designed to evaluate therapy sessions wherein therapists collaborate with patients to generate conceptualizations (C. Padesky, personal communication, 2013). This scale and the manual describing its use are available for download and personal use from: <http://padesky.com/clinical-corner/clinical-tools/>.

The Academy of Cognitive Therapy also has a case conceptualization scoring sheet for download: http://members.academyofct.org/files/documentlibrary/Candidate_Handbook.pdf. It rates particular elements of the case conceptualization as absent; present but inadequate; or present and adequate.

Relationship of Competence and Outcomes

Simons et al. (2013) highlight the inconsistency regarding evidence linking competency and outcome, given that currently available studies use a wide range of methodologies. They also note that because we are not certain which

components of therapy in a given disorder are critical to outcome, our ability to measure competency is limited; there may be important aspects of a session that we cannot measure at present that relate to who responds or recovers in randomized controlled trials. Rector and Cassin (2010) also highlight how the average therapist in clinical practice is not treating highly screened patients; comorbidity, chronicity, and complexity may prevent competence and outcome from being as strongly correlated as they appear in randomized trials.

At least one study (Strunk, Brotman, DeRubeis, & Hollon, 2010) links competence ratings to session-to-session symptom change in early therapy. Using the CTS, this study found that particular items were significant predictors of session-to-session change: agenda setting, focusing on key cognitions or behaviors, pacing, homework, and application of cognitive and behavioral techniques (in descending order of significance). An earlier study also linked competence in specific CBT techniques and outcome (Trepka, Rees, Shapiro, Hardy, & Barkham, 2004). In yet another study, general skills, including agenda setting, collaboration, pacing, and empathy on the CTS, correlated with homework compliance (Bryant, Simons, & Thase, 1999), which can have a positive effect on patient outcome.

Using Assessments in Training and in Lifelong Learning

Even though the tools currently available to CBT educators have drawbacks, creative use of validated assessment methods can be a great way to enhance learning. Obviously, as assessments improve, education may become more targeted and efficient. Experience suggests the following approaches:

- Specifically attend to developing competence in the elements of the CBT session that relate to good outcomes (see prior section for details).
- Pay attention to therapist review of homework in rating tapes because it is a significant predictor of homework completion by patients, which improves outcomes.
- Use checklists of key elements of sessions for novices to review before and after sessions. (See chapter 5, Table 5.2 for an example of such a checklist.)
- Rate trainee performance and have trainees rate each other on brief role plays with scale items.
- Watch tapes of therapy sessions conducted by experts with trainees and have the trainees use an instrument to rate the experts' performance.
- Provide training in the use of at least one instrument that examines the skills required for competent treatment (McManus et al., 2011).
- Review recordings of sessions frequently, both independently and with trainees.
- Require trainees to rate their own session recordings.

- Teach the value of assessing recorded sessions for competence throughout a career. This practice prevents therapy “drift” and increases therapy quality. Several studies (Beidas & Kendall, 2010; Brosan, Reynolds, & Moore, 2008; McManus, Rakovshik, Kennerley, Fennell, & Westbrook, 2011) indicate that therapists frequently inaccurately estimate their own clinical skills.

How to Discuss Recording Sessions with Trainees

Trainees are often reluctant to suggest making recordings of sessions to patients and to have recordings reviewed. Fears about patient reactions, self-consciousness, and concerns about negative supervisory evaluations may contribute to presenting the prospect of recording to the patient in a fairly negative light. There is not a well-established tradition of recording therapy sessions in the United States, unlike in the United Kingdom, where it is standard practice. Guidelines to facilitate recording sessions include the following:

- Normalize anxiety about recording.
- Role-play asking patients to record sessions; develop a “script.”
- Be certain that patients do not feel coerced to tape, understand the rationale for taping, know that they can request that recording stop at any time, and know what is ultimately done with the recording (disposal). Offer patients the option to tape sessions for their own review.
- Develop a handout about the “mechanics” of recording, including types of recording devices, how to get good sound quality, how to upload and send files securely, and where to find consent forms for taping.
- Desensitize trainees by taping role plays.
- Require that once taping is introduced, trainees then tape every session (even if not reviewed) so that taping is less intrusive and becomes a “natural” part of the session.
- Play your own therapy tapes for trainees when possible.

Generally, when the initial review of a recording results in engaging, constructive feedback, the process becomes easier (see chapter 5 for more discussion of the process of giving feedback). Take care to reinforce each effort a trainee makes to tape sessions; provide feedback rapidly, ideally before the patient is seen again.

A concern about recordings is confidentiality. Samples must be protected, particularly when electronic file transfer is used. A confidential file deletion protocol from the Academy of Cognitive Therapy is provided for both Mac and PC users. See www.wiley.com/go/sudak: *Appendix V, Confidential File Deletion Protocol*. File sharing services that are used must be compliant with HIPAA (the Health Insurance Portability and Accountability Act of 1996). Chapter 7 provides a helpful discussion of these issues. Consent documents must be readily available

and should provide details about the purpose of taping, file protection, and destruction of samples.

SCORING THE COGNITIVE THERAPY SCALE

The Cognitive Therapy Scale (also known as the Cognitive Therapy Rating Scale or CTRS) (Young & Beck, 1988), despite the shortcomings previously noted, is a widely used measure and training tool enabling therapists, supervisors, and independent raters to assess competence in CBT. In addition to the brief guide to its use in this chapter, a webinar guide is available on the Academy of Cognitive Therapy YouTube channel led by Leslie Sokol, a contributor to this volume, a nationally known CBT trainer, and current chair of the credentialing committee of the Academy of Cognitive Therapy (Sokol, 2013). The scale and the rating manual (Young & Beck, 1980) are also available on the Academy of Cognitive Therapy website: www.academyofct.org. The manual is a stand-alone teaching tool providing detailed explanations and examples of standard features of competently delivered CBT.

The standard CTS is an eleven-item scale, with each item scored from 0 to 6. The maximal score is 66; most research protocols and credentialing organizations using the CTS have a minimum cut-off score of 40 for a therapist to be considered competent. The scale can be used with audio or video recordings and when observing therapy sessions directly. A revision of the scale, the CTS-R (James, Blackburn, & Reichelt, 2000) has also been validated psychometrically (Blackburn et al., 2001) and includes items regarding facilitation of emotional expression and conceptualization. The manual also provides extremely descriptive anchors. Both the CTS and the CTS-R presume that the rater is familiar with the use of CBT for treatment of the disorder at hand and with the protocols that would be the most efficient to help the patient.

Several preliminary instructions are helpful to remember when employing the scale.

- The session reviewed should not be an intake (assessment).
- The session should be reviewed from start to finish before scoring is completed.
- Elements should be scored independently of one another. The progress of the patient (or lack thereof) should not be a factor in scoring.
- Scoring should be done with a timepiece at hand, because timing and pacing are critical elements; noting the time that a particular intervention occurs (for example, when in the session the agenda was set) increases the accuracy of the rating.
- Raters should be mindful to avoid bias, either positive or negative, resulting from prior experience with a trainee's tapes. Independent raters score samples differently from supervisors over a course of treatment (McManus,

Westbrook, Vazquez-Montes, Fennell, & Kennerley, 2010). Supervisor bias can be a factor, but supervisors also have a longitudinal picture of a patient's treatment and therefore may provide more nuanced scoring. It is very important not to be influenced by the response of the patient to the session. A substantial challenge can be to delineate the skillful behavior of a therapist when a patient is not responding.

When scoring the CTS, remember that the anchors roughly parallel the Dreyfus Competence Model (Dreyfus & Dreyfus, 1980). A score of 3 or 4 means *competent*, a score of 5 indicates *proficiency*, and 6 denotes an *expert*.

Scoring Key for the Cognitive Therapy Scale

- 0: Absence of element or highly inappropriate performance
- 1: Inappropriate performance or major problems
- 2: Numerous problems and inconsistent performance
- 3: Competent, but some problems
- 4: Good features, but minor problems or inconsistencies
- 5: Very good features/minimal problems
- 6: Excellent performance or very good with "tough" patient

In listening to a session, a good technique is to list positive and negative observations about each domain evaluated by the scale. Raters must be familiar enough with the scale and the anchors to be guided by them while making observations.

Studies on the strengths and weaknesses of the CTS point to variability among raters (Keen & Freeston, 2008; Muse & McManus, 2013). Reichelt, James, and Blackburn (2003) found that training raters improves interrater reliability. Recommendations from the literature regarding training groups of raters (Hepner et al., 2011) worthy of inclusion in educational programs include:

- Allow sufficient time for raters to fully understand use of the instrument. They must read the manual, discuss questions, and know how the instrument is employed.
- Three or four sessions should be coded independently for practice and then discussed as a group, with the goal of obtaining a consensus rating about each item.
- Alternatively, groups can rate three or four recordings at the same time and discuss ratings in "real time." Groups should meet periodically and rate a recording together to ensure that norms remain consistent.

Rating recorded sessions for interrater reliability is most helpful when the file to review is one that would score in the 35- to 45-point range. Recorded sessions that are outstanding or that clearly do not meet standards of competence are generally less helpful for comparing experienced raters.

Items on the CTS, including the scoring anchors and a description of what to observe and how to make ratings, are as follows, with some editing for clarity (Young & Beck, 1988).

Specific Items of the Cognitive Therapy Scale

The following are the items and descriptive anchors of the Cognitive Therapy Scale.

Agenda Setting

- 0: Therapist did not set an agenda.
- 2: Therapist set an agenda that was vague or incomplete.
- 4: Therapist worked with the patient to set a mutually satisfactory agenda that included specific target problems (for example, anxiety at work, dissatisfaction with marriage).
- 6: Therapist worked with the patient to set an appropriate agenda with target problems, suitable for the available time. Therapist established priorities and then followed agenda.

Several elements of agenda setting must be considered when rating this item. First, a specific set of target problems, related to the patient's central concerns and appropriate for the stage of therapy, must be collaboratively determined. The agenda must also be set in a timely way, generally within the first five to ten minutes. Optimally, the agenda should briefly refer to the prior session (providing a "bridge to the previous session"). This item can be scored as competent only if the agenda is then followed; if it is not followed, a competent score may be given if such a deviation is explicitly acknowledged and agreed to by both the therapist and the patient.

Feedback

- 0: Therapist did not ask for feedback to determine the patient's understanding of, or response to, the session.
- 2: Therapist elicited some feedback from the patient but did not ask enough questions to be sure the patient understood the therapist's line of reasoning during the session *or* to ascertain whether the patient was satisfied with the session.
- 4: Therapist asked enough questions to be sure that the patient understood the therapist's line of reasoning throughout the session and to determine the patient's reactions to the session. The therapist adjusted his or her behavior in response to the feedback, when appropriate.
- 6: Therapist was especially adept at eliciting and responding to verbal and nonverbal feedback throughout the session (for example, elicited reactions

to session, regularly checked for understanding, helped summarize main points at end of session).

Two types of feedback must be present in order to obtain a score of 4 or higher on this item. First, the therapist must ask questions during the session in order to determine whether the patient understands the therapist's reasoning or explanations or interventions. This type of feedback is often in the form of summaries. Second, the therapist must elicit the patient's reaction to the session, optimally including both positive and negative reactions. The more regularly feedback occurs, the higher the score.

Understanding

- 0: Therapist repeatedly failed to understand what the patient explicitly said and thus consistently missed the point (poor empathic skills).
- 2: Therapist was usually able to reflect or rephrase what the patient explicitly said but repeatedly failed to respond to more subtle communication (limited ability to listen and empathize).
- 4: Therapist generally seemed to grasp the patient's "internal reality" as reflected by both what the patient said explicitly and what the patient communicated in more subtle ways (good ability to listen and empathize).
- 6: Therapist seemed to understand the patient's "internal reality" thoroughly and was adept at communicating this understanding through appropriate verbal and nonverbal responses to the patient (for example, the tone of the therapist's response conveyed a sympathetic understanding of the patient's "message") (excellent listening and empathic skills).

The purpose of this item is to rate the therapist's ability to understand and reflect the experience of the patient accurately and to facilitate and respond appropriately to any emotional expression by the patient. The progression through the ratings is from misapprehending what the patient says (a 0 rating) to capably attending to subtle verbal and nonverbal communication and reflecting and validating the patient's communication verbally and with voice inflection and nonverbal skills (when observable).

Interpersonal Effectiveness

- 0: Therapist had poor interpersonal skills (seemed hostile, demeaning, or in some other way destructive to the patient).
- 2: Therapist did not seem destructive, but had significant interpersonal problems. At times, therapist appeared unnecessarily impatient, aloof, insincere, or had difficulty conveying confidence and competence.
- 4: Therapist displayed a *satisfactory* degree of warmth, concern, confidence, genuineness, and professionalism (no significant interpersonal problems).

- 6: Therapist displayed *optimal* levels of warmth, concern, confidence, genuineness, and professionalism, appropriate *for this particular patient in this session*.

Therapists must earn the trust and confidence of patients. General psychotherapy skills must be employed in order to inspire this, including empathy (both verbal and nonverbal), genuineness, sincerity, openness, and warmth (clear expression of positive regard and concern for the well-being of the patient). In CBT, however, the therapist also is straightforward and direct, and such a communication style must be present to score competently here. Implicit in this item is a requirement of professional and ethical behavior. What distinguishes an expert in this item is the ability to adjust activity and warmth to a particular patient and setting.

Collaboration

- 0: Therapist did not attempt to set up a collaboration with the patient.
- 2: Therapist attempted to collaborate with the patient, but had difficulty *either* defining a problem that the patient considered important *or* establishing rapport.
- 4: Therapist was able to collaborate with the patient, focus on a problem that both patient and therapist considered important, and establish rapport.
- 6: Collaboration seemed excellent; therapist encouraged the patient as much as possible to take an active role during the session (for example, by offering choices) so they could function as a “team.”

A central tenet of CBT is that the patient and the therapist work as a team. This item is scored by noting evidence of teamwork as well as therapist activities that encourage the patient’s participation. Rapport must be present for the therapist to receive a competent score.

Pacing and Efficient Use of Time

- 0: Therapist made no attempt to structure therapy time. Session seemed aimless.
- 2: Session had some direction, but the therapist had significant problems with structuring or pacing (for example, too little structure, inflexible about structure, too slowly paced, too rapidly paced).
- 4: Therapist was reasonably successful at using time efficiently. Therapist maintained appropriate control over flow of discussion and pacing.
- 6: Therapist used time efficiently by tactfully limiting peripheral and unproductive discussion and by pacing the session as rapidly as was appropriate for the patient.

Efficiency is a hallmark of good CBT, and the effective therapist must maintain control over therapy discussions while simultaneously responding empathically to

the patient. The therapist must also adjust the pace of the session so that effective learning may occur. Additionally, the therapist must allow the patient to “wind down” so that the patient can leave the session feeling that positive work has occurred, and, ideally, feeling better than at the outset of the session.

Guided Discovery

- 0: Therapist relied primarily on debate, persuasion, or “lecturing.” Therapist seemed to be “cross-examining” the patient, putting the patient on the defensive, or forcing his or her point of view on the patient.
- 2: Therapist relied too heavily on persuasion and debate rather than guided discovery. However, the therapist’s style was supportive enough that the patient did not seem to feel attacked or defensive.
- 4: Therapist, for the most part, helped the patient see new perspectives through guided discovery (for example, examining evidence, considering alternatives, weighing advantages and disadvantages) rather than through debate (therapist used questioning appropriately).
- 6: Therapist was especially adept at using guided discovery during the session to explore problems and help the patient draw his or her own conclusions (achieved an excellent balance between skillful questioning and other modes of intervention).

The second of the “specific cognitive therapy skills” rates the ability of the therapist to help the patient discover new perspectives (rather than provide them directly to the patient). Even when achieving such a perspective would benefit the patient, the therapist must avoid persuasion and “telling the patient what to think.” Socratic questions are key to guided discovery; scoring the item includes observing the sensitivity with which the therapist employs techniques that help the patient look at alternatives, including considering pros and cons, looking at definitions, evaluating consequences, and so forth.

Focusing on Key Cognitions and Behaviors

- 0: Therapist did not attempt to elicit specific thoughts, assumptions, images, meanings, or behaviors.
- 2: Therapist used appropriate techniques to elicit thoughts or behaviors; however, the therapist had difficulty finding a focus or the therapist focused on thoughts or behaviors that were irrelevant to the patient’s key problems.
- 4: Therapist focused on specific thoughts or behaviors relevant to the target problem. However, the therapist could have focused on more central thoughts or behaviors that offered greater promise for progress.
- 6: Therapist focused skillfully on key thoughts, assumptions, behaviors, and so forth that were most relevant to the problem area and offered considerable promise for progress.

This item assesses a therapist's skill at conceptualization by inference. Certain thoughts and/or behaviors are elicited from the patient during a therapeutic session, and the therapist must determine their importance to the patient's central problems. Hence, the evaluator also must correctly "conceptualize the patient" to rate this item correctly. Behaviors to assess may include compensatory strategies such as avoidance or automatic thoughts; intermediate or core beliefs could be the items examined in the session. This item evaluates only the therapist's ability to elicit thoughts and behaviors, not change them. A therapist might accomplish this using inductive questions or role play and by recognizing mood shifts.

Strategy for Change

- 0: Therapist did not select cognitive behavioral techniques.
- 2: Therapist selected cognitive behavioral techniques; however, the overall strategy for bringing about change either seemed vague *or* did not seem promising in helping the patient.
- 4: Therapist seemed to have a generally coherent strategy for change that showed reasonable promise and incorporated cognitive behavioral techniques.
- 6: Therapist followed a consistent strategy for change that seemed very promising and incorporated the most appropriate cognitive behavioral techniques.

Therapeutic change occurs when therapists use appropriate methods in accordance with a tailored formulation. Because CBT incorporates principles of learning theory, the therapist should employ a variety of methods to engage the patient's interest and promote understanding. Start this rating by noting the particular strategies the therapist used. Note that this item does not assess how skillfully the therapist implemented the strategy or whether it was effective; it rates the therapist solely on the selection of suitable strategies and strategies that reflect cognitive behavioral methods (fidelity to the method). Strategies reflective of other therapeutic approaches (for example, dream interpretation) are not rated as competent; raters must bear in mind, however, that creative CBT therapists use a variety of techniques to accomplish the goals of treatment.

Application of Cognitive Behavioral Techniques (Note: For this item, focus on how skillfully the techniques were applied, *not* on how appropriate they were for the target problem or whether change actually occurred).

- 0: Therapist did not apply any cognitive behavioral techniques.
- 2: Therapist used cognitive behavioral techniques, but there were *significant flaws* in the way they were applied.
- 4: Therapist applied cognitive behavioral techniques *with moderate skill*.

- 6: Therapist *very skillfully* and resourcefully employed cognitive behavioral techniques.

This item rates the skill the therapist uses in executing strategies for change. The teaching acumen of the therapist is key here. Rating the therapist involves looking for indications that the patient understands the rationale for a technique, learns to employ the technique in the session, and has the capability to implement it outside the session. An example might be rating the care with which the therapist modifies thoughts and teaches the patient the rationale and use of a thought record.

Homework

- 0: Therapist did not attempt to incorporate homework relevant to cognitive therapy.
- 2: Therapist had significant difficulties incorporating homework (for example, did not review previous homework, did not explain homework in sufficient detail, assigned inappropriate homework).
- 4: Therapist reviewed previous homework and assigned “standard” cognitive therapy homework generally relevant to issues addressed in the session. Homework was explained in sufficient detail.
- 6: Therapist reviewed previous homework and carefully assigned homework drawn from cognitive therapy for the coming week. Assignment seemed “custom tailored” to help the patient incorporate new perspectives, test hypotheses, and experiment with new behaviors discussed during the session.

Given the observed relationship of homework to the positive outcome of therapy (Kazantzis & Lampropoulos, 2002), it is not surprising that an item on the CTS rates this skill. In order to be competent, a therapist must both review prior homework and assign typical (but relevant) CBT homework; explain it with a rationale; and provide written reminders. Expert ratings are obtained when assignments are “tailored” to the patient and occur in a naturalistic way through the session.

ACCREDITATION AS A CBT PROVIDER

There are organizations worldwide that provide accreditation in CBT for therapists in clinical practice. The Academy of Cognitive Therapy verifies the credentials of therapists, including coursework, readings, and hours of patient care; thereafter, therapists submit a written case formulation and recorded therapy session work sample for review by expert raters. A minimum score of 40 on the CTS and a case formulation score of 20 are required for academy membership.

The British Association of Behavioural and Cognitive Psychotherapy (BABCP) also provides accreditation for therapists. Therapists are required to have four years of CBT experience, with 450 hours of instruction, 200 by a certified CBT trainer. Minimum standards of supervision, numbers and types of patients, and continuing education requirements are specified for accreditation. A work sample is not required, but supervisors must provide recommendations and evidence of supervision.

The European Association for Behavioural and Cognitive Therapies (EABCT) (www.eabct.com/) is a federation of multiple CBT associations that it accredits to provide CBT certification; its requirements are similar to BABCP.

The newly formed Canadian Association of Cognitive and Behavioural Therapies (www.cacbt.ca) accredits therapists in Canada using the European Association for Behavioural and Cognitive Therapies model of accreditation. As CBT becomes more widely disseminated and insurers and national health services recognize its cost effectiveness, other organizations will likely form to provide credentialing services to make certain that patients receive the best possible care.

SUMMARY

The task of developing an assessment system to capture adequate performance of a particular form of psychotherapy is not easy. It requires specifying key elements of the therapy, defining a standard of competent performance, and developing a psychometrically valid tool that measures the depth and breadth of attainment of therapeutic skills. The future development of valid measures of CBT quality will improve our ability to educate therapists and disseminate treatment in a more targeted and efficient way.

LEARNING EXERCISES

- Rate one of your own sessions using the CTS or another test of therapeutic skills. Take notes about the evidence you have for each rating.
- Exchange recordings and CTS ratings with a colleague. Rate your colleague's recording. Discuss ratings you obtained and evidence for each.
- Rate a recording from an independent therapist with a group of colleagues. Do not discuss as you rate. Then discuss each item and the reason for your rating.
- Use the anchors on the CTS to improve one element of your weekly sessions to reach expert level. Change the item weekly. Keep a checklist in the office to remind yourself. Employ this method of therapy refinement with trainees.

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Chapter 5

FEEDBACK IN COGNITIVE BEHAVIORAL THERAPY TRAINING

Donna M. Sudak

Prue and Fairbank (1981) defined performance feedback as “information provided to individuals about the quantity or quality of their past performance.” Performance feedback is a necessary ingredient in developing and refining cognitive behavioral therapy (CBT) skills (or any skills). Acquiring new skills without specific information about their execution limits improvement. As we learn new skills we implement and store them in our declarative memory; this makes them more malleable and easier to improve. We execute new skills step by step until they are stored in our working memory. Once a skill is a part of working memory and has become “automatic,” only careful attention to small components of the skill with feedback produces improvement. Best practices in training CBT skills include the provision of routine, specific, and informative direction toward acquiring and refining therapy skills. Feedback is more than “Good job,” but a specific and targeted means of providing information about performance.

The goals of this chapter are to:

- Illustrate how feedback is used in skill acquisition
- Discuss how to provide summative feedback in a nonthreatening and meaningful way
- Suggest techniques for giving feedback to problematic trainees
- Describe the use of feedback to promote expertise, and
- Inspire the use of patient feedback in an ongoing way to promote better patient outcomes

FEEDBACK AND SKILL TRAINING

Teaching new skills to adults is most efficiently accomplished with feedback. Feedback is an essential part of the shift from declarative to procedural knowledge; it helps a trainee move from “knows” to “knows how.” Feedback may be most powerful when implemented after role play or when the instructor is listening to a patient tape with a trainee. Steps that work most efficiently are listed in Table 5.1.

Teaching therapy skills is a more complex task than teaching a technique, because therapy requires the use of such skills in an environment that has multiple variables. Trainees must progress from knowing how to execute a particular skill (through training) to learning to employ the skills in a creative and efficient way (through feedback and supervision). Trainees must have both theoretical understanding and practical skill. Behavioral rehearsal has been used as a fidelity tool as well as a training tool by researchers interested in dissemination of evidence-based interventions (Beidas, Cross, & Dorsey, 2014) and is a key component of teaching therapy skills when combined with feedback.

PROVIDING FORMATIVE FEEDBACK

Providing meaningful feedback as a trainer or supervisor is a skill that takes practice. Formative feedback must include information about what the trainee does well. This reduces the trainee’s anxiety about receiving feedback and makes it more likely that he or she can then absorb constructive criticism. When commenting on performance, build on strengths that the trainee has demonstrated, directing feedback toward one or two skills. The closer feedback comes to the performance of the task, the better. Trainers are often reluctant to provide feedback because of the negative experiences they themselves have had in receiving feedback; another sticking point is lack of practice in making succinct and informative observations about what behaviors the trainee should modify.

Using specific rating instruments (see chapter 4) can help trainers focus on target behaviors. Supervisors and trainers must also attend to “linking” skills

Table 5.1 Teaching New Skills to Adults

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1. Ask the trainee to demonstrate the skill.
 2. Note a specific item that was well executed.
 3. Make a specific comment about the most important thing that the trainee should do differently.
 4. Demonstrate the modification.
 5. Ask the trainee to redemonstrate the skill.
 6. Make any corrections needed.
 7. Give the trainee positive feedback about performance.
 8. Assign a particular task related to the skill.
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Note: Also see Linehan (1993), pp. 31–37, for key elements of training skills in adults.

appropriately, developing a series of “when/then” rules with the trainee. To ensure generalization and practice once these steps are implemented, written assignments can lead to practice of the skill in multiple contexts, tailored to the context of the trainee’s work environment and including specifics (who, what, when, and where) about the practice of the new skill.

ADULT LEARNING AND FEEDBACK

Good teachers understand the process of learning and the need to motivate trainees to keep improving over a lifetime. One of the most important things CBT educators do when teaching trainees is to use the same tools that the therapeutic process incorporates in helping patients acquire skills. Key principles of adult learning are vital to this endeavor. Humans are able to hold only a small number of new items in their consciousness when acquiring new skills. Think about the process of learning to drive: in the beginning, the student driver must focus on one particular aspect of driving at a time and is unable to attend to anything else. Relatively quickly, however, skills become automatic. After that point it requires deliberate effort to see what can be done to improve. Improving what is automatic is one element of attaining expertise (Ericsson, 2008).

When we apply this principle to training therapists, it’s clearly critical for a trainer to observe actual events in a therapy session to determine the level of skill development. Nondisclosure in supervision is known to be a significant problem, and process notes do not provide reliable indicators of the presence of particular skills (Ladany, Hill, Corbett, & Nutt, 1996). Therefore, either observation of live patient encounters or review of audio or video recordings is necessary in order to assess skill acquisition. A complete recording should be assessed by both the trainee and the supervisor with a rating instrument at intervals throughout supervision (see chapter 4). Specific skills can be repeatedly evaluated with role-play demonstrations as well, to improve execution.

PROVIDING SUMMATIVE FEEDBACK (DID YOU REACH THE GOAL?)

Providing summative feedback and evaluation is even more difficult for many trainers and supervisors than providing formative feedback. This process may involve informing a training program or certifying body about trainee progress and therefore may involve a substantial degree of anxiety for the trainee. Supervisors should keep records regarding what is discussed in supervision and when feedback is given; they must also have a plan for managing trainees who are problematic. Programs are not always careful to inform trainers and supervisors about the nature of the evaluation process (some just send a form at the end of the academic year, for example). The supervisor should take the initiative to become familiar in advance with what information is required and in what format by a training

program. Plan carefully to set aside a specific time to review summative feedback with the trainee. Both trainer and trainee should thoughtfully review and prepare for the feedback session. Try to strike a balance between positive and negative comments, whenever it is possible, to alleviate trainee anxiety.

Functions of summative feedback include the following:

- Promote specific behavioral changes
- Increase motivation for learning
- Measure a trainee's progress relative to programmatic standards, and
- Enhance the trainee's self-knowledge/self-observation

Steps to Minimize Threat When Giving Summative Feedback

Trainees may experience feedback as shaming or threatening, thus minimizing its value. This means that particular care must be exercised if feedback is to be provided in a group setting. Because meaningful feedback happens only with sufficient time and forethought by both parties, the following steps may make the process of providing summative feedback a better experience:

- Orient the trainee to the process.
- Make sure the environment promotes reflection—don't do it in the cafeteria.
- Prepare for summative feedback during the initial meeting with a trainee:
 - Review educational goals and objectives.
 - Review the methods by which summative feedback will occur, and when.
- Be respectful and nonjudgmental. This is vital to the process. Though it may seem an obvious point, in some circumstances trainee attitudes, behaviors, or performance can elicit responses from any supervisor that may be less than helpful. We all have ideas of how trainees "should be," occasionally making us vulnerable to being less than objective and neutral.

Good summative feedback begins by asking the trainee to provide self-observation and evaluation of the training experience and his or her performance. Ask the trainee to prepare for the feedback session by reflecting about what goals he or she has met, his or her strengths, and areas for growth and improvement. Discuss the trainee's self-evaluation first, and then provide direct, specific observations regarding goal attainment that build on the trainee's self-evaluation. Often trainees do not recognize their own strengths, so note these and give evidence for growth toward goals. Provide specific examples of behaviors to modify and goals for future growth. Linking summative feedback to goals increases the likelihood that the trainee will find the experience constructive.

Next, ask the trainee to reflect about how he or she might improve performance, and augment this discussion with specific suggestions. Tie this action plan to the trainee's goals. Record the plan in writing. Just as when we assign therapy homework, be as specific as possible about the action plan for performance improvement, and cognitively rehearse and troubleshoot obstacles. Finally, summarize the feedback session, and express a belief that the trainee will succeed.

Ask the trainee for feedback about the evaluation process and about your performance as well; this is a powerful way to model the continuous collection of data to improve. Open and honest communication about the most important aspects of the educational encounter is vital to the process. For example, specific inquiry about the level of challenge versus support the trainee felt and the key items the trainee learned from the encounter fosters the type of learning environment that encourages and models lifelong learning. Remember how we get feedback from patients and engage in a similar process here; ask the trainee specifically what he or she did *not* like about the supervisory process, and show genuine appreciation when feedback is given.

Last, if supervision will be ongoing with the trainee after the summative feedback session, schedule a follow-up to assess adherence to the action plan.

WHEN FEEDBACK SESSIONS GO WRONG

Several important caveats about feedback can help avoid problems and misunderstandings.

- Do not give feedback by e-mail, text, or by telephone. Just as when ending a relationship, feedback should be done face to face.
- Monitor a trainee's schedule (and yours) when giving feedback. Feedback sessions should not be scheduled after a stretch of difficult night calls or when either the trainee or the supervisor is exhausted.
- Start from the trainee's baseline. How much progress does the trainee believe he or she is making? What problems does he or she identify? Difficult feedback may be provided more easily after accessing the trainee's self-assessment.
- Be respectful but courageous. The future mental health care of a patient depends on it.
- Give feedback only when in good emotional control.
- Be behaviorally specific when addressing problematic areas. This is particularly important in problematic trainees; it may be tempting to talk instead about personality issues, but less useful. Know the avenues for discussion of corrective action plans with problematic trainees in the training program. The more problematic the trainee, the more written documentation you need regarding learning and performance issues.
- Give feedback privately and allow sufficient time for discussion.

WHY DON'T WE LIKE TO GIVE FEEDBACK?

The common reluctance to give feedback has many causes. Discomfort with giving negative feedback can stem from our own thoughts and beliefs about it. Many therapists themselves have had a lack of good modeling and have not practiced the skillful delivery of formative and summative feedback. Many supervisors have concerns about trainee responses to negative feedback. Time pressures may impinge. We may not have a systematic means of collecting specific information about trainee performance, resulting in inadequate feedback. Troubleshooting the specific problems you note about your feedback sessions can occur with self-reflection, watching recorded material of feedback sessions with trainees, or role-play practice with other supervisors.

PROBLEMATIC TRAINEES

Problematic trainees bear special mention and attention, because they frequently consume significant amounts of a supervisor's time and energy. Problematic trainees occupy a great deal of "mental space," particularly when the trainer anticipates providing feedback to them.

Addressing Common Problems

Addressing common problems with trainees that interfere with skill acquisition and job performance may include the following:

- Identify existing skill deficits that interfere with acquiring the skills of CBT. A good example of this is a trainee who has not had basic psychotherapy skills training (or who has had only a didactic experience but no opportunity to practice) who joins a program that assumes such skills as a prerequisite.

WATCH: Go to www.wiley.com/go/sudak: *Appendix VII, Video Library* and View Video:

- Trainee Does Not Have Necessary Skills
- Find creative approaches to increase the trainee's skill level. For example, trainees with limited capability to self-observe may need to practice with role play and self-reflection, reflective writing, and reflection about recorded material observed in supervision.
- Employ principles of motivational interviewing if the trainee is not adherent to learning contracts; illustrate the discrepancy between trainee behavior and goals and program requirements to increase adherence.

WATCH: Go to www.wiley.com/go/sudak: *Appendix VII, Video Library* and View Video:

- Trainee Does Not Believe in Psychotherapy

- Identify work habits that may be impinging on a trainee's relationship with a supervisor and interfering with acquiring skills. This may include poor time management, procrastination, or problems with setting priorities. Many circumstances lead to these behaviors. The supervisor ideally will have some ability to conceptualize the issues involved and formulate an action plan with the trainee.
- Note attitudes or beliefs that the trainee may possess that pose challenges to adequate skill development. These might include beliefs about CBT or about therapy in general that cause problems. (If a trainee's rigid ideas about an approach to patients are causing problems, good strategies are to conceptualize the cause or origin of the trainee's rigidity; focus on clear goals and objectives as delineated by the training program; and identify one of the trainee's learning objectives that he or she can more easily meet by learning CBT.) A Socratic, nondefensive attitude that frames learning the approach as an experiment can be of significant benefit. The video illustration "Trainee Does Not Believe in Psychotherapy" provides an example of how to manage such attitudes.

WATCH: Go to www.wiley.com/go/sudak: *Appendix VII, Video Library* and View Videos:

- Trainee Afraid CBT Will Damage Therapeutic Alliance
- Trainee Believes CBT Is Superficial
- Trainee Does Not Believe in Psychotherapy

- Help trainees develop proficiency in assessing competence on their own by requiring them to use instruments to review tapes of clinicians with a variety of levels of expertise.
- Finally, identify specific personality characteristics that interfere with work or forming relationships generally that may affect training relationships and the therapeutic alliance adversely.

When trainee difficulties occur because of interpersonal or mental health problems, it is crucial that supervisors have information about sources of support available for the trainee, including provisions for leave and mental health assistance. As mental health professionals we should be particularly sensitive and attentive to psychiatric illnesses that impinge on work performance or psychosocial stressors that interfere with job performance. When such stressors exist we must

offer the trainee ancillary supports and then problem-solve how the trainee may prioritize and plan to fulfill clinical duties even in the face of such stresses.

Reevaluate the supervisory alliance when problems occur. Prior supervisory experiences may also produce attitudes and behaviors in the trainee that are unhelpful. Understanding these together may lead to alternative perspectives and to approaches that work. An important alliance issue is insufficient trust in the supervisor so that trainees do not disclose skill deficits or problems with patient care. The supervisor–trainee relationship must be safe enough to encourage such disclosure. Additionally, if the trainee avoids certain therapy topics, the supervisor must probe further to become certain what skills the trainee possesses. Role playing is often the key to discovering the trainee’s capabilities.

WATCH: Go to www.wiley.com/go/sudak: *Appendix VII, Video Library* and View Video:

- Trainee Does Not Have Necessary Skills

COMPETENCE IS INSUFFICIENT: ADDICTING TRAINEES TO LIFELONG LEARNING

The teaching of CBT skills must emphasize that *competently* employing skills is insufficient as an endpoint for practitioners. The Dreyfus model of skill acquisition (Dreyfus & Dreyfus, 1980) places “competent” midway on the scale. Would any of us want a competent rather than an expert surgeon? A competent rather than an expert therapist? Trainees must aspire to continue to develop and refine skills over a lifetime. Reviewing checklists with a trainee and problem-solving ways to overcome any barriers to implementation is an excellent way of increasing skill level and should be taught as a lifelong way to improve performance. An excellent example of a CBT session checklist is provided in Table 5.2. Teaching methods to systematically practice elements of CBT (for example, agenda setting) can improve skill level and prevent “drift.”

Patient-derived feedback about progress in therapy is an invaluable resource for performance improvement. Lambert, Harmon, Slade, Whipple, and Hawkins (2005) summarize a series of groundbreaking studies suggesting that therapists who receive objective information regarding patient responses to treatment have better patient outcomes. Information about deterioration in progress or a decrease in the expected quality of the therapeutic alliance may help the therapist increase the intensity of care or alter treatment course accordingly. Lambert’s study also notes that the best outcomes are obtained if both the patient and the therapist are given data about progress. Symptom checks (and tracking symptoms with the patient) at the start of each session and obtaining feedback at the end of a session regarding the patient’s reaction to the session (or more formally assessing the working alliance) are core processes in a CBT session.

Table 5.2 CBT Session Checklist

-
- ☐ Came into session with a clear plan regarding process that I was confident in
 - ☐ Came into session with a clear plan regarding content that I was confident in
 - ☐ Set agenda
 - ☐ Worked mutually with the client on a strategy for change that felt on point
 - ☐ Effectively tied current tasks to broader treatment goals
 - ☐ Was flexible in identifying “stuck cycles” and disengaging from them
 - ☐ Was flexible in connecting to the emotional experience of the client
 - ☐ Reviewed homework adequately
 - ☐ Received feedback/reviewed outcome data and discussed adequately
 - ☐ Developed clear and specific homework
-

Source: Included with the permission of Cannon Thomas, PhD (2007).

Further underscoring the importance of feedback, Simons, Rozek, and Serrano (2013) note that the difference in outcomes achieved in empirically supported treatment trials relative to community settings may be a result of the consistent supervision and feedback about patient progress provided to the patient and to the therapist. Even with continued research and refinement of current therapeutic methods, 35 percent to 40 percent of highly screened and selected patients do not benefit in randomized controlled trials, and a small group of patients lose ground (Hansen, Lambert, & Forman, 2002); we must continually assess progress and adjust our treatment decisions rather than assume that we can accurately estimate how patients are doing. Training therapists to obtain consistently positive outcomes with a range of patients means that expertise is the goal. Continually assessing performance and patient progress so that outcomes continually improve should be our practice as well as our teaching paradigm.

As trainers we must inculcate in trainees the principle behind gathering feedback and the need to reflect on the feedback (for example, reflecting on how an intervention affected the patient, how to understand progress or lack of progress) and adjust behavior accordingly. Three areas must be systematically monitored: the therapeutic alliance, the patient's progress, and the adequate implementation of the therapy. Go to www.wiley.com/go/sudak: *Appendix II, Forms and Tools for Websites with Scales to Track Patient Outcomes*, which provides information on websites that provide instruments to track patient progress. At least one group of researchers (Dimeff & Koerner, personal communication, 2014) is developing comprehensive Internet-based software that tracks clinical outcomes and delivers them graphically and narratively to the therapist and patient along with evidence-based materials that will facilitate recovery. Recently published catalogs of free, brief standardized instruments (Beidas et al., 2014) for tracking patient progress can be useful as well.

Recent reports highlight developing expertise (Ericsson, 2008) as a goal of therapeutic training. Expert therapists should learn how to use data from their own practices to improve the quality of patient care. Teaching trainees the value of

continuing to improve skills by deliberately practicing and using independent evaluation and coaching (for example, using the CTS), or evaluating the accuracy of complex pattern recognition (for example, discussing conceptualization of patients with a colleague for feedback), ensures lifelong learning and the development of expertise.

SUMMARY

Acquiring and providing feedback are critically important activities for therapists. It assists us in the initial acquisition of skills and in teaching skills to patients and trainees alike. Feedback provides corrective information to novice trainees and is important to assure patient safety. Feedback can also help us to continually improve our skills in practice and facilitate patient recovery.

LEARNING EXERCISES

- Pick a specific CBT skill. Using the principles of skills training, role-play or train a trainee in that skill. Review a tape of this exercise and refine your skill as a trainer.
- Review the forms and procedures your program requires for the delivery of summative feedback to your trainees.
- Role-play giving summative feedback to a problematic trainee with a colleague. Ask the colleague to progressively increase the degree of difficulty of the role play.
- Develop a library of outcome measures to use regularly with your patients.
- Track one or two different CBT skills per week in your clinical practice for performance improvement.
- Listen to a recorded session from a trainee. Make three or four behaviorally specific observations about the session.

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Chapter 6

TEACHING CBT FOR SPECIFIC DISORDERS

Leslie Sokol and Marci G. Fox

Key components for effectively teaching cognitive behavior therapy for depression, anxiety, personality disorders, substance abuse, and severe and persistent mental illness are identified in this chapter. Trainees are helped to clearly understand the specific cognitive conceptualization of each psychological disorder and then accurately connect it to the patient's specific cognitive conceptualization and disorder-specific cognitive behavioral treatment strategies. In this way, trainers should have a clear guide of what is necessary in the implementation of each specific treatment.

The chapter presents a cognitive conceptualization of each disorder followed by a discussion of a strategic plan to effectively address the disorder-specific problems in thinking and behavior. A detailed discussion of disorder-specific treatment strategies, didactic components, and experiential exercises address common learning needs of trainee groups.

TEACHING CBT FOR DEPRESSION

Conceptualization

Psychological difficulties involve problems in thinking regardless of the etiology of the disorder (Beck, Rush, Shaw, & Emery, 1987). Once a patient is clinically depressed, his or her thinking becomes negatively biased, and this bias is demonstrated in three major spheres of thinking: negative view of the self, negative view of the future, and negative view of the world (Beck et al., 1987). This cognitive triad of negative bias is correlated with paralysis of will, depressed mood, suicidal wishes, increased dependency, and avoidance wishes. The

cognitive conceptualization is often taught using a clinical example to connect each individual's conceptualization with the current triggers and subsequent symptoms. A typical example includes how the patient's early experiences led to the formation of dysfunctional assumptions and beliefs that when activated by a critical incident lead to situation-specific automatic thoughts, emotional distress, and ineffective behaviors.

Let us use the clinical example of Andrea; she describes her parents as strict and not emotionally demonstrative and her older siblings as popular and attractive. Such a developmental history, combined with a punitive parochial school education, led Andrea to believe she was unattractive, unloved, and less valuable than her siblings. As a result, she placed perfectionistic demands on herself—believing she had to be perfect and always accommodate other people's needs in order to be accepted and loved. A typical upsetting trigger was any relationship in which she perceived rejection or criticism. For example, when she was not asked to join others for lunch it meant she was not liked and not good enough to be part of the popular crowd, that she would never be included, and no one would ever accept her. An unreturned phone call meant the person did not want to be with her, he wanted to end the relationship, and that all people would eventually let her down. Andrea's situation-specific automatic thoughts can be seen as reflections of negatively biased views of herself, the future, and her world. These negatively biased views led Andrea to retreat from others, ruminate on her perceived inadequacy, and feel depressed and hopeless.

Therapeutic Strategies

Behavioral Activation Although removing the negative thinking bias of depression is essential in the reduction of depressive symptoms (Beck et al., 1987), behavioral activation is often a necessary early step in treatment prior to accessing and working with cognition. Getting patients activated can provide necessary data for cognitive change to take place, along with improving mood.

Teaching students to implement behavioral activation is best done through an interactive exercise.

- Ask the students to think of a goal they have wanted to address but have not begun to tackle.
- Ask them to make a list of all the reasons it makes sense to pursue this goal. Include advantages that might affect both their personal well-being and benefit others who matter to them.
- Ask whether they tell themselves they have to or should pursue this goal. If so, replace this demand with a request. Instead of I should go to the gym, it makes sense to go to the gym, and then remind oneself of those reasons you are pursuing this goal.

- Ask, “What action is likely to get you closer to your goals or is in your best interest?”

Action, however, is not easily forthcoming in a depressed person. Depressive bias can lead to lack of energy, apathy, and inactivity. Depressed patients often believe action cannot come until they feel better, have more energy, or want to do something. Instead an interactive conversation with your students can help teach the concept that action *precedes* motivation.

- Ask the students, “How many of you wanted to get up when the alarm went off this morning or wanted to brush your teeth?” Doing things requires taking action rather than motivation, energy, or strength. However, action without a plan will likely lead to a fruitless effort.
- Have the students make a concrete plan, including what they are going to do, when, where, and all the steps of the how. Be as specific as possible. Many times legitimate and nonlegitimate obstacles interfere with well-formulated plans. Instead of giving up, teach the person that by continuing to reschedule the goals, they remain obtainable and even the process of rescheduling is effort toward the goal. This is also valuable in the battle of hopelessness. Activity schedules are useful tools in both monitoring behavior and helping to facilitate action. Phone check-ins, covert rehearsal, and coping notes that reinforce the plan are additional tools in helping patients to follow through.

Increase Motivation and Decrease Procrastination Another obstacle to patients making their plans happen is interfering “give-up” (goal interfering/vanquishing energy) thoughts (Fox & Sokol, 2011).

- Ask students what excuses they tell themselves that give them permission to avoid working toward their goals. These excuses are simply thoughts that serve to block action.
- “Give-up” thoughts can be reframed in ways that lead toward action. Instead of the thoughts, “I’ll do it later, I’m too tired, or It’s too hard,” use alternative thoughts, called go-to (goal orienting) thoughts such as, “Do it now and you will enjoy later so much more,” “It doesn’t matter if I’m tired I can still take action,” or “It may not be as hard as I think if I just try.” Using the students’ own examples as well as patient examples is helpful.

Coping Cards Have examples of coping cards that remind the depressed patient of the concepts being taught. Coping cards can include the rationale, the plan, and the reasons it makes sense to take effective action on the student’s own behalf. The following two coping cards reiterate the concept of action preceding motivation:

1. Action comes before motivation; I don’t have to feel like it to do it. Get started! And accept that depression is stealing my motivation so

it will be harder to do things. Reminding myself to just take action will help.

2. Action precedes motivation; you can do it even if you do not feel like it. You can do it even if you don't want to. Take action.

These coping cards can be on paper, texted to a phone, left as a voice message, or programmed on a computer.

Credit Lists Depressed patients often compare themselves with nondepressed individuals or even to themselves when they are not depressed. Such comparisons lead them to discount and minimize their accomplishments. The credit list is designed to help patients take credit for anything they do, regardless of how little or insignificant they perceive it to be. Patients must accept that depression itself makes each effort more difficult. Additionally, it is important to recognize that success is in solely trying and not in only the outcome, which often is affected by variables out of one's control.

- Have the trainees give credit to themselves for at least five things per day. Start the credit list in supervision. Then the supervisee can try this with their patients as a strategy to help to improve mood. For example, the patient who has been lying in bed all day manages to get himself mobilized. Taking credit for getting out of bed, showering, making a meal, and taking a walk may seem insignificant, but to the patient impaired by depression these are huge gains and deserve credit. As the patient rallies, credit for more sophisticated tasks, such as shopping and preparing a meal, running errands, and doing tasks in and out of work, belong on the list.

Role Play Role-play exercises can be used to put all of these principles into practice. Role plays are more helpful when the trainee playing the patient plays an actual patient they are treating or uses a real problem with which they are struggling. When role plays are done with imaginary characters, often the patient responses are exaggerated and not true to real-life interventions. Try this exercise by having the trainee role-play the patient or himself, with you acting as the therapist, and then you can switch roles.

Restructuring the Negative Bias

Cognitive Model It is essential to train supervisees to help patients elicit automatic thoughts. Drawing a schematic of the cognitive model is helpful to illustrate that situations don't cause individuals to feel a certain way, but rather it is their perception of the situation that causes them to feel, behave, and physiologically respond in a certain way (A. T. Beck, 1973). Show your trainee how to draw out the model and then help them explain it with several examples to practice

demonstrating it to the patient. It's also important to help trainees recognize that thoughts can be completely true, partially true, or distorted, or inaccurate.

Downward Arrow Technique Some trainees may focus on a more superficial thought that does not evoke any emotion, and that is when it is important to do the downward arrow technique or what David Burns (1999) refers to as the vertical arrow technique. Supervisees must make sure that automatic thoughts logically parallel the emotion given and that its intensity rating make it worthwhile to pursue. The downward arrow technique is a strategy to go from a more superficial automatic thought to a deeper thought more connected to the conditional assumptions or core beliefs. Supervisees can practice this technique by asking the trainee to provide an example of a situation, thought, and emotion from a patient. Then they can practice asking questions such as “What does that mean to you that they said that or that took place?”; “What does that mean about you in relation to what you just said?”; or “What’s the worst part about it?”

Questioning Thoughts In the case of depressed patients, the negatively biased depressive thoughts contribute to driving and sustaining the depression. The depressive helpless, often hopeless content of the thoughts become ruminations that interfere with recovery. The key to overcoming the depressive mind-set is to teach patients how to objectively evaluate the validity and utility of their thoughts in order to formulate a more helpful view of themselves, their future, and world. Questioning thoughts is a skill that can be taught. It is helpful to look at this process in two ways. Thoughts may be examined by looking at the evidence for and against the thought, seeing alternative explanations, examining the worst, best, and most realistic outcomes, imaging giving advice to others or seeing a friend in a similar situation, and in general seeing the situation in a more reasonable, helpful way. Depressed patients do not have the ability to see their thoughts from alternative perspectives, and the therapist guides the patient to this new healthier view. This is accomplished by asking guided Socratic questions that lead the patient to see situations and themselves more accurately or more helpfully. The second method of managing negative thinking is questioning the validity and utility of specific thoughts, assumptions, and beliefs.

Often depressed patients are afraid to examine their own thinking. “My negative thoughts are so many and so negative and so firmly entrenched that if I let them surface they will destroy me.” To some extent the patient is right. Focusing on the negatively biased thoughts may lead to an exacerbation in symptoms in a patient who does not have the appropriate skill to evaluate those thoughts. Therefore, it is important to caution therapists to explain this to the patient and first work with thoughts in session until the patient has sufficient skill to independently address her or his thoughts.

A mistake novice therapists sometimes make is using generic examples to teach people how to evaluate thoughts. This technique often can serve to disengage the

patient from the process, lead to a lack of understanding, and fail to produce the emotional or cognitive shift the therapist was trying to obtain. Instead of having the patient imagine a made-up scenario, such as an adolescent being out after curfew or on a baseball field with bases loaded, find a thought the patient spontaneously produced and examine its validity directly with the patient. Through the process of asking Socratic questions using the patient's own thought examples, the therapist and patient can collaboratively and systematically examine the automatic thoughts and then together formulate a new, more helpful, and less distressing viewpoint.

The thought record is a widely used tool that helps guide both the therapist and the patient through the thought evaluation process. The many versions of the thought record all have the same key components: documentation of the situation, situation-specific automatic thoughts, broader assumptions and beliefs associated with that situation, emotion, behavior response, alternative view, and ratings of belief for all domains. Teaching therapists how to do Socratic questioning is best accomplished through downward arrow examples, cartoon illustrations, role plays, and vignettes.

Cognitive Errors Beginning trainees benefit by learning to label cognitive errors the patient makes. Errors in thinking tend to be thematic—patients have a tendency to use one or more varieties fairly consistently. Through the use of thought records trainees can bring to the patient's attention his inaccurate patterns in thinking. Some typical distortions include extreme thinking, depending only on your emotions, nasty name calling, catastrophizing, forecasting the future, expecting too much, and zooming in on the negative (Fox & Sokol, 2011). Use such a list for your trainees to begin to identify the cognitive errors they use in their own lives—this makes them aware of how common and also patterned, distorted thinking is. Teach them to define each distortion with patients and have their patients identify examples of each to increase awareness and recognition when filling out the automatic thought record.

WATCH: Go to www.wiley.com/go/sudak, Appendix VII, Video Library, and View Videos:

- Dealing with Difficulty to Identify with Negative Thoughts, Parts I and II

TEACHING CBT FOR ANXIETY DISORDERS

Conceptualization

The most important concept in teaching CBT in the treatment of anxiety is embracing the concept that anxiety in itself is neither dangerous nor a disease; anxiety is a normal adaptive mechanism of human survival. Anxiety is simply nature's way of preparing us to face difficult and sometimes dangerous situations.

Anxiety is the internal alarm mechanism inside humans that alerts us to trouble. This internal alarm system, unfortunately, cannot discriminate real from imagined danger, so anxious patients often have “false alarms” in response to incorrectly perceived danger. Patients report that their physical symptoms are real, and they are right! The physiological experience is real—sugar and fats are pouring into their blood stream, the heart is beating rapidly, and chemicals are released causing the sympathetic nervous system to experience an adrenaline rush of arousal. Anxious patients must reformulate their appraisal of this arousal, not as a cue that they are facing a genuine threat and not as a sign that the arousal is dangerous and must be avoided.

Risk/Resource

The cognitive model of anxiety is a model of appraisal: risk and resource (Beck & Emery, 2005). According to the model, the patient has a tendency to overestimate the risk of a negative outcome. What that means is that patients predict the worst-case scenario will occur in ambiguous situations. Individuals with anxiety typically see themselves as more vulnerable and believe they are less equipped with the skills, talents, abilities, intelligence, and experience they need to be effective. In underestimating their resources, they may be less likely to ask for help or feedback. The key principle to be learned about risk and resource ratio is that therapy is designed to help a patient more accurately appraise risk and resources in each specific situation in order to reduce anxiety.

Risk/Resource Illustration This concept is best taught through illustration. Using a caveman example, think about a single cave dweller left to watch over the community cave while the others are out hunting for food, when suddenly a saber-toothed tiger shows up snarling and sniffing, hoping to find a meal. The cave dweller feels afraid and is most likely experiencing physiological arousal. His activated body is the internal alarm telling him to take evasive action to protect himself from the threat; he proceeds to run away or hide in a crack in the cave. Suddenly, out of the corner of his eye he notices his fellow cave dwellers returning from the hunt. He sees twenty lit torches in the distance and his fear subsides. Why? The threat remains; the saber-toothed tiger is just as dangerous, but what have changed are his resources. The cave dweller now has outside rescuers coming to help. But the torches are not enough to ward off the tiger, and now there are twenty-one scared cave dwellers running for safety. More resources are necessary to face the very real and dangerous threat of the tiger. A time traveler jumps into the picture and arms each cave dweller with a loaded machine gun. Instead of running away, the strategy changes and the cave dwellers stand their ground and fight the tiger. Rewarded with meat for the month to come, the lesson is that regardless of the threat, armed with the correct resources one can handle almost any situation.

Acknowledging the resources one has is a critical part of the risk/resource equation. Anxious patients fail to see the resources they have within and outside of themselves. When teaching the concept of resources, it is helpful to ask your trainees what resources they possess to face life's challenges. Help them create a long list of personal assets such as intellect, experiences, aptitudes, interests, knowledge, communication, and other skills (Sokol & Fox, 2009). Help them see a vital and important internal resource that all of us can bring to a situation: self-confidence. Armed with the belief that we have the capability to handle performance-related situations and the social desirability to face interpersonal situations, we are far more capable to manage novel situations. Self-confidence means you do not have to be perfect, know everything, or have everyone like you. Self-confidence means you can ask for help, get more practice or knowledge, make mistakes, and face things even if they are difficult. Acknowledging and recognizing outside rescue factors is also an important piece of reducing anxiety, even in confident people. Ask the trainees what outside rescue factors they have across different situations. Encourage them to consider relatives, friends, colleagues, teachers, coaches, significant others, family members, and even strangers, depending on the situation.

Therapeutic Strategies

Building Resources Building resources is often necessary and helpful to assist patients in believing they are equipped to face difficult situations. An assessment of what skills would be helpful and what skills are lacking is important before randomly adding resources. For example, a socially anxious person who has never engaged in small talk at a party may need practice; a person who has never been able to say “no” may need assertiveness training before tackling a task that frightens him.

Accurate Assessment of Threat In the risk/resource equation, a critical component is an accurate assessment of threat. Anxious patients imagine danger that is not there by overestimating the risk—either in the severity, extensiveness or duration of an adverse event. One goal of CBT for anxiety disorders is to accurately appraise the threat. The critical question to ask is, “Is the danger real or imagined?” When the building is on fire, the threat is real. Sitting in a waiting room when you believe everyone is staring and making negative judgments about your character is an appraisal that is imagined. Patients learn through Socratic questioning to make more valid estimations of threat.

Comic Strip Illustrations Comic strip illustrations can be used to teach the risk/resource concepts. A comic illustration of a small child about to take a bath reads, “Whenever I take my bath... I always put my ducky in first.” The other person in the room asks, “For companionship?” The young child answers, “To test for

sharks.” This simple comic can become a teaching tool for understanding safety mechanisms, evaluation of danger, and assessment of resources.

1. Ask trainees what guided questions they could ask the young child in the cartoon that would help him more accurately appraise the threat. “Where do sharks live? How would the shark travel from the sea to the home? Could it fit in the pipes? How big are the water faucet and the drain? How big is the shark, its teeth? How many sharks have been reported in bathtubs? How many times have the child, his siblings, and his parents had a bath and how many sharks have they come across? Has the duck ever been eaten?” These Socratic questions lead the child to see that the probability of the shark threat is very unlikely.
2. Then teach the trainee about safety seeking. The duck is a safety mechanism that serves as an avoidance strategy for the child, thus he never faces the threat of the shark. Once the threat has been diminished, the child must be encouraged to face the tub without first putting in his duck so that he can face his fear.

Facing one’s fears is possible only if the patient feels equipped. Sometimes more resources are necessary before a fear can be faced. Use examples to teach trainees this concept. Take, for example, a new skier—it would be unsafe for her to tackle an advanced slope without first taking a lesson, getting some practice, and becoming competent on her skis.

Specific Anxiety Disorders: Conceptualization

Assessing the specific content of the patient’s fear can help trainees work with patients to distinguish real danger from imagined danger. Typically, anxiety disorders are distinguished by specific types of threat and typical dysfunctional coping strategies (Beck & Emery, 2005). Using ordinary life experiences, the trainer can use this concept to educate trainees. For example:

1. A person who is afraid to fly has a specific phobia of flying and the content of fear is simply the fear of the plane crashing.
2. A person who is afraid that she may get air sick in public or leave a foul odor in the bathroom (afraid of social humiliation) may be socially phobic.
3. A person who is afraid of opening the emergency exit and jumping out while the plane is in the air (afraid of their intrusive thoughts and urges) may have obsessive compulsive disorder (OCD).
4. A person afraid and worrying about everything may be exhibiting generalized anxiety disorder (GAD).
5. A person who is afraid of bodily symptoms of anxiety as medically dangerous and fears he will have to demand the plane land may have a panic disorder.

6. A person who may be afraid of a medical event taking place while flying may have health anxiety.

In all of these cases the patient is afraid to fly, but the specific content of his or her fear defines the type of anxiety disorder that needs to be addressed. In every case the dysfunctional coping strategy is to avoid the threat. The specific phobic avoids flying, the social phobic takes the flight but she will fail to look at the public and instead focuses internally on her imagined persecution. The OCD patient avoids the flight, confusing thoughts with actions. The GAD patient worries regardless of he takes the flight or not, and the panic and health anxious patients remain vigilant to their symptoms regardless of the situation.

Therapeutic Strategies

Exposure There is well-established evidence about using cognitive strategies in the treatment of anxiety (Hoffman & Smits, 2008; Tolin, 2010). Exposure strategies enhance cognitive restructuring and are frequently essential to overcome fear. Regardless of the type of exposure—in vivo, imaginal, interoceptive, or virtual reality—the key principles of exposure frequency, duration, and intensity remain the same. Facing a fear once is ineffective; the fear must be repeatedly faced for a significant duration with enough arousal for emotional learning to take place. Intellectually, the patient may know the danger is less significant than he or she thinks; changing the belief and fear structures requires firsthand data. Providing a clear rationale for exposure exercises and an explicit and clear conclusion is essential. Learning is enhanced when hypothesized predictions are contrasted with real consequences. Teaching via video is helpful, but experiential exercises are most effective.

Exposure Exercises Simulate how focusing internally on a symptom can exacerbate the unpleasantness by asking trainees to repeatedly swallow until it is uncomfortable. Ask trainees to write a horrifying sentence about someone they care about very much, such as, “I hope my husband dies in a horrible car crash tomorrow.” This exercise demonstrates the power of thought–action fusion.

Socially phobic individuals commonly imagine they are being observed, judged, and criticized by others. Ask trainees to take note of what people are doing in various situations to make it clear that the average person is too preoccupied with phones, TV, children, reading material, and so on to take note of others. In addition, socially phobic individuals imagine that others can tell how anxious they feel. A key exposure practice in social phobia is to ask trainees to observe another person and then ask them if they can accurately tell how the person is feeling or what they are thinking. This helps them recognize that unless one is overtly crying or pacing, no one can accurately tell how another person feels. Exposure to negative information or rejection is another exercise one can do

to reinforce the learning that negative appraisal and rejection is not the catastrophe people imagine.

Interoceptive exercises allow patients to address the fear of anxiety symptoms and can be done in a group format. Typically in anxiety disorders, the patient is afraid of the feeling of anxiety, irrespective of the cause. To do an interoceptive exercise in a group, simply ask everyone for their current anxiety score from 0 to 10. Then ask them to participate in a diagnostic experiment to better understand anxiety.

First have them imagine they have panic disorder and ask them what symptoms they typically experience and fear. Then ask the group to over-breathe, which means taking deep rapid breaths with an open mouth. After a minute of doing the over-breathing exercise, ask the group how anxious they feel, what specific symptoms they are experiencing, and whether any fearful thoughts crossed their minds. Then help the trainees draw accurate conclusions from the experience.

It is important that the conclusions gained are that the symptoms themselves are not as dangerous as the trainees imagined, that they cannot and do not cause bodily harm, and that with no action the symptoms will eventually subside. Communicate that there is no need to control the symptoms because they are simply an internal alarm system communicating signals of danger. When danger is no longer assessed, the alarm will stop ringing.

Intolerance of Uncertainty Patients with anxiety have difficulty tolerating uncertainty. Life is often uncertain, and one needs to accept this fact. It is important to work with the patient to remember the facts in the moment and not make inferences about the future.

Differentiating Worry from Realistic Concern Trainees can help patients differentiate worry from realistic concern (Sokol & Fox, 2009) as a strategy to reduce anxiety. Worry without any need for immediate problem-solving is toxic. When concerns are realistic, effective action options should be identified and implemented.

Addressing Worry Worry thoughts are persistent nagging thoughts. More specifically, worry thoughts have a content concerning things that may have happened in the past or may happen in the future but have no present problem focus, so no clear action can be taken. Realistic concerns, however, are intrusive concerning thoughts that may serve as an appropriate warning signal. Taking appropriate action or problem solving in this case is functional and helpful. Worry leads to emotional fear, physical discomfort, and ineffective behavioral actions. Worry thoughts often take the form of “What if” and “Awfulizing,” such as “What if I miss my airplane connection?” “What if my child doesn’t get into the college of her choice?” “It would be awful if my date never calls me again.”

Worry in itself is a disorder of thinking. The act of worrying has no advantages and a long list of disadvantages. Worrisome thoughts may interfere with one's ability to pay attention. Missing the punch line, plot, or point of a conversation may inhibit functioning, the ability to connect with others, and joy. Worry may exacerbate pain, increase physical problems, waste time, induce stress and fatigue, and disrupt sleep.

The key in worry intervention is first and foremost to help the patient recognize the futility of worry. When a worrisome thought first crosses one's mind, ask yourself:

- Is the danger I am concerned about real or imaginary?
- If it came to pass, what is realistically the worst that could happen, and could it be survived?
- What is the best that could happen?
- What is most likely to happen?
- If it is likely to happen, and it is a problem, what can I do to address the problem, or what steps can I take to begin problem solving?

When fleeting thoughts become persistent it is helpful to identify them as worry. Like any obsessive thought, dwelling on it only increases the occurrence and persistence of the thought—the harder one tries to repress it, the stronger it speaks. Instead, like all fears, the worrisome thought must be faced and addressed. The following coping card may be used by patients to help them address their worry:

Worry is a disorder of thinking. It steals energy, fatigues, distracts, and otherwise causes torture. The goal is not to delay, time limit, or suppress the thoughts, but to change the strategy and no longer use worry as a means to cope. Instead of worrying, tell yourself: "There is nothing I can do in this moment to tackle the issue. When I am ready or it is necessary, I will figure it out and tackle it then. Take it and go participate in the now. Remember I am a pretty good problem solver so when I am ready or it is necessary to face the problem, I do have the skills to face it or I can get the help I need to face it. It is okay if I haven't figured everything out.

Additionally, tolerating uncertainty also comes into play for worriers because no one can possibly be prepared for every possible unknown outcome or event. Life has risks and unknowns, and accepting that is an essential part of managing worry.

Decrease Avoidance Avoidance tends to be the key strategy used by patients struggling with anxiety. The key rationale to teach is that avoidance may temporarily reduce discomfort but may generate more difficulties in the long term. Avoidance can grow the imaginary danger into something it isn't. It prevents new helpful learning that can take place only if the fear is faced and the imaginary

outcome fails to happen or happens without the excessively imagined consequences. Delay in facing a problem can turn a minor issue into a bigger dilemma. Avoidance reduces a patient's confidence in his or her ability to be effective because data to boost self-efficacy are unavailable. After helping patients identify the specific anxiety-producing situation and realistically appraising their risk and their resources, trainees must help patients to list as many potential outcomes as possible. Collaboratively the trainee and the patient can select one or more options and use imagery about this action option, then discuss potential difficulties that may come up, and script out any conversation. Role play, coping cards, and a plan can follow such an exercise.

TEACHING CBT FOR PERSONALITY DISORDERS

There is a growing body of evidence that cognitive-behavioral treatment can be effective for personality disorders, but the empirical research is limited (Beck et al., 2014), antisocial (Woody, McLellan, Luborsky, & O'Brien, 1985), avoidant (Felske, Perry, Chambless, Renneberg, & Goldstein, 1996; Greenberg & Stravynski, 1985), and borderline (Linehan, 1987, 1993). Personality disorders have been the subject of controlled outcome studies and demonstrate a positive treatment response. The cognitive conceptualization of personality disorders has had limited research validity (A. Beck, Davis, & Freeman, 2014). However, the hypotheses that dysfunctional beliefs are related to personality disorders in ways that are consistent with cognitive therapy are supported by Beck's work with the Personality Belief Questionnaire (Beck et al., 2001) and Young's Schema Questionnaire (Young, 1999).

The cognitive conceptualization of personality disorders suggests that a patient's genetic predisposition in combination with life experiences leads to the development and sustainment of underlying dysfunctional beliefs that then shape the way the individual perceives specific situations and consequently how they react emotionally, physiologically, and behaviorally. Findings support the hypothesis that dysfunctional beliefs are related to personality disorders in ways that are consistent with cognitive theory (Arntz, Dietzel, & Dreessen, 1999; Beck et al., 2001).

Conceptualization and Identifying Underlying Beliefs

The key to effectively treating personality disorders is to understand how the patient's worldview affects her or his perceptions, rules, and behavioral strategies. Teaching students how to formulate a conceptualization requires the collection of necessary information. Dr. Judith Beck's cognitive conceptualization diagram (J. S. Beck, 2011) is a helpful tool to organize and guide the data collection. Situation-specific perceptions, emotions, and behaviors are linked to pervasive underlying dysfunctional beliefs that are then connected back to early childhood

or life experiences that helped the formulation of this dysfunctional view. Once a dysfunctional belief or beliefs is identified, further data are gathered to understand how that belief has shaped the patient's behavioral strategies and consequent rules they operate under. These rules are often called "conditional assumptions" and link the underlying core belief with a specific behavioral strategy in a conditional statement.

Acquiring the necessary data to formulate a cognitive conceptualization is a key skill. Having a conceptualization of oneself is a valuable tool in learning how to understand others. Therefore it is often helpful to have students first practice identifying data and formulating a self-conceptualization. Following is a group exercise that students can do to develop cognitive conceptualization skills. The students can either do this exercise using their own examples or those of a patient.

Cognitive Conceptualization Exercise

- Think of a situation that recently activated strong emotions in you. What were you thinking at that time? What were the feelings? What action did you take?
- Think of one or several situations and ask the same questions.
- Ask if there are thought themes across these situations that might be an underlying belief.
- Once a belief is identified, ask what early or life experiences have fueled that belief.
- Ask what behavioral strategies you used in the specific situations identified as well as the strategies you often use in difficult situations.
- Identify the link between the belief and the behavior and specify the conditional assumptions.

This exercise can be modified in the following ways:

- *Option 1.* Start by asking people to think back to a vivid early memory that is associated with affect and collect the information above based on that starting point.
- *Option 2.* Start by asking people what their typical behavioral strategies are (delegating, taking control, perfectionism, avoidance) as a starting point.
- *Option 3.* Use a universally accepted difficult situation, such as your house has burned down or your spouse has died, and ask what you might think, feel, and do in those situations.

Instruments to Identify Dysfunctional Beliefs in Specific Personality Disorders Knowing beliefs and behavioral strategy characteristic of specific personality disorders can help in pinpointing the therapeutic work that needs to be done. Beck et al. (2001) have a measure called the Personality Belief Questionnaire that can be used to assess the beliefs associated with previous and current

DSM personality disorders diagnoses. Instruments such as the Dysfunctional Attitude Scale (Beck, Brown, Steer, & Weissman, 1991) are also useful for identifying dysfunctional beliefs.

Therapeutic Strategies

Modifying Dysfunctional Underlying Beliefs and Ineffective Behaviors

The goal in working with personality disorders is to help individuals reduce their distress and increase their level of functioning both occupationally and socially. In order to do this the cognitive strategy is to modify the underlying dysfunctional beliefs into more accurate and helpful beliefs. Previously discussed was the identification and understanding of the development of the belief; now the goal is modification. The first step in modifying the belief is to make sure the patient is ready to do the work. A list of all the advantages of doing so is helpful as well as a list of those reasons the patient believes make change challenging. For each of the specific disadvantages, it is helpful to evaluate whether or not the concern is valid, and if it is valid to formulate an alternative viewpoint that makes that concern less of an obstacle. A teaching exercise to practice this skill could be

- List the advantages and disadvantages of both modifying the belief and keeping it.
- Examine the disadvantages of changing and the advantages of keeping the dysfunctional belief and reformulate new viewpoints.
- Draw conclusions that acknowledge the price of change and the worthiness of the gain.
- Once the patient is motivated to change, or at least accepts that it makes sense to face her fears and begin the work, the next step is examining and modifying the belief. This work typically starts by acknowledging that it is understandable that the person has developed the negatively biased view of herself. This negatively biased view stems from how she interpreted her life experience.

The question is whether or not there is contradictory data that now suggest the belief is not completely true and in some cases totally untrue. It is easiest to start with current information that provides evidence against the belief and supports a new more adaptive belief. Evidence that is collected that continues to support the dysfunctional view is evaluated for validity and often reframed in a way that no longer allows it to support the old dysfunctional view. Information is continually collected to fuel the more adaptive view. The Core Belief Scale (J. S. Beck, 2011) is an instrument that is often used to do this work.

When the patient tells the therapist that he rationally knows the old dysfunctional view does not make sense but it still feels as if it is true, one can do a brain-gut exercise to help the patient's objective rational brain

convince the emotional subjective gut of the truth. Select a dysfunctional belief and a new modified less dysfunctional alternative belief to work on. The patient can be asked to play the parts of both the brain and the gut, with the therapist helping feed the information to the brain; or the therapist and the patient can take turns playing each part. The key is to help the brain articulate all the information that supports a more helpful belief as well as dispute all the information the gut continues to hold on to in support of the dysfunctional view. Teaching exercises that allow students to role-play this technique are helpful.

- State the old dysfunctional belief and new modified belief.
- Start with the brain stating all the evidence in support of the new belief.
- Allow the gut to object with any “buts.”
- For each objection make sure the brain has evidence to defeat the “but” or an alternative viewpoint to quiet the “but.”
- Continue the exercise until the brain wins.
- Write out new conclusions.

Examining the data that the patient used to support his dysfunctional beliefs can also be done through taking a historical perspective. One can go back to any point in time and reexamine the data that the patient thought supported his view and look for alternative viewpoints that would reframe that information to modify the extreme conclusion. Using imagery is a way to reevaluate one's history in an affectively strong way that may in fact enhance the emotional learning. When using imagery, one must use caution, because highly charged emotional information is being faced and enough time to process the exposure is important.

LEARNING EXERCISE

Modifying Dysfunctional Beliefs

1. Have trainees break into dyads with one person first playing therapist and the other patient. Reverse roles halfway through so both participants play each part. In this exercise the trainee can play themselves or a patient that they have treated. Have the patient identify a previously identified dysfunctional belief.
2. Ask the patient to think back to an earlier, if possible a childhood, memory in which he was aware of the presence of the belief.
3. Suggest the patient relive that memory, using all of his senses to engage in the memory. As he is experiencing the memory, collect thoughts, feelings, behaviors, and the belief that is being activated.
4. Help the patient examine both these thoughts and beliefs, guiding him to see facts that may help him draw different conclusions. Ask him to insert their older, more mature self into the image and help his younger self see

the situation differently or help his younger self take a different course of action.

5. Make sure to follow the image until a safe or less stressful place is found and discuss what is learned. The key is to help the patient draw new conclusions by seeing alternative explanations for the personal meaning given to the experience.
6. State the new, more realistic belief, and if there is enough time ask for data from that time period that could support this new healthier viewpoint.
7. Summarize the learning from the experience and agree on homework that would help fortify a new, healthier self-view.

Modifying the dysfunctional belief is not enough to improve functioning; modifying the dysfunctional behavioral strategies is also important. In personality disorders the patient has overdeveloped some strategies and underdeveloped others. She tends to use those strategies that she believes are in her best interest even when they do not work. Strategies such as avoidance, dependency, fighting, self-harm, substance abuse, overly controlling behavior, and suspiciousness are ineffective, yet the patient chooses to continue to use them. In fact, instead of modifying their strategy, when strategies don't work the patient simply does them more frequently and intensely. It is important to identify overdeveloped strategies and help to reduce them while adding the underdeveloped strategies; for instance, learning to be more trustful and less mistrustful but not to be globally one or the other, less avoidant and more self-assertive, less controlling and more spontaneous, or less help-seeking and more self-sufficient. Teaching exercises that concern difficult situations and demonstrate multiple behavioral options can be helpful.

- Imagine being faced with a difficult task. What are the advantages and disadvantages of the strategies listed:
 - Break the problem into small steps and tackle one piece at a time.
 - Avoid facing the task.
 - Use help.
 - Give up and find something fun to do.

TEACHING CBT FOR SUBSTANCE ABUSE

Conceptualization

The key to treating substance abuse is in the formulation of the patient's problem. Once a cognitive behavioral analysis is elicited, specific interventions are designed to reign in the abuse. The cognitive model of relapse (Beck, Wright, Newman, & Liese, 1993) stipulates that patients face high-risk stimuli that evoke underlying drug-related beliefs that lead people to formulate perceptions in the form of substance-biased automatic thoughts. These thoughts lead to craving and urges of

high risk followed by the activation of permission-giving beliefs. The patient then focuses on instrumental strategies to secure the substance of choice followed by continued use or relapse.

Therapeutic Strategies

High-risk situations are elicited, including both external stimuli such as bars, playing an instrument, attending a party, and internal stimuli such as strong feelings, images, or bodily sensations. The goal is to avoid these stimuli when possible. When the trigger is internal, such as stress or boredom, the goal is to find ways to make those triggers less of a problem. In the examples of stress and boredom, the intervention would be to reduce stress by helping the patient evaluate threat and focus on coping resources, and in the case of boredom, making concrete plans or learning to tolerate the boredom.

Basic drug-related beliefs perpetuate substance abuse. Thoughts such as “I create better music when I am high,” “I’m more fun when I drink,” “Being high is the only way to be happy” convince the substance abuser that drugs and alcohol are necessary. Cognitive behavioral therapy helps the patient modify these beliefs into more accurate viewpoints. The thought “I create better music when I am high” is replaced with alternative viewpoints such as “I create equally good music when I am straight but it is different.” The person who believes he is more fun when he drinks can experience a role-play simulation in which the therapist slurs her words and slobbers onto the floor, demonstrating how unattractive the alcohol makes you. Instead of accepting that being high is the only route to happiness, evidence can be found from one’s past to contradict this statement, or new experiences can be tried to find outlets for pleasure. The key is to formulate new healthier viewpoints, such as “I don’t need drugs to be creative. I have a lot to offer people and I don’t need alcohol to deliver those things, or there may be things I can enjoy if I give myself an opportunity to try them.”

Drug-related automatic thoughts are associated with the affect generated by the trigger and the subsequent drug-related belief. Thoughts such as “I’ll just have one drink, I will start fresh tomorrow, I want a smoke, or man I’m jonesing” exacerbate cravings. Like all biased thoughts, patients are taught to evaluate the validity of them instead of blindly accepting them as truths. Instead of “I’ll just have one drink,” a new, more accurate thought replaces it: “I cannot have only one drink. One drink will lead me to bingeing and disaster.” Instead of accepting the thought that “I will start fresh tomorrow,” help the patient learn there may be no tomorrow if he doesn’t get control of this now, or every minute he continues to yield to his cravings will only make stopping harder. Thoughts about wanting a smoke or jonesing can be replaced with thoughts that remind the person that he can exhibit control, and what he tells himself can play a significant role in doing that.

When the high-risk cravings and urges take over, tools to manage the cravings are encouraged. Anti-anxiety techniques like slow breathing or relaxation can be

tried; imaging the horrors of using in graphic detail can reduce urges. Encourage delay and help patients recognize that urges peak, plateau, and subside. The new belief that just because you get an urge doesn't mean you have to act on can help as well.

Following is a helpful exercise to do with patients that can be demonstrated on trainees.

1. Ask audience members to imagine they are addicts and ask how strong their desire to use is at that moment.
2. Use an over-breathing interceptive exercise to activate the sympathetic nervous system and bodily arousal. Try having the audience breathe deeply and rapidly for one minute while standing.
3. Ask the audience at the peak of their discomfort how much they crave a fix to these uncomfortable feelings. Imagine they are substance abusers and how much that fix would be the patient's drug of choice.
4. Ask the audience to now sit down and breathe as slowly as possible in and out through the nose. Ask them to monitor how they feel and whether the desire to use a substance to take away the feelings has diminished.
5. Help the audience come to a clear conclusion from this exercise:
 - a. Cravings come and go and can go without having to act on them.
 - b. Cravings are linked with anxiety and distress. Learning to reduce anxiety and distress can be a tool in managing cravings.

The substance abuser acts out on her cravings when she listens to her permission-giving beliefs that facilitate using. Permission-giving beliefs such as "Everybody is using, this is my only chance to have fun this whole week," or "I can just have one drink, one line, one smoke" lead to the active pursuit of the desired substance. These facilitating beliefs can be examined and replaced with more accurate rational beliefs. The belief "Everybody is using" is replaced with "It is just not true that everybody is using. Most people are actually not." Instead of accepting the belief that this is the only chance to have fun, remind oneself of the price that will be paid in pursuit of that fun, or question whether or not fun will really be obtained. Often the perception is that it will be fun, but the bliss of the high is very short-lived and the horrible sickening pain and discomfort follows. Help patients remind themselves that an addict cannot have just one, and one means they are headed down the path to destruction. It is helpful to have patients imagine that ugly path, such as picturing themselves lying curled up in a ball, doubled over in pain, covered in their own vomit and urine.

Once the addict's permission-giving beliefs have taken over, the addict yields to their cravings by focusing on instrumental strategies in order to use. In place of focusing on instrumental strategies like calling a friend to get high, heading to a bar, liquor store, or party, one can try going to a gym, cooking dinner, taking a walk, calling a non-using friend, rereading all the reasons to stay sober, going to a

movie, finding a chore to do, taking a shower, or any of many other actions instead of seeking out drugs or alcohol.

Once the addict has yielded to their cravings and urges, the cycle can either end there with a temporary lapse or continued use can result, causing more harm. Helping the addict acknowledge that he has messed up is essential, but instead of judging his mistake and dooming or degrading himself, he can learn to take appropriate action toward recovery. Instead of heading right back into the situation that resulted in continued use, the addict can visit a sober friend or relative and stay there, make a therapy appointment or attend a meeting, or find any alternative action that leads him away from continued use.

Typically role plays are helpful to demonstrate how to intervene at each step in the model. Trainees can be given vignettes to role-play or practice with patient examples of their own. These role plays also work when the trainee uses something in their own lives they have trouble resisting. The beauty of this model is that it applies to any form of substance abuse, whether it is dangerous drugs or overeating.

TEACHING CBT FOR SERIOUS MENTAL ILLNESS

Conceptualization

The stress diathesis model of psychosis suggests that biological and psychosocial factors influence the onset and course of psychosis and that most people exposed to sufficient stress can become psychotic. Additionally, individuals can have some control over their symptoms (Zubin & Spring, 1977). Although there is compelling evidence of the efficacy of CBT for psychosis in treating both negative and positive symptoms, these tools are often used in combination with pharmacotherapy (Kingdon & Turkington, 1994). The key in treating psychosis is not to eliminate the delusions or hallucinations but to reduce the distress associated with them. It is not the symptom that is the problem; it is the emotional behavioral consequences (Beck, Rector, Stolar, & Grant, 2011). In fact, therapy can take place without even tackling the delusions and hallucinations when other issues are problematic.

Therapeutic Strategies

The key treatment components in treating delusions and hallucinations is to make them less threatening by altering the meanings associated with them. In delusions, a gentle, collaborative Socratic style is used to weaken the delusional belief. In hallucinations, the goal is for patients to realize voices are self-generated and reflect personal concerns.

Establishing a relationship with the severely mentally ill patient is often the first step in treatment. Patients are often mistrustful, suspicious, and paranoid, which

creates difficulties in therapy. The trainee should work toward establishing trust. This can be gained by listening to the patient with a nonjudgmental, open mind. The cognitive model makes this easy because the empirical model allows for the patient's hypothesis to be tested rather than disputed. Instead of telling the patient what he is saying is not valid, a more curious and questioning approach is taken. The patient's own explanations of what is happening to him are elicited, and a problem list that goes beyond the psychotic processes is established.

Often focusing on problems exacerbated by the patient's illness—estrangement, withdrawal, anxiety, hopelessness, depression, suicidal ideation, or passivity—can help in establishing trust and lay the groundwork for future work on the positive symptoms of psychosis. Standard cognitive behavioral principles and practice allow the patient to play a role in reducing her own distress while learning that the therapist is an ally she can count on.

Delusions Common misperceptions of delusions are that they are associated with deficits in reasoning, are not amenable to reason, are absolute, and are qualitatively different from nondelusional beliefs (Kingdon & Turkington, 1994). However, it is now known that patients with delusions use less information and more likely jump to conclusions. They also are less likely to have alternative beliefs available or look for confirmatory data. The cognitive model of delusions is that a patient faces an anomalous experience or activating event that leads to the activation of a belief delusion resulting in affective, behavioral, and physiological consequences (Beck et al., 2011). For example, a person waiting in line at a takeout counter at a restaurant hears a man place his order and believes his thoughts are being passed on to others because he himself was waiting to place an order for lunch. The patient becomes afraid and runs away without purchasing his lunch. Often paranoid patients hear a sound, and the belief that people are saying bad things about them leads them to run away from the situation or attack the perceived offender.

Techniques to address delusions use peripheral and Socratic questioning to help reality test the ideas (Beck et al., 2011). Using a gentle, non-interrogative style, the therapist begins with the patient to examine the patient's beliefs. Accept that the belief is very real to the patient and may in fact have some truth. Then take it slowly and aim for the session to be a positive experience that allows a conversation to take place. It is helpful to give context to the beliefs or make sense of an unusual or confusing circumstance. The patient who believes she works for the FBI and as a result must remain positioned on a street corner, even though the community is bothered by her presence and the police have asked her to leave, can be helped to recognize her belief may not be valid. Instead of telling her she does not really work for the FBI, the therapist can use guided Socratic questions to help the patient recognize that it is possible that this belief is not true. Example questions are "I hear the government pays well, how much money do you get paid? What kind of insurance benefits does the job provide? How does

your supervisor communicate to you and you to them? Do you get any paid vacations? What kind of retirement plan have they offered you? What job is a 24/7 schedule?" Help the patient see that the answers to these questions mean it may be possible that she doesn't actually work for the FBI and it might be okay to leave her post and pursue a real job instead.

In weakening delusional beliefs, it is important to consider the impact on self-esteem and mood. For instance, a man who believes he has a son and spends his nights knocking on strangers' doors looking for his lost child may be devastated to learn he actually has no son. Similarly, a mother who has had a miscarriage and is convinced her baby has been stolen by neighbors may grieve upon realizing she has no baby.

Hallucinations Hallucinations are not uncommon. Romme, Honig, Noorthoorn, and Escher (1992) reported large numbers of people who reported hearing voices but were not troubled by them. Stress, emotional trauma, sleep disturbance, and suggestibility can all help generate and perpetuate hallucinations. Kingdon and Turkington (1994) suggest reality testing and anxiety management training, including exposure to feared situations, as reasonable strategies when working with hallucinations.

The cognitive model can be applied to voices because it is believed the emotional and behavioral reaction to the voice is mediated by the beliefs about the voice (Beck et al., 2011). It is therefore important to elicit information about the omnipotence, malevolence, and benevolence of the voices. Understanding the voices' identity, purpose, power, and perceived consequences of obedience or disobedience is critical in reducing the patient's distress. The voices are not the problem, but rather the patient's appraisal of the voices. The distress associated with the inaccurate perceptions lead to vigilance, safety behaviors, and avoidance. For example, hallucination voices that command you to hurt another person may lead to acute distress in the patient who doesn't want to comply but fears the consequences of disobedience. The result may be a loud argument between the voice and the patient, or the patient may hurt himself or hit a wall in frustration. Similarly, a patient who hears voices that call him nasty names may disrupt neighbors, yelling at them to stop. Therapy can help the patient learn that the voices have no power. Experiments that defy the voices teach the patient that the voices lie and have no power. Experiments that activate stress like running in place, over-breathing, or mental calculations can increase the volume of the voices, while anti-anxiety tools can reduce the volume, showing the patient the voices are not the menace he thinks they are. Coping with the voices means the patient no longer feels distress when he knows the voices have no power and do not have to get in the way. Ideally, the patient learns that the voice is simply a reaction to stress that is internally generated. Cognitive behavioral therapy for hallucinations and delusions is designed to reduce stress and disability; reducing delusions and hallucinations is only a means to that end.

SUMMARY

Teaching CBT for specific disorders requires a solid cognitive-behavioral conceptualization of the identified problem. Once the problem is conceptualized through the lens of the cognitive model, the treatment strategies become clear. Linking each specific cognitive conceptualization of each psychological disorder to the patient's cognitive conceptualization allows the trainee and therapist to develop individually—tailored, disorder-specific cognitive behavioral treatment strategies.

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- **PODCAST:** Cognitive Behavioral Therapy with Families and Couples: Frank Datillio Tourette's
- **PODCAST:** Cognitive Behavioral Therapy with Tourette's Syndrome: Doug Woods

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Chapter 7

TECHNOLOGY IN CBT TRAINING AND SUPERVISION

R. Trent Codd III

There is currently an explosion of sophisticated technologies germane to the teacher of cognitive behavioral therapy. This upsurge in available technology renders a comprehensive review in this chapter unfeasible. However, a useful survey containing references to specific applications for further review, study, and implementation in training is provided. Thus, the primary purpose of this chapter is to introduce the reader to many existing tools and several of their possible applications.¹ After the review of technology, pertinent ethical and legal issues related to the use of these technologies for training and supervision are discussed. Then, general considerations when using technology for training purposes are noted and, finally, a process for staying up to date in this ever-evolving area is described.

TECHNOLOGICAL APPLICATIONS FOR SUPERVISION

Store-and-Forward Technology

Store-and-forward refers to an asynchronous approach in which prerecorded patient interactions are forwarded to a clinician who can review the material at his or her convenience. This is desirable in telehealth because it avoids the difficulties associated with coordinating the schedules of multiple persons, multiple locations, and multiple time zones. For example, a patient can have a scheduled interaction recorded at her local primary care physician's office and then have that recording forwarded to a specialist (for example, a psychiatrist) who

can review the recording when convenient (see Yellowlees et al., 2010, for an example of this procedure). Similar advantageous parallels exist in a clinical supervision context. A therapist trainee can make a recording at a regular patient appointment and then forward the recording to a supervisor for review and feedback.

There are a number of store-and-forward technologies available to the clinical supervisor. These technologies allow more than simple uploading by trainee, viewing by supervisor, and subsequent written or follow-up phone call feedback. Tegrity (www.Tegrity.com), for example, allows the trainee to upload his video and then allows the supervisor to flag specific places where he or she wishes to reinforce or correct clinician behavior. Further, this application allows the supervisor to provide detailed comments at each flagged spot, and allows the trainee to post comments or questions at specific points in the recording for the supervisor. Supervisor and trainee can enhance efficiency by “clicking” on any comments noted on the timeline and then be taken instantly to the relevant point in the recording. An additional useful feature is the ability to upload supporting files such as PDFs of research articles. If group supervision is occurring, multiple supervisees can use these same functions. For example, each may bookmark and comment on a fellow supervisee’s recording. Finally, it is also possible for supervisor or supervisees to speed up or slow down playback when needed. An example program of this kind is Teachscape (www.teachscape.com/video/captureoptions/overview). However, there are many good store-and-forward strategies, and the reader is encouraged to pursue a comprehensive review of them all.

Synchronous Solutions

Live, or “synchronous,” supervision may be facilitated by the use of technology, either alone or in conjunction with asynchronous approaches. The advantages of synchronous supervision include the ability to provide immediate feedback and, depending on the model, to shape the course of the therapeutic interaction being supervised. One software application that may be used for this purpose is Jabber (www.cisco.com/web/products/voice/jabber.html), which when installed on a laptop allows the supervisor to interface with the student and the patient live. This live interaction, through instant messaging (IM), voice, video, desktop sharing, and conferencing, allows the trainee to consult with multiple supervisors or consultants. It can also render the supervisor visible to the patient and facilitate co-therapy with the student if desired.

TECHNOLOGICAL APPLICATIONS FOR INSTRUCTION

The principles presented in the empirically supported instructional methods chapter (chapter 3) should be kept salient when evaluating technologies for

instructional use. For example, one should ascertain whether a program being considered would allow for the delivery of evidence-based instruction. One might ask whether the technology is capable of allowing for the programming of rapid and frequent active student responding (ASR). One should not lose the capacity to adhere to the principles of effective instruction just to employ specific technologies.

A sampling of technologies available to the trainer follows.

Student Response Systems

Student Response Systems (SRS) are audience response technologies that allow participants to interact dynamically with a trainer. These come in a number of forms. Initially SRSs were devices that were fairly intuitive and resembled TV remote controls; currently options are available on devices that trainees may already possess personally (for example, laptops, tablets, smartphones). Presenters commonly make use of this technology by embedding questions at various points, all of which are answered instantly by the participant through the SRS device. The trainer has instant access to each participant's response, which allows for the immediate provision of feedback (for example, a visual display of the mean responses given to each of four multiple-choice items in response to a question).

SRS is an advantageous adjunct for training. First, it's a form of active student responding, which, as covered in chapter 3, is a best-practice instructional intervention. Second, it may enhance trainee motivation and interest as the instruction can take on a game-like quality. Third, SRS can ensure participation, because it is immediately evident whether a participant is participating. This advantage may be of particular importance when training the nontraditional trainee where investment in training may be less robust. Finally, SRS allows real-time feedback for the trainer about trainees' knowledge acquisition. If acquisition is not optimal, the trainer can return to the unmastered material before progressing with instruction of newer material.

Companies that provide SRS technology include e-instruction (www.einstruction.com/), i-clicker (www1.iclicker.com/), and Turning Technologies (www.turningtechnologies.com/). Many other companies exist, and the reader is encouraged to survey them to find a suitable match. Finally, getkahoot.com is a great solution and requires only that the participant possess a smartphone, tablet, or personal computer.

Digital Interactive Programs

A number of programs allow a trainer to create interactive video instruction. For example, a video can be created of a CBT session in which the trainer embeds a number of choice points. The trainee can click on the various choice points and display different content. To visualize a possible application of this technology,

imagine a video showing a cognitive therapist asking a client, “What was running through your mind right before you noticed a shift in your mood?” Immediately following this question a number of choice points in the video can be offered to a trainee, such as (1) the client readily reporting his or her negative automatic thoughts, (2) the client responding with, “I don’t know; I wasn’t thinking anything,” or (3) a client who reports a large pool of negative automatic thoughts. The trainee can then select one of these responses and observe video of the therapist responding accordingly. Such a range of responses allows the trainee to learn to manage a wide variety of patient issues and difficulties. Many of the tools that allow this are free. Some options for the reader to explore include RAPT Media (www.raptmedia.com/), TouchCast (www.touchcast.com/), Zaption (www.zaption.com/), and GuidedVideo (<http://guidedvideo.com/>). Digital interactive programs may also allow you to collect data, so determine whether data collection is important to your training effort.

Remote Training Delivery

Delivering training remotely is increasingly important because it allows for the dissemination of CBT to more trainees—especially those who reside in rural areas and for those for whom travel and lodging costs related to attending training are barriers.

Remote training delivery methods vary in what they allow the trainer to do. For example, Office Mix (<https://mix.office.com/Gallery>) and Articulate (www.articulate.com/) allow one to create interactive online instruction. Other options include Podcasting, Web conferencing, and platforms for delivering lectures online.

Podcasting Podcasting is a useful method of delivering information to trainees. One good example is a podcast maintained by the author, R. Trent Codd III: www.CBTRadio.org. In this podcast leaders in the field of CBT are interviewed about timely topics and new research. Listeners may retrieve episodes by visiting the previously listed URL or by subscribing within iTunes.² Listeners may download episodes for listening at convenient times. Continuing education credit is also available for listening to these episodes. Listeners may earn credit by simply following a link where they are presented with questions about the content of the episode, and if their answers meet a specified criterion they can immediately print out a certificate of completion.

Web Conferencing Solutions Web conferencing solutions allow for the delivery of live training events, a distinct advantage. Such training can include delivering live lectures to passive or mostly passive recipients, or it can be highly interactive. The types of interactions possible vary as a function of the technology. Some of the more well-known solutions are WebEx (www.webex.com), Adobe

Connect (www.adobe.com/products/adobeconnect.html), and GoToMeeting (www.gotomeeting.com).

Online Asynchronous Lectures Lectures may be recorded and delivered asynchronously through various online platforms. An example of such delivery can be found at www.BehaviorTherapist.org and is a service provided by R. Trent Codd III, the author of this chapter and second author of this volume. Video and audio lectures are prerecorded and synced with PowerPoint slides that parallel the lecture content. Trainees may access this material at their convenience and may complete the material over a number of self-paced sessions. At completion of the lecture, they may immediately take an exam, and if they meet a specified criterion can immediately generate a certificate of completion that may be submitted for continuing education purposes. Some training oversight is permitted by these platforms. For example, at the BehaviorTherapist.org site trainees are not able to access the exam until viewing of the lecture is complete. An advantage of this service is that trainees can access material from a variety of leaders in the field at their convenience and also earn continuing education credit. The disadvantage is that this service does not offer interactivity, which is highly important to the learning process.

ETHICAL AND LEGAL CONTEXTS

In the context of teaching and training, most legal and ethical issues pertain to telesupervision, but there are some concerns related to direct training events as well. In general, prior to selecting a technology for use, one should evaluate its compatibility with specific professional ethical guidelines and with its ability to satisfy the requirements of relevant legal standards.

Professional Association Guidelines

Because specific guidelines for telesupervision and training have not been developed, practitioners and researchers with interests in this area generally suggest that until such formal guidelines are developed, trainers should use the guidelines pertaining to telehealth. The American Telemedicine Association was the first to publish guidelines. Currently they have two sets of guidelines (www.americantelemed.org/members/ata-member-groups/special-interest-groups/telemental-health#.U9pvG_ldV8F) that might guide decision making for supervision, one pertaining to online video and the other to traditional telehealth. Some of the primary concerns addressed in these guidelines pertain to licensing requirements across state lines, familiarity with local crisis management strategies and resources (that is, local to the patient and supervisee, but not necessarily the supervisor), as well as which technology is used and whether it maintains HIPAA (Health Insurance Portability and Accountability Act) compliance.

The American Psychological Association (APA) has a set of published guidelines regarding the provision of services via telehealth (www.apadivisions.org/division-31/news-events/blog/health-care/standards-telehealth.pdf). The APA Committee on Accreditation has a rule that *no more than half of the supervision hours of doctoral students or interns can occur by video*, which, unfortunately, significantly limits the supervision of rural students from a distance (for more information, see www.apa.org/ed/accreditation/about/policies/implementing-regs.pdf). The current ACGME (Accreditation Council for Graduate Medical Education) (www.acgme.org) requirements for psychiatry resident supervision also specify that all supervision must be conducted in person. The National Board for Certified Counselors (NBCC) established policies with the publication of *Standards for the Ethical Practice of Web Counseling* in 1997, with their most current version *The NBCC Policy Regarding the Provision of Distance Professional Services* (www.nbcc.org/Assets/Ethics/NBCCPolicyRegardingPracticeofDistanceCounselingBoard.pdf). The National Association of Social Workers and Association of Social Work Boards similarly developed guidelines for social workers in 2005 that are detailed in *NASW & ASWB Standards for Technology and Social Work Practice* (www.socialworkers.org/practice/standards/NASWTechnologyStandards.pdf). Finally, a number of psychiatry-specific resources are available, including American Psychiatric Association–compiled guidelines and resources (www.psychiatry.org/practice/professional-interests/underserved-communities/telepsychiatry-internet-resources) and resources available through the American Association for Technology in Psychiatry (www.techpsych.org).

Trainers and supervisors should become familiar with specific disciplines' guidelines; if their discipline has not yet published guidelines, become familiar with a “neighboring” profession's guidelines. Some state licensing boards maintain requirements pertinent to telehealth, so the reader is advised to consult with relevant state licensing boards.

Relevant Law

Legal matters are important to consider when selecting and using technology for training and supervision purposes. Legal considerations involving HIPPA, the HITECH (Health Information Technology for Economic and Clinical Health) Act of 2011, and the destruction of multimedia are discussed next.

HIPPA Beyond the aforementioned guidelines there are a number of additional considerations in evaluating technology for training and supervision. The first consideration pertains to legal standards (for example, HIPPA). Many computer programs have strong security and privacy elements, but may not be HIPPA compliant. A good example of a program that fits this scenario is Skype, which could be utilized for telesupervision. Although the number of practitioners using Skype for supervision purposes is unknown, it likely enjoys some popularity for this

purpose, because it's free, easy to navigate, and professionals and trainees alike are likely to have used it personally. However, at the time of this writing Skype is not considered HIPPA compliant despite the reasonable privacy and security measures they have in place. Most programs that are HIPPA compliant clearly state this on their websites (Skype does not) and must be willing to sign a business associate contract, which Skype also does not offer. Thus, Skype should not be used for telesupervision or for direct service. Fortunately, alternatives to Skype that are HIPPA compliant are available, such as VSee (www.vsee.com). The supervisor or trainer should conduct a thorough review of existing technology in relation to training goals and the technology's compliance with ethical and legal requirements. It is recommended that they use the telemental health therapy comparisons site in their review process: www.telementalhealthcomparisons.com/.

Two programs are worth mentioning specifically with respect to HIPPA because of their general popularity: FaceTime and ooVoo.com. Currently, FaceTime is considered HIPPA compliant if certain settings are selected. If a trainer or supervisor intends to utilize FaceTime, she or he should investigate the specific steps required to achieve HIPPA compliance with this program. ooVoo.com, in contrast, is not HIPPA compliant. In fact, they specifically state "We do not satisfy HIPPA requirements. Currently we don't have any plans to encrypt the audio and video since the encryption would increase the required CPU usage" (<http://support.ooVoo.com/ics/support/KBResult.asp?searchFor=HIPPA&button=&task=knowledge&basicSearch=1>). Thus, ooVoo should be avoided for telesupervision purposes.

HITECH Act of 2011 In addition and closely related to HIPPA, technology used for telesupervision should also be compliant with the HITECH Act of 2011. The Health Information Technology for Economic and Clinical Health Act (HITECH) is part of the American Recovery and Reinvestment Act (ARRA) of 2009 and interacts with HIPPA in a number of ways relevant to this discussion. The three most relevant interactions involve enforcement, breach, and business associates.

First, enforcement of HIPPA has been relatively lacking historically, which many have found troubling. Thus a major thrust of the HITECH Act is to increase enforcement and penalties for noncompliance with HIPPA. HITECH specifies a number of breach notification requirements and tightened restrictions pertaining to business associates. Under HIPPA, providers were required to have contractual arrangements with business associates. However, many providers did not make such contractual arrangements or maintained contractual arrangements that were insufficient (more common with smaller providers). Under the HITECH Act, business associates are automatically responsible for compliance with HIPPA and are themselves susceptible to criminal and civil penalties for noncompliance. The HITECH Act provides a particular emphasis on privacy and security, with a large

emphasis on enforcement. HITECH directly regulates business associates and specifies that the HIPPA privacy and security rules apply to them.

Destruction of Multimedia Multimedia files containing personal health information must be destroyed after their use. This should be accomplished by both the trainer/supervisor and trainee/supervisee. Supervisors should instruct trainee/supervisees how to accomplish this. Because destroying such information involves more than simply clicking “delete,” supervisees may unintentionally maintain such files.

The Academy of Cognitive Therapy’s procedure for how to delete confidential files is provided in the online resources. See www.wiley.com/go/sudak: *Appendix V, Confidential File Deletion Protocol* for a PowerPoint walk-through for Mac and PC users.

Section Summary

Although not a comprehensive review of relevant legal and ethical issues, the preceding should raise awareness of key regulations that may be pertinent to training activities when utilizing technology. It is essential that the trainer/supervisor investigate regulations fully and fully comprehend how to avoid breaches of confidentiality when providing technology-assisted training and supervision.

OTHER CONSIDERATIONS WHEN SELECTING TECHNOLOGY

Three additional factors, two non-legal and one legal, are also important to consider when evaluating technology for training and supervision purposes. These are transmission quality, technological reliability, and informed consent for the trainee or supervisee. These factors are discussed next.

Transmission Quality

The quality of audio and video transmission varies widely as a function of program, hardware, Internet speed, and other factors. Video quality is relevant if the trainer or supervisor wants to discriminate facial and other bodily cues on the part of the trainee or supervisee and patient. Relatedly, attention should be given to the lighting on both sides of the transmission to enable enhanced contact between participants. Audio quality is critically important; vocal variety discriminations and hearing clearly is a must. A common experience with audio is distortion or delay, which can frustrate everyone. It is helpful to have a written guide and discuss the procedure to follow with supervisees or trainees when these problems occur.

Technological Reliability

Trainers should ascertain whether the technology can be relied upon to perform as designed during training and supervision events as much as possible. Trainee and supervisee learning and motivation may be adversely affected by unstable technology. In worst-case scenarios trainees or supervisees may discontinue participation in these learning experiences if confronted with significant reliability difficulties. When considering reliability one should also take into account the likely technology available to the typical trainee or supervisee.

Informed Consent for Trainee or Supervisee

The trainee or supervisee should receive a valid informed consent regarding the technology proposed for delivery. The primary areas to be reviewed include the advantages and disadvantages of receiving education via the proposed technology as well as risks associated with confidentiality or security.

ADDITIONAL FACTORS

Stay Current

Trainers must be competent in the technologies they use and must stay current with updates to those technologies as well as to ethical or legal requirements. Such issues change with some regularity and should be monitored routinely. Suggestions for maintaining up-to-date knowledge are provided next.

Conduct Pretraining Practice Sessions When feasible it's ideal to have one or more practice sessions with trainees or supervisees prior to the training or supervision event. This allows for any difficulty with technology to be addressed and to reduce stress and anxiety for both parties.

Provide Reference Material Provide simple, step-by-step instructions that detail how a trainee or supervisee is to connect, disconnect, upload files (when appropriate), and perform any other required tasks. This will greatly reduce technical difficulties during scheduled events. It can also be useful to construct a simple and brief video tutorial for students. Trainees should be able to focus all of their attention on the training—not the technology.

Have a Backup Plan Despite your best efforts, technical difficulties will occasionally occur during training events. Some examples include participants being unable to join a training event, participants joining a training event but having only audio or video when both should be available, or the experience of an unstable program. One should be prepared for this by having an alternative method of communication and, potentially, training delivery available. For

example, obtain a phone number that the trainer or supervisor can use to contact students prior to the event and have it on hand. Or, if the event is to occur via a video-conferencing program and the audio fails, have a conference line available so that everyone may use this option for the audio portions of the training event. The type of necessary contingency plan will vary with the type of technology used as well as the type of training event.

How to Stay Current

Technology advances rapidly and it is a challenge for anyone to stay current. To remain competitive and effective, the trainer or supervisor must make staying current a priority. Here are some suggestions to facilitate this:

1. *Schedule a regular time dedicated to staying current.* Schedule a weekly time as you would any other appointment. Otherwise it's all too easy to let competing priorities interfere.
2. *Use news aggregation tools.* These are tools that help build content that is customized to your interests. Because so much information pertaining to technology exists, such tools can really reduce your time burden and weed out the noise. Here are some examples that we recommend (although this is certainly not a comprehensive list):
 - a. Zite (www.zite.com/). Zite learns what you like to read and searches the Web more effectively for information that specifically relates to your interests over time. It can learn to provide you with information on educational training technology and thus make you more efficient.
 - b. Google Alerts (www.google.com/alerts). Google Alerts allow you to enter key words of interest and sends you an email alert every time Google finds new information related to your key terms. Google searches the Web fairly comprehensively.
 - c. Feedly (<http://feedly.com/#discover>). Feedly compiles customized news feeds for your review.
3. *Read blogs that provide current information.* Many bloggers do the hard work of staying current for you, which is a genuine advantage, but with one caveat: Don't subscribe or frequent too many blogs to prevent feeling overwhelmed and decrease your efforts to stay current. The best strategy is to choose one to three blogs to read daily. News aggregation tools may assist you in finding the most useful blogs for your review.
4. *Engage in behavioral practice with these technologies.* Reading about technology is important but, ultimately, you must employ it in order to integrate it into how you train (recall the importance of ASR from chapter 3). There are a few ways to employ new technologies. First, make use of the free demo periods that many services allow. Second, present at a conference about a particular technology. There's no better way to learn a technology than to have to teach it to others, especially when your teaching involves

demonstrations. Third, attend conferences related to educational technology—education sessions and dealer booths are a good way to learn about and sample what's new.

5. *Don't implement technology simply for the sake of adding technology to your repertoire.* Strive to use the least invasive method of technology necessary and ensure it adds something important to your instruction or supervision, whether that's through reaching populations that would not otherwise have access or increasing engagement and motivation.

SUMMARY

There are many technological applications that can serve the CBT trainer and supervisor well. The effective trainer or supervisor should remain current about technological developments and should readily incorporate these tools to help them meet training objectives effectively and efficiently. An essential is to stay abreast of legal and ethical issues as they pertain to the use of technology.

LEARNING EXERCISES

- Implement items 1 and 2 under “How to Stay Current.”
- Choose a category of technology pertinent to your training and/or provision of supervision goals. Identify three technological solutions within that category to research. Create a Word document specific to each solution that includes the following: (1) cost, (2) hardware and other technical requirements, (3) what sort of technical support is available, (4) whether it's HIPPA compliant, (5) the ways it may assist you with your training goals, and (6) any drawbacks with its use in relation to your goals.
- Obtain your professional association's guidelines (if any) regarding the use of technology in training and supervision. Contact your licensing board for the requirements (if any) on the use of technology for the same purposes.

NOTES

1. Specific products are discussed because this serves as a useful vehicle for instruction. However, we are not endorsing any of these products nor do we maintain any commercial interests in them. The selection of products for discussion is based on their utility in illustrating features. Nothing else should be inferred from their inclusion.
2. Open iTunes → click “store” → click “podcasts” → enter search term “CBTWNC,” and all episodes will appear.

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Chapter 8

GRADUATE TRAINING

Robert Reiser and Derek L. Milne

In this chapter we review current recommendations and evidence-based practices in graduate training in cognitive behavioral therapy (CBT) and present a model CBT training program that incorporates a competency-based approach that adheres to these best practices. Rather than attempting a comprehensive theoretical review, we adopt the selective stance of experienced trainers (for example, see Milne, 1986), highlighting what we perceive to be the best available practices, and detailing some of their most promising educational applications. But unlike most existing reviews of CBT training, we draw on the wider training literature (Arthur, Bennett, Edens, & Bell, 2003; Goldstein & Ford, 2001; Kirschner, Sweller, & Clark, 2006; Mayer, 2008) to better comprehend the requirements of an effective approach.

The goal is to provide an evidence-based blueprint for designing a practical CBT syllabus that can be adapted to a number of academic environments, but with a focus on graduate-level academic instruction (pre-qualification university degree programs, at the undergraduate and graduate levels, designed to prepare mental health practitioners for independent practice).

Although there are well-established descriptions of the content of such training (for example, BABCP, 2010; IAPT, 2008; Klepac et al., 2012), the problem of operationalizing best practices in teaching and training this content in CBT has been a limiting factor in dissemination efforts. Therefore, this chapter primarily addresses the first two tasks of curriculum design (Prideaux, 2003): specifying the most appropriate instructional content, and relating this to the most effective teaching and training strategies.

PROBLEMS WITH GRADUATE TRAINING IN CBT

Graduate-level training has been viewed as a critical pathway toward developing the full competencies for delivering CBT. However, in a comprehensive national survey of psychotherapy training, Weissman et al. (2006) concluded that although most programs offer electives in evidence-based treatments (including CBT), few actually require a combination of both teaching (didactic instruction, especially lectures, intended to improve reasoning) and training (experiential learning, especially clinical supervision, intended to improve behavioral competencies). The survey also noted a possible explanation: accreditation guidelines (The Committee on Accreditation [COA] of the American Psychological Association, APA, 2006b) permitted individual programs to determine their own philosophy of training and to ignore evidence-based treatment approaches that were inconsistent with their model.

Another possible explanation is that we lack adequate descriptions of evidence-based instruction. In their summary of clinical training within research trials that have demonstrated CBT's effectiveness, Roth, Pilling, and Turner (2010) concluded that such training has yet to be carefully defined, operationalized, and standardized within clinical protocols. In grappling with these problems, our basic question becomes: What is the optimal evidence-based combination of teaching and training when providing CBT instruction for graduate students? In developing our answer we first consider expert consensus, then review research. This leads us to consider the role of competencies, leading into our blueprint illustration.

Expert Consensus about Teaching CBT

One of the challenges facing undergraduate and graduate educators is determining how best to integrate effective teaching and training methods with the required content. While there are a diversity of CBT syllabi, for example through the Association of Behavioral and Cognitive Therapies (ABCT) website: www.abct.org/Resources/?m=mResources&fa=Syllabi, most material is a summary of lectures and required reading, with little attention to the optimal methods of teaching and training. Similarly, although the Klepac et al. (2012) task force guidelines on CBT training in doctoral psychology programs are quite prescriptive in terms of content, they do not specify integration with the methods of training (for example, how best to combine didactic and procedural knowledge). In particular, the role of supervision, training, and practice experience is poorly defined and minimally operationalized. For example, although strategies for the development of clinical competence are broadly outlined: "Training in (CBT) requires theoretically consistent and practice informed face-to-face supervised clinical experiences. Other supervisory modalities may be used as appropriate including modeling, role playing, co-therapy, bug in the ear/eye, and video/audio review/feedback" (Klepac et al., p. 695). Short shrift is given to discussing instruction utilizing evidence-based teaching and training strategies. By contrast,

Ducheny (2009) discussed the importance of integration of classroom and practicum activities within academic programs, “To catalyze student learning and achievement, clinical training activities should be carefully interwoven with classroom didactics . . . on a conceptual and a logistic level” (p. 216). A major, systematically derived expert consensus reached similar conclusions, adding an emphasis on competencies and transfer (Kaslow et al., 2004). This integration is consistent with curriculum design, which recognizes the need to utilize a range of educational methods together with procedural learning in practice settings (Prideaux, 2003). The functions of such a design are fundamentally to develop problem-solving capability through education (Fraser & Greenhalgh, 2001), and procedural competence through training (Milne, 2009: see especially Table 5.1). A particularly helpful illustration can be found within the *Improving Access to Psychological Therapies (IAPT) Implementation Plan: Curriculum for High-Intensity Therapies Workers* (IAPT, 2008). This plan is quite prescriptive in its teaching and training methods, recommending the use of experiential, skills-based workshops, including small-group exercises, role plays and other behavioral methods, workplace supervision to practice skills, and the use of self-directed study including observing videos and a case-focused learning strategy. In a related example, the British Association for Behavioural and Cognitive Psychotherapies (BABCP) course accreditation guidelines (BABCP, 2010) suggest that at least 50 percent of training programs be devoted to skills training, with a strong emphasis on ongoing clinical practice: “Trainees are expected to have worked with a minimum of eight clients from assessment to completion or termination of treatment during the period of training before a therapist is regarded as having completed their training” (p. 8). These UK approaches (BABCP, 2010; IAPT, 2008) explicitly and systematically integrate skills-based training in the clinic alongside didactic classroom-based teaching, something that has not yet been fully applied within US graduate training, where there is often a wide divide between classroom experiences and clinical practicum.

Recent reviews of training support this blend of experiential methods, indicating that the most effective methods of developing clinicians competent to practice CBT involve a combination of didactic presentations (traditional lectures, class discussions) and more interactive methods, involving role play, coaching, feedback, practice, and ongoing reflection (Mayer, 2008; McHugh & Barlow, 2010; Rakovshik & McManus, 2010; Reiser 2014; Reiser & Milne, 2012). A nicely reflexive aspect is the use of CBT principles and techniques within CBT teaching, as practiced by Beck (for example, using Socratic dialogue to encourage workshop participants to discover theoretical concepts: Padesky, 1996). A major meta-analytic review indicates that training that utilizes such a blend of methods yields a medium to large effect size (that is, 0.60–0.63: Arthur et al., 2003).

Taken together, these reviews echo the ancient Chinese proverb: “I hear and I forget; I see and I remember; I do and I understand.” Additionally, effective instruction provides direct guidance to the novice learner (Kirschner et al., 2006).

These reviews build on a somewhat more recent foundation in CBT training, one that goes back in our own experience to comparisons between “active” (experiential) and “passive” (didactic) methods (Milne, 1982).

Research Findings: Which Methods of Classroom Teaching Are Most Effective?

In a controlled comparison between traditional teaching and more experiential methods, we found that educational role play, video-presented modeling, and lectures were significantly more effective than lectures, discussion, reading, and demonstrations, when measured by a knowledge quiz and a simulated proficiency instrument. Several additional comparative evaluations have substantiated the superiority of experiential methods in the acquisition of clinical competence and particularly in the transfer of training to routine CBT implementation (for example, Milne, 1984; Milne, Baker, Blackburn, James, & Reichelt, 1999; Milne, Westerman, & Hanner, 2002). But perhaps our most original contribution was the development of an instrument for measuring evidence-based teaching and training methods, called “Teachers’ PETS” (Process Evaluation of Training and Supervision: Milne, James, Keegan, & Dudley, 2002). This instrument represents a detailed operationalization of effective teaching and training while also affording a device for assessing and developing teaching and training. To illustrate, just as CBT may not always be delivered with fidelity to the model (Waller, 2009), so this PETS study showed that a “training workshop” was dominated by didactic methods (observed on more than 90 percent of sampled occasions) and hence was not sufficiently experiential to merit this label. However, with some experiential training of the trainer, the workshop became suitably experiential (including corrective feedback, goal setting, and modeling). Teachers’ PETS was sensitive enough to detect these different instructional profiles, so is a promising way to reflect on one’s instruction (see Learning Exercise at end of this chapter). Table 8.1 summarizes Teachers’ PETS.

Unlike workshops, many of the traditions of graduate teaching are designed to educate for capability, including such methods as lectures, discussions, presentations, seminars, tutorials, debates, and research assignments. They are intended to cultivate reflection, reasoning, and problem-solving ability: the “powers of the mind.” Being quintessentially theoretical, such didactic methods naturally have limited practical use. To develop competence, we need to supplement this symbolic mode with methods that utilize the enactive and iconic modes of experiential learning (Kolb, 1984), such as the “structured learning format” (Bouchard, Wright, Mathieu, Bergeron, & Toupin, 1980). Such methods require the student to act on material (for example, educational role play: enactive learning) and to integrate visual representations of that material (for example, video demonstrations of competent practice: iconic learning). Since the 1980s, a succession of studies have demonstrated that teaching that utilizes workshop

Table 8.1 Teachers' PETS: An Instrument for Measuring CBT Teaching and Training

Teacher/Trainer Behaviors	
1. Listening/Observing	Active nonverbal attention to the learners' speech and behavior (silent listening).
2. Supporting	Nonspecific reassuring, agreeing, and encouraging; collaborating; empathy, warmth, and genuineness; motivating; rewarding.
3. Questioning	Closed, gathering specific information (yes/no answer); open, requesting unrestricted information. Socratic—leading questions that highlight and draw out knowledge from the learner (for example, heightening awareness, recognizing links).
4. Formulating	Interpreting, defining, and making sense; exploring or offering an understanding.
5. Managing	Structuring; establishing order (introducing topic or creating task); making decisions and goal setting.
6. Informing	Providing abstract (public, not personal data) to learner; information transmission (facts and figures, theories and ideas, methods); didactic approach.
7. Guiding Experiential Learning	Leading practical learning activities in which the learner actively develops competence (demonstrating correct performance); observing model (video/audio recording or live); simulations (role play, learning exercise); behavioral rehearsal; learning tasks (diaries, charts, forms).
8. Self-Disclosing	Teacher refers to self in order to reveal something new about self.
9. Challenging	Creating optimal anxiety, uncertainty or perplexity; destabilizing learner's constructs.
10. Disagreeing	Nonspecific verbal or nonverbal direct negative reaction to learner's opinion or grasp of facts (shaking head).
11. Evaluating	Monitoring or checking competence.
12. Feeding Back	Giving negative or positive, verbal or written information that is intended to weaken or strengthen specific aspects of the learner's behavior, thoughts, or feelings.
13. Other	Cannot decide on suitable category from above; not observable; other behaviors (social chat, paperwork).
Student/Trainee Behaviors (Experiential Learning)	
14. Experiencing	Involved and engaged in task (tears, smiling, laughter). Expressing an emotion or an attitude.
15. Reflecting	Considering own perspective (describing, recalling, clarifying, "story telling").

(continued)

Table 8.1 (Continued)

16. Conceptualizing	Assimilating/accommodating/integrating public information (for example, research findings, theories).
17. Planning	Making decisions, setting goals (homework task).
18. Experimenting	Engaging in action (role-play exercise).
19. Other	Cannot decide on suitable category from above; not observable; other behaviors (social chat, paperwork).

Note: This is a reduced version of PETS; all tables are similarly reduced for space reasons. Full copies can be obtained from the authors.

Source: Milne, James, Keegan, & Dudley (2002). *Teachers' PETS. Clinical Psychology & Psychotherapy*. Copyright © 2002 John Wiley & Sons, Ltd. Reproduced with permission.

formats and that combines presentations and the other symbolic methods with suitable forms of experiential learning (iconic and enactive) foster the acquisition of competence within the classroom context as well as fostering transfer to workplace environments (McHugh & Barlow, 2010; Rakovshik & McManus, 2010; Reiser & Milne, 2013). Transfer is further fostered through regular supervision, coaching, and reflective practice (Sholomskas et al., 2005).

To illustrate, drawing on Kolb (1984) and subsequent research, Bennett-Levy (2006) has described and researched an accessible model involving didactic, procedural, and reflective learning, each acquired using different instructional methods. According to this model, only didactic knowledge is typically acquired through lecture and large-group presentation; procedural knowledge develops based on more active experiential learning, including direct experience with clients during clinical practicum experience and through modeling, behavioral rehearsal, and educational role play within the classroom. Reflective learning is an active, iterative process that requires students to process their learning experiences. Studies that have examined training (Rakovshik & McManus, 2010) suggest that explanatory models of adult learning as set forth by Kolb (1984) account for the types of training that are successful in the development of competence, including reflection: "The model encompasses a process in which an individual maximizes the learning opportunities of an experience by taking time to consider it and integrate it with previous knowledge so that new conclusions are drawn (the processes of observation and reflection). Then plans are made to apply conclusions to a new situation. Consequently, new experience becomes the initial stage of a new cycle and the process of learning continues" (p. 512).

A research illustration from the work of Bennett-Levy, Lee, Travers, Pohlman, and Mamernik (2003) is the use of "self-practice/self-reflection" (SP/SR), a method whereby clinicians observe their own practice, enabled by guided imagery, role plays, and group processes. In this study, one group of CBT

practitioners applies CBT to itself and a second engage in co-therapy. Reflective diaries indicated that the SP/SR method improved reflective and clinical skills, but that both of these experiential learning methods resulted in comparable self-reported benefits, for example, more refined and flexible use of CBT. In a subsequent survey, Bennett-Levy, McManus, Westling, and Fennell (2009) considered 120 clinicians' perceptions of the relative effectiveness of these different methods. Consistent with the foregoing, they found that didactic methods were judged best for acquiring declarative knowledge (for example, understanding concepts), whereas procedural knowledge developed best from experiential methods, including behavioral practice, role plays, and modeling.

This convergence of perspectives strengthens confidence in our understanding and facilitates implementation. It also helps us to progress from the traditionally dichotomous approaches, encouraging us to develop a more integrated approach to didactic and procedural knowledge, even in the classroom. In practice, this means that students should find it easier to apply their didactic knowledge procedurally, within case-focused, clinically oriented practicum training experience. In our own work, we have addressed this disparity between traditional classroom teaching methods and effective training through an integrated syllabus, one that combines didactic instruction and procedural training and that is intended to blend active experiential methods (role play, coaching, and feedback) and exercises in self-reflection (via interactive discussion and reflective homework exercises) with other mainly didactic instructional methods. We summarize this integrated approach in "Curriculum Design: Integrating a Competency-Based Approach within Graduate Education in CBT" found at www.wiley.com/go/sudak: *Appendix IV, Sample Syllabi, Course Modules, and Training Design Sample*. This example also includes assessment and evaluation arrangements, critical elements within such planning (Prideaux, 2003). Note that these, too, represent a blend of complementary approaches.

Integrating a Competency-Based Approach within Graduate Education in CBT

A competency-based approach toward CBT training has developed rapidly over the past several years, as initially illustrated in the Roth and Pilling (2007) CBT competency framework and utilized broadly in the IAPT training program (IAPT, 2008). This latter document identifies a competency-based model for training CBT therapists to provide "high-intensity" clinical services, including specific course content, a well-developed learning and teaching strategy, and learning assessment approach. This competency-based framework has not yet been fully integrated or operationalized within graduate and doctoral-level training programs in the United States, despite a decade of recommendations on a competency-based education model (APA Taskforce Report, 2006a; Kaslow et al., 2004), the development of competency-based assessment toolkits (Kaslow et al., 2009), and

competency-based benchmarks (Fouad et al., 2009). In a review of several national dissemination and training efforts, McHugh and Barlow (2010) noted that “evaluation of the success of efforts to train clinicians will need to rely on clear definitions of the didactic knowledge and competence benchmarks required for completion of training” (p. 74).

A Blueprint for Graduate Training in CBT

We now illustrate the integration of a competency-based approach into graduate training in CBT by utilizing the Roth and Pilling (2007) competency framework, and by tying classroom activities closely to the evidence-based methods for competency development outlined earlier. You may also want to refer to chapter 2 in this volume, “Core Competencies in Cognitive Behavioral Therapy Training,” for further discussion of competency-based training. Also see www.wiley.com/go/sudak: *Appendix IV, Sample Syllabi, Course Modules, and Training Design Sample*, where you’ll find Sample Syllabus: Outline of Competency-Based Skills, again focusing on an introduction to CBT. It can be seen that the competency framework is specified in the first column, and is in the form of learning outcomes (the intended effects of the instruction), consistent with good educational practice, and with CBT. We also draw your attention to the distinctions made between declarative and procedural parts of this syllabus, and to the inclusion of a section concerned with “professional and ethical attitudes.” This duly reflects a rounded view of competence as embodying thoughts, behaviors, and feelings, and is again consistent with CBT.

Completing our illustration, we provide three sample course modules as part of a course outline (www.wiley.com/go/sudak: *Appendix IV, Sample Syllabi, Course Modules, and Training Design Sample*):

- Module I: Key Elements in CBT
- Module II: Ability to Structure Sessions
- Module III: Use of Guided Discovery/Socratic Questioning

This adds specific details concerning the application of instructional methods within a three-hour class, but is again linked explicitly to the same list of CBT competencies. Such detail enables teachers to utilize fully the blend of instructional methods, helped by the provision of materials (for example, videos, handouts). As such, the module outline equates to the therapy manual in clinical research and to clinical guidelines, similarly fostering high fidelity to the intended methods. You may also wish to refer to *Appendix I, Recommended Readings and A/V Resources* (www.wiley.com/go/sudak) for recommended readings for applications of CBT to various psychiatric disorders and Audio-Visual Resources for CBT Training and Supervision. Also see chapter 6 in this volume, “Teaching CBT for Specific Disorders.”

SUMMARY

We set out to address the question: “What is the optimal combination of teaching and training when providing CBT instruction to graduate students?” Reviewing expert consensus, research findings, and CBT competency statements suggested that a blend of multimedia instructional methods was optimal (Mayer, 2008). These teaching methods should combine didactic and experiential approaches as appropriate to the syllabus and its learning outcomes, but with the goal of consistently aiming to stimulate all learning modes (reflection, conceptualization, and so on, as per Table 8.1). Beyond such initial learning in the classroom we should anticipate and address challenges in transferring competencies to the clinic (Milne et al., 2002; Reiser & Milne, 2013). Additionally, CBT trainers need to consider the balance between competence and capability, as the half-life of competence is all too brief and the need for strategic (meta-cognitive) awareness and professional adaptability is great (Fraser & Greenhalgh, 2001).

LEARNING EXERCISES

- Pick a specific teaching skill to experiment with from PETS (Table 8.1), such as “questioning” or “informing.” Using your preferred approach within one of your lessons or classes, study the effect that this skill has on the students’ experiential learning (PETS items 14–19). One option would be to ask the class to give feedback on what they were thinking, perhaps ranking the impact on items 14–19. Reflect on this transaction and feedback, considering how you might achieve a more focused or enhanced effect (for example, how might you obtain a better effect on “reflecting” or “conceptualizing”, less impact on secondary impacts like “experimenting”?).
- Repeat the previous exercise, but utilize a training skill (for example, one or more methods from “guiding experiential learning”), intending to affect a specific area within the students’ experiential learning (for example, experiencing, PETS item 14). Invite the class to help you grasp what was different, and how this contrast might be enhanced (or study a tape privately, discussing your reflections with a peer).
- Observe a colleague’s workshop and use PETS as a checklist, noting as many different items as possible. What could the trainer have done to increase the number of items observed? Compare what you observed with your own approach: Is there something useful that you can incorporate within your training?

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CBT IN PSYCHIATRY RESIDENCY TRAINING

Donna M. Sudak

In 1967, Aaron T. Beck published *Cognitive Therapy and the Emotional Disorders*. Thereafter, various clinical trials established cognitive behavioral therapy (CBT) as a stand-alone treatment for major depression and anxiety, equivalent to pharmacotherapy and with superior durability. Since 1980, research has expanded the role of CBT as an adjunctive treatment for schizophrenia and bipolar disorder; as a primary treatment for bulimia nervosa, posttraumatic stress disorder, and borderline personality disorder; and as an extremely helpful adjunct in coping with many types of medical disorders. This body of work has contributed to the rationale for requiring psychiatry residents to attain competence in CBT.

This chapter reviews diverse aspects of CBT training in psychiatric residencies, describing the following:

- The history and current status of CBT training in psychiatry
- The governance of psychiatry residency training
- Specific challenges to educating residents in CBT, and
- How to plan for appropriate CBT training in psychiatry residency

This chapter specifically addresses CBT training in psychiatry residency, but there is also a need to train primary care providers to implement CBT interventions, and most of the guidelines presented here are equally applicable. Nearly half of the patients in the United States who undergo treatment for mental health disorders originally present to and are treated by primary care providers (Searight, 2009). The Patient Protection and Affordable Care Act will increase the percentage of patients who access mental health services in primary care settings. Moreover, office-based visits for mental health care for children and adolescents are rising significantly in nonpsychiatric physician practices; more psychotropic

medication visits for children and adolescents are made to nonpsychiatrists than to psychiatrists (Olson, Blanco, Wang, Laje, & Correll, 2014). Thus dissemination efforts regarding effective CBT for children and teens are critical in pediatrics and primary care training.

HISTORY OF CBT TRAINING IN PSYCHIATRIC RESIDENCIES

Although the desirability of educating psychiatric residents in CBT was described early in the development of the method (Johnson, 1972), the extent of CBT training that is included in psychiatric residencies has not matched the pace of the research supporting CBT applications. In 2001, the Accreditation Council for Graduate Medical Education (ACGME) residency review committee for psychiatry, recognizing the need for more robust psychotherapy training, mandated training in five types of psychotherapy, including CBT, to a level of “competence” (ACGME, 2001). At that time at least 25 percent of the residency programs in psychiatry in the United States reported no requirement for any CBT education, and at least 21 percent reported that no faculty were available to teach CBT (Sudak, Beck, & Gracely, 2002). Much has changed since 2001. A recent survey reported that residency programs have significantly increased didactic and supervisory requirements in CBT, although the number of hours remains far less than in psychodynamic therapy, and finding suitable patients and adequate faculty continues to be a problem (Sudak & Goldberg, 2012).

UNDERSTANDING RESIDENCY TRAINING

Individuals who are working with psychiatry residents should understand the educational and regulatory environments to most effectively plan training and to hold accurate expectations of trainees.

Accreditation

CBT educators should understand the governance and administration of psychiatry program requirements. In addition to this summary, Sudak (2009) has published a detailed review of CBT residency education. Residency requirements are established by the ACGME, a nonprofit organization founded in 1980 with a mission to standardize and ensure the quality of graduate medical education. The ACGME periodically evaluates programs regarding adherence to specific standards. Each specialty has a review committee that delineates specialty requirements. The review committee in psychiatry is composed of members nominated in equal numbers by the American Psychiatric Association, the American Medical Association, and the American Board of Psychiatry and Neurology. In 1997, the ACGME’s philosophy of educational evaluation shifted significantly to focus attention on residents’ attainment of competencies and educational milestones

rather than on programs' offerings of didactic, clinical, and supervisory programs (further information is available at www.acgme.org). Programs are required to have specific mechanisms for competency evaluation and remediation for trainees; such mechanisms, however, are currently not specified. Six general competency areas pertain to all residencies and include patient care, medical knowledge, practice-based learning, interpersonal and communication skills, systems-based practice, and professionalism. Subsumed under each of these general competencies are the requirements in specific specialties, including the current requirement for psychiatry residents to learn three types of psychotherapy (psychodynamic, cognitive behavioral, and supportive). Between 2001 and 2007, the ACGME focused on psychotherapy training during program reviews because it was concerned that many programs were eliminating quality training in psychotherapy. One result of the requirement for CBT education is that psychiatry trainees are the mental health trainees most likely to receive training and clinical supervision in any evidence-based therapy (Weissman et al., 2006). However, because residency programs are responsible for setting standards for competency and choosing measures of evaluation, enormous variability remains in the amount and quality of training experiences in psychiatry. In some programs CBT experiences are integrated throughout all four years of training; others include only brief experiences during an outpatient year. The public health benefits of training psychiatrists to perform CBT may be considerable, given the potential to improve patient outcomes (Sudak, 2009). Residencies are ideal settings to provide the training, defined patient care responsibilities, and readily available clinical supervision that may influence new therapists' future practice habits (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005).

CBT Educators Respond to the ACGME Mandate

Multiple organizations and CBT educators responded to the ACGME mandates for psychotherapy training. The American Association of Directors of Psychiatry Residency Training (AADPRT) drafted core competencies for CBT (available at www.aadprt.org) and the other mandated psychotherapies (Sudak, Beck, & Wright, 2003). The American Psychiatric Association, AADPRT, and the Association of Academic Psychiatrists (AAP) held multiple workshops by CBT educators for psychiatric residency educators and developed and tested model curricula. Extramural training programs in CBT (for example, at the Beck Institute for Cognitive Therapy and Research) were established and tailored for training directors, and the Academy of Cognitive Therapy established a website section for residency (and other) trainers.

These efforts have substantially affected the training of psychiatry residents. In 2012, Sudak and Goldberg published the results of a survey of training programs regarding psychotherapy didactic training hours, supervision hours, and mandated patient care hours in the three mandated psychotherapies (Sudak & Goldberg,

2012). Psychodynamic psychotherapy outpaced the didactic and supervision hours in CBT and supportive therapy. However, the number of supervisory hours in CBT increased more than fourfold from the 2001 survey. However, nearly 93 percent of programs responding required that each resident treat just three or fewer patients with CBT. Nearly 96 percent of programs reported that finding patients for therapy was an obstacle to adequate training. Finding faculty qualified to teach and supervise residents was also difficult. In addition, clear guidelines are still lacking for “competency” standards.

PROBLEM AREAS IN TRAINING PSYCHIATRY RESIDENTS IN CBT

Trainers and supervisors in psychiatry residency can be more effective if they understand typical problems that exist in many training programs.

No Psychotherapy Training Prior to Learning CBT

Before undertaking CBT training, residents must have training in general psychotherapy skills as prerequisites:

- Ability to relate empathically to a patient in an accurate way
- Genuine, warm relatedness
- Ability to appreciate affective shifts in a session
- Cultural sensitivity and competence
- Professionalism—including an understanding of appropriate therapeutic boundaries
- Flexibility and creativity
- Willingness to provide and elicit feedback

Frequently, psychiatric trainees have developed a sophisticated repertoire of clinical skills during a variety of training experiences teaching differential diagnosis and pharmacotherapy, but they may have had little or no formal psychotherapy training. Additionally, many psychiatric trainees have no experience in caring for ambulatory patients when they start outpatient assignments. When programs use CBT treatment manuals as an “entry point” for learning psychotherapy, faculty must first facilitate the development of basic psychotherapy skills (empathy, genuineness, rapport, and warmth), and an understanding of the professional framework (boundaries, confidentiality) that characterizes good treatment. CBT educators must be familiar with the entire resident curriculum to make certain such skills are included prior to planning CBT educational experiences. Reflective writing and self-practice can be extremely helpful in teaching beginning psychotherapy skills. An example of such practice, the “Reflective Writing Exercise” is included in *Appendix II, Forms and Tools*, at www.wiley.com/go/sudak.

Such skills may be taught in a variety of ways, for example, in an introductory psychotherapy course or via an interviewing and assessment didactic with role-play experience. If they are not taught, the CBT curriculum should begin with a module that provides some experiential skill training.

Multiple Educational Demands

ACGME requirements specify twelve months of continuous outpatient training, and most programs use this year to educate residents in every required psychotherapy modality, in addition to requiring residents to manage a caseload of patients with medications. Imagine a requirement to learn multiple therapeutic paradigms at once—practicing multiple styles of therapy and receiving supervision from a diverse group of clinicians who may disparage alternative approaches. It is, as a respected colleague once remarked, “a pedagogical nightmare.” Psychiatry residencies have historically been the “home” of psychodynamic psychotherapy training. Moreover, psychiatry residencies today are highly influenced by biological approaches to psychiatric illness (notwithstanding recent data about the biological effects of psychotherapy). These factors combine to make CBT a less well-known and less respected approach. CBT educators must advocate for the need for residents to learn each modality well and teach trainees that learning each type of therapy independently (rather than trying to “blend approaches”) facilitates learning, is less confusing for the patient, and has a much better evidence basis.

Treating Chronically Ill Patients

Residents are frequently assigned to clinics that treat patients with complicated and chronic conditions, so the learning curve in all therapeutic approaches is steeper. Thus, educators must spend time in early supervision and training discussing how to manage transferred patients and help the resident advocate for appropriate CBT patients in the outpatient setting. Residency supervisors should be competent in the use of CBT for severe and persistent mental illness so that their trainees can recognize how CBT tools can be helpful in these populations. Teach trainees that learning the “micro-skills” of therapy—setting agendas, soliciting feedback, doing mini-formulations, and identifying and setting small and relevant goals—results eventually in the ability to perform competent CBT. Finally, residents are often the decision makers regarding the type of treatment the patient will receive, and many residents may automatically assume that introspective, verbal patients with less complex needs should automatically be offered psychodynamic therapy. Early supervision should include discussions of how to “prescribe” therapy based on evidence. This may resonate with the biomedical approach that is most familiar to the resident.

Cultural Differences

Psychiatry trainees come from multiple backgrounds and cultures. In 2012, 33 percent of psychiatry trainees were international medical graduates (IMGs) (Jeste & Rao, 2012). In the recent past, a larger percentage of IMGs in psychiatry have been US citizen-students from medical schools in the Caribbean. Large numbers of psychiatry trainees emigrate from other countries. Thus, careful assessment of the cultural competence of trainees is critical. The *DSM-5* (*Diagnostic and Statistical Manual of Mental Disorders*, 5th ed.; APA, 2013) acknowledges this by including cultural formulation as a key component of the assessment and treatment of all psychiatric patients. American subcultures are often unappreciated and misunderstood by both US graduates and IMGs, so including culture in supervision and training is vital.

Behavioral and Psychological Principles Are Variably Taught in Medical School

Medical students must assimilate an enormous quantity of information in four years. They necessarily receive less instruction in behavioral and psychological principles than do graduate students in psychology. Such variable experiences in education may increase psychiatry residents' struggle to use the active approach that characterizes CBT. It is far easier to let patients take the lead when you are unsure than to actively direct treatment—actively directing treatment requires knowledge and skill. Assigning homework and undertaking prolonged exposure (or other activities that are potentially initially uncomfortable for the patient) may seem damaging to the therapeutic alliance, and may be presented to the patient with a less credible rationale without a solid knowledge of behavioral principles and learning theory. Many residents believe that if they set an agenda, patients may be offended or unable to air their concerns. Good CBT training requires uncovering these beliefs sensitively. Planned behavioral experiments may test trainee assumptions.

WATCH: Go to www.wiley.com/go/sudak: *Appendix VII, Video Library* to View Video: Problematic Trainee: CBT seems Superficial, for an example of how to manage such situations.

It is difficult to overestimate the degree of anxiety residents experience, fearing they may do something that harms the patient. Furthermore, the culture of medical education focuses on “having the right answer,” so residents are often reluctant to disclose their lack of knowledge.

WATCH: Go to www.wiley.com/go/sudak: Appendix VII, Video Library to View Video: Trainee Does Not Have Necessary Skills, for an example of how to manage such situations.

Maintaining an Active Problem-Solving Orientation in Therapy

A particularly thorny area is teaching residents to plan treatment, and to develop the active mind-set that is required to set goals for patient encounters. Much like teaching supervisors that supervision should be far more than “showing up to hear about a patient,” and instead should be an interaction with defined learning goals and objectives, teaching residents to plan therapy involves a similar change in culture. The usual “Say what comes to mind” approach to therapy must give way to an interaction that proceeds according to a plan. Teaching a problem-solving focus in therapy can be challenging. Problems may include the following:

- *Reluctance to set agendas.* Trainee beliefs may disrupt this process, such as, “Patients won’t like it,” “Patients won’t be able to let their true feelings out,” “There will be too much to work on and the patient will feel even more hopeless.”
- *Not following an agenda once set.* Residents may become sidetracked by data gathering about symptoms, medications, or medication side effects. These topics are more familiar and residents are frequently tasked with managing patients receiving combined treatment, so time management must be emphasized early.
- *Misidentifying the patient’s problems.* Residents have been taught to specify *diagnostic criteria*, not problem lists; they are likely to assert, for example, that “the patient has anhedonia” rather than “she has stopped enjoying movies and isn’t talking to friends” (Bootzin & Ruggill, 1988).
- *Not obtaining sufficient data to develop a strategy to manage the problem, or spending the entire session data gathering.* This is often a problem in early trainees. Gathering information and asking questions is often the “default mode” of anxious residents.
- *Not having confidence in their ability to help patients to solve problems.* Residents often “draw a blank” when asked how they might help a patient, but have no difficulty if asked how they might solve the same problem if it were personal.
- *Being too eager to intercede in solving a problem* for the patient rather than conceptualizing what the difficulty with problem solving represents and whether it is a skill or capability deficit; and
- *Using pharmacological interventions without considering other options,* particularly when insomnia and anxiety are present. Residents without

confidence in providing alternative psychotherapeutic approaches will reach for a prescription pad. They must learn when combined treatment approaches enhance outcomes and when they derail patient progress.

WATCH: Go to www.wiley.com/go/sudak: *Appendix VII, Video Library* to View Videos:

- Problematic Trainee: Trainee Afraid CBT Will Damage Therapeutic Alliance
- Frustration, for illustrations of how to handle these problems

PLANNING TRAINING IN CBT IN PSYCHIATRIC RESIDENCIES

Four critical elements should be included in planning residency training in CBT. These comprise didactic training, clinical supervision, patient care, and evaluation methods. This section details each of these in turn and then considers faculty development.

Didactic Training

A well-structured training program generally includes readings and lectures, but more important it must provide ample opportunity for residents to role-play and to observe experienced clinicians providing CBT (either live or recorded). Role playing is often a “hard sell” with residents, who may be anxious and reluctant to feel vulnerable. Introduce it gradually, in short segments in the classroom, and be a participant yourself to “break the ice.” Do not, however, succumb to entreaties to frequently play the therapist role for the whole class rather than engage in group role play. Residents must practice skills in class and engage in experiential learning. Role play is most useful in participant triads including the roles of patient, therapist, and observer. Participants in role play cannot monitor performance, so an observer may provide specific feedback to the role-play therapist. CBT curricula should assign residents to practice using the tools of therapy themselves (for example, actively scheduling, keeping thought records) (Bennett-Levy, Lee, Travers, Pohlman, & Hamernik, 2003). Frequently, confidentiality concerns may preclude residents from sharing completed materials in class, but the experience is invaluable. Teaching materials should include CBT approaches to the patient populations with whom the residents work; for example, if training occurs on an eating disorders unit, the didactic series should focus on the elements of CBT and treatment protocols applied to patients with eating disorders. Several sources list competencies that can serve as a guide for curriculum development (www.AADPRT.org; www.babcp.com). Chapter 2 illustrates teaching methods for CBT core competencies.

Using treatment manuals as an initial way to introduce residents to CBT has advantages and disadvantages. First, the structure of treatment and a set of standard procedures are specified; second, the manual itself articulates the model of therapy and treatment plan (Dobson & Shaw, 1988). When treatment manuals are used, however, it is critical to teach residents how to tailor treatment to an individual patient and how to conceptualize patients whose treatment is more complex.

Specific didactic topics that should be included in a didactic series (assuming that residents receive instruction in basic counseling skills independent of CBT training) are listed here:

- Introduction to CBT: research, theory, neurobiological effects of CBT
- Cognitive conceptualization: individual patient and models for at least two disorders
- Therapeutic alliance: including collaborative empiricism, using Socratic questions, monitoring affect, bidirectional feedback
- Goal setting and treatment planning
- Teaching patients the cognitive-behavioral model
- Structuring treatment within and across sessions
- Homework
- Behavioral techniques
 - Behavioral activation
 - Exposure
- Cognitive techniques
 - Thought records
 - Guided discovery
 - Rational response generation
 - Identifying and modifying core beliefs
- Relapse prevention and termination

Generally this didactic curriculum provides twelve to twenty hours of material. Such classroom time should be structured to be as experiential as possible to facilitate skill acquisition. A variety of sources exist that may provide a framework for such didactic experiences (Rector & Cassin, 2010).

Depending on the time available, the didactic experience could include review of the modifications of and indications for CBT in common disorders managed by psychiatrists, including bipolar disorder and psychosis. A unit regarding the use of CBT to enhance medication adherence has enormous value for psychiatry residents. In fact, this critical skill can be taught early in residency with a dual purpose: it will benefit patient care and may increase trainees' interest in providing CBT. An example of a didactic syllabus—Cognitive Behavioral Therapy Course—Didactic Syllabus (postgraduate year 3)—is provided in *Appendix IV, Sample Syllabi, Course Modules, and Training Design Sample* at www.wiley.com/go/sudak.

Clinical Supervision

Six to twelve months of supervised clinical experience is considered the “gold standard” for learning a form of therapy (Weissman et al., 2006). This amount of time is required for psychiatry residents and may be different from other trainee groups for several reasons. First, psychiatry trainees are required to have multiple supervisors simultaneously; generally these supervisors have different theoretical orientations. It is not considered unethical for psychiatry supervisors to comment about patients whom the resident is discussing in supervision elsewhere; for example, a resident might bring up questions about psychodynamic cases with her CBT supervisor and also ask her psychodynamic supervisor whether CBT is “appropriate” for a given patient (the video content previously viewed illustrates this problem). This can confuse residents and lengthen the process. Supervisors’ groups can discuss these learning issues and agree on ways to handle them. Many programs provide advanced-level case conferences where patients can be discussed from multiple points of view, while maintaining the understanding that it is easier to learn each therapeutic approach separately.

CBT supervisors are in short supply in residency training, so residents are frequently in group supervision for CBT and individual supervision for psychodynamic therapy. When groups are the preferred formats, it is absolutely essential for CBT supervisors to exploit the advantages of supervision in a group format and minimize the drawbacks. When supervision occurs in groups, mechanisms must ensure the review of session recordings and written case conceptualizations to make certain that individual residents can thoughtfully and competently manage patients. Because many residents are sensitive to receiving feedback in a group, feedback about performance must be delivered carefully or outside the group. Additionally, patient consent forms for recording must be modified to include information regarding the use of such recordings in group supervision if that is the preferred mode of supervision in a training program.

Additionally, the ethos of much training in medicine is “learn as you go.” In the early weeks of training in CBT, residents will likely be caring for patients before they have attended didactic lectures or participated in role-play practice. This raises anxiety and may require supervisors to provide training in certain skills before the didactic series “catches up.” Supervision will be enhanced by the following:

- Plan each supervisory session with learning objectives or goals.
- Coordinate supervision with didactic training as much as possible.
- Quickly ascertain which skills are absent and use supervision for role play and treatment planning. And
- Review at the start the goals, objectives, and methods of evaluation to be employed.

Patient Care

Patient care is a known area of concern in CBT training in psychiatry residency. Patient care issues play an important part in training in the implementation of evidence-based treatments (Beidas & Kendall, 2010). Patients cared for by residents are frequently indigent, with complex needs, and chronically ill. Residents often “compete” for new patients with other types of trainees in clinical settings and are frequently assigned patients who require medication management. Certainly, many of these patients benefit from psychotherapy, but their cases may be more complicated and they may have more chronic conditions. Here are several possible solutions for this problem:

- Consider training in CBT in a defined rotation *prior* to the outpatient year. Inpatient services where CBT is part of the treatment program (with groups led jointly by residents and staff) can be a terrific resource for training. Faculty and staff can demonstrate CBT skills with patients on such units, for example, working with patients with severe hopelessness and suicidal ideation, doing skills training, and explaining the rationale for behavioral activation. Residents can then “hit the ground running” with CBT in the outpatient year.
- Consider training CBT on specialty services, for example, in eating disorder units, which can provide a tremendous foundation in CBT principles.
- Provide close administrative supervision in the outpatient year; caseloads should be monitored and a defined number of patients specified for each therapy modality. Both the *type* of patient and *duration* of patient care should be quantified. Residents will take longer to implement CBT and must have a sufficient caseload of patients with reliable attendance. Supervision sessions must include discussion of interventions that increase treatment retention, for example, discussing patients’ reactions to transfer of care; providing early, targeted psychoeducation; educating patients about how therapy works; and troubleshooting obstacles to attendance, particularly transportation and child care.
- Help the resident to be more confident with patients, particularly early in the outpatient year, by using Socratic questions about what the resident *does* have to offer the patient. And
- Teach the use of CBT in combination with medication management. CBT and pharmacotherapy are a “natural” combination to teach in psychiatry residencies because both are empirically based and grounded in a problem-solving, symptom-relief approach to patients. Recent publications (Sudak, 2011; Wright, Sudak, Turkington, & Thase, 2010) highlight the use of CBT in combination with medication. If this is the designated forum for CBT education, careful attention must be paid to teaching residents the principles of case conceptualization, and residents must have several

opportunities to manage a case from start to finish. Integrating CBT treatment with pharmacotherapy also conveys the advantage of learning a session structure that can easily unify the two approaches. For example, setting agendas, monitoring symptoms, eliciting and giving feedback, assigning activities between sessions, and psychoeducation are common elements to both pharmacotherapy and CBT. Adherence to medication often involves prescribing self-monitoring and other behavioral approaches. Cognitions about medication, psychiatrists, or mental illness derail adherence and need to be modified.

Evaluation Methods

Resident competency must be evaluated in several different ways. First, residents' knowledge base must be assessed (with tests and/or written assignments); then patient care is observed and a rating instrument is employed to assess competence. Supervision should assess the development of clinical skills from session to session. Chapter 4 describes measures of competence that may be used as training and evaluation tools. Evaluation of patient care should occur in an ongoing manner in order to provide continuous formative feedback to the resident.

FACULTY DEVELOPMENT

One significant obstacle in developing robust CBT training is the lack of trained CBT faculty in most departments of psychiatry. Psychodynamic psychotherapy is often taught by volunteer psychiatrists on the clinical faculty of an academic department. The number of clinicians skilled in CBT is limited; many are nonpsychiatrists who (understandably) want to be compensated financially. This means a department must commit resources to provide effective training. An added benefit to psychiatry departments and residents is that having multidisciplinary educators improves the training process. The requirement that residents learn CBT should produce a larger pool of volunteer supervisors in the future. Until then, here are some ways to augment existing faculty resources (Sudak et al., 2003):

- Find and recruit available CBT practitioners in your area. Several organizations (Association for Behavioral and Cognitive Therapies [ABCT], Academy of Cognitive Therapy [ACT]) list providers by region on their websites. These lists may provide departments with available practitioners either to hire or engage as volunteers to augment existing faculty.
- Consider promoting and augmenting the advantages of a volunteer faculty position. A promotional brochure listing the benefits of faculty appointments (for example, library services, continuing education, networking opportunities) can help recruit new teachers. Meaningful evaluation, supervisor training, and support are important benefits as well. These

benefits are valuable to practitioners who work in private practice and feel isolated.

- “Trade” expertise by teaching psychopharmacology, DSM diagnosis, and so on in departments of psychology or social work that have CBT faculty available to exchange for supervision hours. And
- Form self-study groups in your department. A planned educational activity among several interested faculty members can increase the number of trained supervisors because one or two trained faculty can train other faculty members in CBT. This training might even occur in conjunction with a resident group. A “kick-off” for such training might occur with an invitation to a known CBT trainer to provide an in-department workshop. Faculty could make tapes to use in resident training and/or provide one-way mirror sessions with patients so that residents can see a course of treatment from start to finish.

SUMMARY

Training psychiatry residents in CBT imparts to them a powerful tool for patient care. Trainers and supervisors can be more effective by understanding the unique issues common in residency. Psychiatrists should be taught ways to use CBT in all aspects of clinical practice, including during medication management sessions.

LEARNING EXERCISES

- Review the resident curriculum in psychotherapy at your institution. Modify the CBT training you provide if basic therapy skills are lacking.
- Engage your supervisees in a discussion about your respective cultural backgrounds; discuss the cultural background of every patient in supervision.
- Advocate for regular meetings of the supervisors in your institution.
- Form a self-study group with one or two faculty members to augment expertise.

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Chapter 10

CONTINUING EDUCATION FOR THERAPISTS IN PRACTICE

John Ludgate

Many therapists in practice will have received some introductory instruction in CBT. Surveys (Sudak & Goldberg, 2012; Weissman et al., 2006) have shown that evidence-based therapy training, including CBT, is frequently offered in graduate training in psychology and social work and is required in psychiatry residency training. However, as noted elsewhere in this volume, such training can be of variable quality and in many instances is solely didactic and, in addition, does not include supervised patient care (described as the “gold standard” of training in evidence-based treatment).

Therapists may be eager to pursue more intensive training after they begin practice. Their motivation for such training may be to provide a best-practice approach, to widen their therapy arsenal, or to offer a therapy that is evidence based or sought after by clients. Some may want to augment good basic training and develop by proceeding to more advanced skills, some may desire a refresher, and others may wish to pursue a more programmatic or systematic CBT to treat certain disorders (depression, anxiety, substance abuse). Experienced individuals may desire a “fine tune” or wish to prevent drift in how they apply CBT, which research has shown to be an issue (Ryan, Cullinan, & Quayle, 2005).

This chapter addresses training for professionals in practice, describing:

- Differing options for CBT training
- Important questions for trainees to consider
- Research on training therapists in CBT, and
- Designing training for therapists in practice

BACKGROUND AND EVOLUTION OF CBT TRAINING FOR THERAPISTS

Historically, trainings offered in CBT were related to research trials (Shaw & Wilson-Smith, 1988). As described in chapter 1, cognitive therapy (CT) training began with Aaron T. Beck's supervising both therapists who provided the treatment in a clinic setting and those providing therapy in the first outcome study of CT for depression (Rush et al., 1977). Despite the burgeoning interest in CBT in the late 1970s and early 1980s, following the emergence of three seminal texts in CBT in the years from 1975 to 1979 (Beck, Shaw, Rush, & Emery, 1979; Mahoney, 1974; Meichenbaum, 1977), there were few opportunities for training for therapists in practice apart from one-day workshops or brief seminars available at conventions, congresses, and annual conferences. More intensive and sequential training was not available until 1979, when a one-year post-doctoral fellowship in cognitive therapy at the University of Pennsylvania was established, an important milestone in the training of therapists in CBT. This fellowship program is described in chapter 1, as is the evolution of extramural training in CBT.

The Institute of Rational Emotive Therapy has offered intensive trainings for professionals through its fellowship and associate fellowship programs since the late 1960s (Ellis, 1989). The first postgraduate intensive training for professionals outside Philadelphia was initiated at the Cleveland Center for Cognitive Therapy in 1982, with ten months of systematic training in the theory and applications of CBT. In 1985, the Atlanta Center for Cognitive Therapy began to offer a similar nine-month, one-day-a-month training augmented by case supervision. Subsequently, other agencies and organizations in the United States, usually clinical practice CBT centers (for example, in Asheville and San Diego) began offering training of this intensive type.

In the United Kingdom training in CBT took a somewhat different path, with cognitive therapy centers in association with local universities offering postgraduate diplomas in cognitive behavior therapy. The first such training was offered in Britain in 1982–1983 at Goldsmith College at the University of London. This was followed over the next two decades by diploma courses at the Institute of Psychiatry in London, the Oxford Cognitive Therapy Centre, and Newcastle University Cognitive Therapy Centre, among others. Training courses similar to these are now offered in many universities and CBT centers in the United Kingdom, as described in chapter 1. Similar training courses leading to the award of postgraduate diplomas in CBT have been introduced in New Zealand and other countries. Advantages and disadvantages regarding these different ways of obtaining post-training are detailed in subsequent sections of this chapter and in chapter 1, Table 1.1: Summary of Alternatives for CBT Training.

CURRENT CBT TRAINING OPTIONS

Motivating factors for therapists seeking training in CBT include:

- Agency or state mandate
- Need for continuing education credits
- Interest in acquiring more knowledge
- Desire to acquire, refine, or maintain CBT skills
- Plan to obtain credentialing or certification

The intensity of and goals for training are different depending on the therapist's goals (obtaining continuing education credits, acquiring skills, or seeking peer-based credentialing); this should be considered both by trainees choosing courses and by trainers designing training.

Current training opportunities available for therapists in practice may involve:

- Agency-based training for therapists on staff (by requirement or request)
- Brief seminars and workshops available at national or local conferences or through continuing education groups
- Intensive training (often leading to certification)
- Postgraduate degree or diploma courses
- Postdoctoral fellowships in CBT

See *Appendix VI, Training Opportunities* at www.wiley.com/go/sudak for a compilation of resources for individuals or agencies seeking various training options. When pursuing training, it is important to examine the advantages and disadvantages of available formats to make certain that the educational experience meets the intended goals.

The following provides an overview of the benefits and drawbacks of each type of training.

Participation in Brief Workshops

Participation in brief workshops is the most frequent route to increasing knowledge of the theoretical and technical aspects of CBT. These workshops are often offered by international (for example, the International Association for Cognitive Psychotherapy [IACP]), national (for example, the Association for Behavioral and Cognitive Therapy [ABCT]), and local CBT organizations (for example, the Philadelphia Behavior Therapy Association).

Continuing education companies such as PESI (Provider Education System Incorporated) and Cross Country Education frequently offer one-day seminars or workshops. Information regarding these can be obtained from *Appendix VI, Training Opportunities* at www.wiley.com/go/sudak. Many of these trainings are also available via webcasts and DVDs as well as in person. These introductory workshops may not actually change therapist behavior; the literature suggests that

such brief training has an effect on knowledge acquired and retained but little effect on skill development or behavior change as shown in studies on training in motivational interviewing (Miller & Mount, 2001) and trauma-focused CBT (Jensen-Doss, Cusack, & de Arellano, 2008). However, they may serve to “whet the appetite” and motivate attendees to pursue more extensive training or supervision in CBT. Our experience at the CBT Center in western North Carolina has been that many individuals who attend one-day introductory workshops subsequently sign up for our more intensive nine-month training.

Weekend or Multiple-Day Workshops

- Weekend or multiple-day workshops offered by some CBT centers may involve a more skill-focused or disorder-specific training approach. This type of training can be more tailored and sequential and progress attendees from a beginner level to a more advanced level. Workshops presented by the Beck Institute (see *Appendix VI, Training Opportunities* at www.wiley.com/go/sudak) exemplify this graded, stepped-up approach, with some workshops devoted to fundamental or basic skills (the model and applications to depression and anxiety) and others devoted to advanced topics (applications to personality disorders or children). The option of receiving case consultation and supervision can be a very useful augmentation to this scaffolding type of training. As will be seen in the literature review included later in this chapter, supervision may be a critical determinant of transfer of training and therapist behavior change (Beidas, Edmunds, Marcus, & Kendall, 2012; Sholomskas et al., 2003).
- The provision of CBT “camps,” for example, those offered by Christine Padesky (see *Appendix VI, Training Opportunities* at www.wiley.com/go/sudak) are another option for those therapists seeking to acquire more advanced skills in CBT. High-quality, brief online courses about more specific topics, such as those offered by Medical University of South Carolina on Cognitive Processing Therapy and Trauma Focused CBT (see *Appendix VI, Training Opportunities* at www.wiley.com/go/sudak) provide practical, skill-based CBT training and are a great resource for therapists in practice, particularly when they have foundational knowledge of CBT. All of the previous approaches are more likely to lead to more in-depth knowledge and greater skill acquisition than the more didactic short workshops, but these trainings formats may still lack practice and supervision components.

Comprehensive Nine- to Twelve-Month CBT Training

- Comprehensive nine- to twelve-month CBT training (such as those offered in Philadelphia, Cleveland, Atlanta, Asheville, and San Diego; see

Appendix VI, Training Opportunities at www.wiley.com/go/sudak) have a stronger skill development component because clinical practice involving casework and supervision are often part of the training experience. Such training can help fulfill the criteria for credentialing as a CBT therapist, which may be a goal of participants.

Full-Time Postdoctoral Fellowships in CBT

- Full-time postdoctoral fellowships in CBT (such as those in Chicago, Los Angeles, and Albuquerque; see *Appendix VI, Training Opportunities* at www.wiley.com/go/sudak) lead to an educational award. Such fellowships involve providing services to clients under supervision while receiving intensive didactic training have many benefits because of the intensity of the training experience and are most likely to lead to competency and optimal skill development, as supported by the training literature. Several psychiatry residency training programs (Drexel University College of Medicine and University of Louisville) offer such intensive experience to trainees.

Postgraduate Diploma or Degree Courses in CBT

- Postgraduate diploma or degree courses in CBT, such as those available in the United Kingdom and elsewhere, allow employed trainees to attend part time on day release or a similar basis. These courses involve a very systematic program with both a robust didactic component promoting knowledge acquisition and supervision and feedback regarding therapeutic practice and patient care. The individual receives an educational award; training can lead to certification or credentialing.

Certification and Credentialing

Many CBT training programs offer certification by the agency providing the training, and most trainings offer continuing education units (CEUs). In addition, some assist in the process of credentialing by the Academy of Cognitive Therapy or other credentialing organizations. This is often an important consideration for practitioners who wish to demonstrate that they have reached a certain level of competency. The process of credentialing is described in chapter 4. Receiving a postgraduate degree, diploma, or fellowship also clearly establishes the trainee's competency. National CBT organizations in many countries now credential individuals with experience in CBT. Practicing therapists who have received or plan to accumulate significant training or supervision in this field are encouraged to look into this process in their country of practice.

Chapter 1 and Table 1.1 contain further information regarding the advantages and disadvantages of these different types of training experiences. CBT training, especially if it provides supervision of actual practice, leads to changes in knowledge, attitudes, and, most important, skills immediately after training (Rakovshik & McManus, 2010). However, over time therapists tend to revert back to previous habits or drift from the model (Ryan et al., 2005). There are a number of options to prevent a drift away from best practices in CBT or to maintain an acquired skill set. One option is to take refresher courses or state-of-the-art workshops focused on cutting-edge developments in the field that might not have been part of the practitioner's initial CBT training (for example, mindfulness-based CBT, motivational interviewing, or compassion-focused therapy). Another potentially beneficial option is ongoing supervision from suitably qualified individuals. The training and credentials of the trainer should be investigated before making a contract. Suitably credentialed individuals can be found through the Academy of Cognitive Therapy and the British Association for Behavioural and Cognitive Psychotherapy (BABCP).

CONSIDERATIONS FOR PRACTITIONERS EVALUATING TRAINING OPTIONS

Length and Breadth of Training

Rakovshik and McManus (2010), in a review of CBT training programs, described training as (1) brief (60 hours or less); (2) intermediate (61–137 hours); and (3) extensive (137 hours or more). Most trainings for practicing therapists offered as part of continuing education are brief using these criteria. When supervision is provided, as in many intensive trainings, the total number of hours spent in training and supervision might lead to classification as intermediate or extensive.

The literature demonstrates (Rakovshik & McManus, 2010) that lengthier training, especially with built-in supervision of clinical practice, is likely to lead to better outcomes in trainee competence. The content of training, including both the broad applications of CBT and the specifics of how it relates to the population with whom the trainee works, is also an important consideration. The topics covered and in what depth will determine if it is a suitable fit (for example, the potential trainee works exclusively with children or families and there is no consideration of this in the training).

Time Commitment, Cost, and Organization of Training

Individuals considering training will want to establish whether training, especially the more intensive training type, can be completed while working at an existing job or will require full-time participation. The cost of training, both upfront and in

lost work time (if the individual does not have paid leave to attend) needs to be considered. Additionally, trainees will need to know how training is organized (monthly, weekly, or in other time blocks). Another consideration may be the availability of further advanced training, building on the training in question, and whether supervision either during or after training is possible.

Expertise and Credentials of Trainers

Many individuals attending training do not give any consideration to the question of who is providing the training and how much demonstrated expertise or experience the trainers have in the field. This is important because the training may be of poor quality if certain criteria are not met. Such substandard training may produce inferior outcomes for both trainees and their clients. Unfortunately, in the same way that therapists with no specific expertise may advertise themselves as cognitive behavior therapists, individuals can also hold themselves out as CBT trainers in an unregulated manner. Similar to the advice given to individuals seeking treatment, trainees should evaluate the credentials, experience, and approach to training of a trainer.

A trainee can assess the credentials of the trainers using criteria such as membership in credentialing organizations, clinical experience, publications in the field, and so forth.

Organizations such as the Academy of Cognitive Therapy and the British Association for Behavioural and Cognitive Psychotherapy credential qualified individuals at the level of trainer-consultants; trainees can access this information easily on these organizations' websites (see *Appendix VI, Training Opportunities* at www.wiley.com/go/sudak).

Training Methods Employed

The trainee may want to ascertain whether some form of supervision or consultation is included; research (see following) points to the critical importance of this component in skill development. If supervision is included, it is important to know the type (group, individual), frequency (how often), and duration (whether it continues after the training period). Because it has been shown to be a considerable influence on training outcome (see chapter 3), active learning methods should be sought as part of training. Another consideration, when geographical distance is an issue, is whether online training and supervision is available. Chapter 7 describes the uses of technology in CBT training.

Certification and Credentialing

Trainees should determine whether on completion of training they receive CEUs, certification, or educational awards and from what organizations, including

whether the training and supervision counts toward credentialing by the Academy of Cognitive Therapy or other organizations.

Evaluation of the Training

Training programs often have built-in evaluations of trainees' competency during and after training. This benefits trainees' skill development and level of competency. Also, trainees may wish to consider whether the training program itself has been evaluated and whether data exist on prior trainees' post-training knowledge acquisition, satisfaction with training, and skill development. Some training organizations and continuing education companies collect such data, and some training CBT training centers and groups, especially in the United Kingdom, have published evaluation studies on their training programs. Methods of evaluating competence are described in chapter 4.

EFFECTIVENESS OF CBT TRAINING FOR THERAPISTS

In chapter 11 of this volume, studies of training effectiveness with nontraditional trainees are reviewed. In this chapter we concern ourselves with studies of training with practicing therapists. Studies that measure the effectiveness of training can be grouped into three categories:

- Brief general CBT training
- Intensive general CBT training
- Training in CBT for specific disorders (such as substance abuse, depression, child anxiety)

Brief General CBT Training

Bennett-Levy and Padesky (2014) looked at the effects of short-term training in a study evaluating a two-day training workshop provided to ninety-eight trainees who were followed up with nine to ten weeks post-training. The trainees were divided into two groups; the first received the two-day workshop alone and the second received the two-day workshop with an added self-reflection component. Although both groups reported learning gains and utilization of skills post-training, the latter group showed a significantly better outcome. Williams, Martinez, Dafters, Roland, and Garland (2011) trained community and inpatient mental health staff in CBT self-help delivered therapy with 38.5 hours of didactic training and 5 hours of supervision. They evaluated both knowledge and skills. Both indices showed significant improvement and gains were maintained at a three-month follow up. Rees and Gillam (2001) reported on video conference-based brief CBT training over twenty weeks for rural health therapists in Australia. There

was a significant effect from pre- to post-training on knowledge gained, satisfaction with training, and confidence in using CBT with clients.

Intensive General CBT Training

Historically, the first study done on intensive postgraduate training in CBT was that of Williams, Moorey, and Cobb (1991), who compared the Cognitive Therapy Scale (CTS; Young & Beck, 1980) at baseline (before training) with the same measure administered after training was complete. Although eight of the eleven trainees showed improvement on this scale, the authors reported that, overall, trainees did not show significant improvement. Freiheit and Overholser (1997) evaluated a one-year training for forty clinical psychology graduates whose knowledge of CBT, attitude about CBT, and self-reported skill were assessed pre- and post-training. Significant gains were found on all measures. A postal survey was carried out on trainees who completed the Newcastle Cognitive Therapy training by Ashworth, Williams, and Blackburn (1999). Self-rated skill was found to have increased as a result of training. Milne, Baker, Blackburn, James, and Reichelt (1999) found therapist competence on the Cognitive Therapy Scale-Revised (CTS-R; Blackburn et al., 2001) improved significantly over the nine-month training period. Additionally, patient outcome on a coping scale also improved significantly. The highly significant increase in the CTS-R over three time points were found on both the overall and specific item scores. James, Blackburn, Milne, and Reichelt (2001) also assessed trainees on a nine-month CBT training course using the CTS-R.

Trainees were assessed at three time periods over twelve sessions of therapy conducted by trainees. A significant increase in competence was found. Apart from the training itself, previous experience of CBT was found to be a predictor of competence acquisition. Similarly, Keen and Freeston (2008) used the CTS-R at two time points during training and found a significant increase in competence with trainees also reaching competency criteria by the end of training. They also used essays and case studies as measures of competency and found the former was the most reliable measure and also that case studies were more useful than audio ratings using the CTS-R.

Myles and Milne (2004) used measures of self-reported skill, reactions to training, knowledge of CBT, and generalization to the work environment. These measures were used at four time points during a nine-month training and compared to a waiting list control group. There were significant differences on all measures favoring the training group over the control group who was assessed at the same time points.

Barnfield, Mathieson, and Beaumont (2007) found that therapist competence measured by the CTS-R improved significantly from the first rated tape (two months into training) to the second (rated at the six-month point). The post-graduate training, which was conducted in New Zealand, involved a thirty-week

training course with supervision. Bennett-Levy and Beedie (2007) assessed competence, measured by self-report at six points during a one-year training. They found a significant increase in self-reported competence over time. In the most extensive study on the effects of CBT training to date, McManus, Westbrook, Vazquez-Montez, Fennell, and Kennerley (2010) evaluated the one-year Oxford Cognitive Therapy training course by examining scores on written essays, case reports, and the CTS for all trainees ($N = 248$) who completed the training course over more than a decade. Significant improvement was reported on all of the measures used, which assessed both skill and knowledge. Table 10.1 summarizes these findings.

Training in CBT for Specific Disorders

Beidas, Edmunds, Marcus, and Kendall (2012) evaluated three training modalities (training as usual, computer-based training, and augmented training that stressed active learning), which were delivered via a one-day training workshop followed by three months of ongoing consultation. Training was focused on CBT for anxious youth (Kendall, 1992). Adherence and skill were measured during role plays, and knowledge and satisfaction were assessed before and after training. Although modality did not influence outcome on skill, participants were least satisfied with computer-based training. The amount of consultation following the initial training was a crucial factor in adherence and skill at three-month follow-up, while training alone did not lead to behavior change, a finding that has been consistently reported.

Manassis et al. (2009) evaluated a twenty-session weekly training in CBT for children that included didactic and supervisory components and was provided to community mental health practitioners. Measures of knowledge and self-reported confidence in their ability to use CBT with children were significantly increased.

Simons et al. (2010) described the training of twelve community mental health therapists through a two-day workshop, followed by one year of phone consultation. The goal was to train experienced individuals to deliver cognitive behavior therapy to depressed patients. The CTS scores before and after training showed significant changes, which were maintained at six- and twelve-month follow-ups. Patient outcome following training was also shown to be affected by training in that therapy, which was superior to treatment as usual. This study was important in that competency ratings by observers were utilized. In addition the study show maintenance of training effects. Hamblen, Norris, Gibson, and Lee (2010) trained 104 community therapists to deal with trauma following Hurricane Katrina through a two-day training in CBT for post-traumatic stress disorder with ongoing consultation. The training was evaluated by measures of self-reported knowledge and both self- and client-report of utilization of skill. They reported that 90 percent of the therapists showed excellent retention of CBT, and both client-report and self-report showed utilization of skills.

Table 10.1 Studies Evaluating Intensive Training in CBT

Study	Training	Trainees	Outcome Measures	Results
Williams et al. (1991)	1-year postgraduate training course	11	CTS pre- and end of training	8 of 11 showed improvement, but, overall, trainees did not show significant improvement
Freiheit & Overholser (1997)	1 year	40 Clinical psychology graduated with differing theoretical orientations	Knowledge, attitude toward CBT, and self-report of application of skill pre- and end of training	Significant gains on all measures
Ashworth et al. (1999)	9-month postgraduate training course	Completed one year of training	Self-rating of CBT skill following course	Increase in self-rated skill
Milne et al. (1999)	9-month postgraduate training course	20 Mixed professions	CTS-R at three time periods and patient coping	Highly significant increase in overall and item scores (initial 30.3, final 37.0) Significant improvements in patient coping
James et al. (2001)	9-month postgraduate training course	20 Varying experience	CTS-R at three time points over 12 sessions of therapy	Significant increase in competence
Myles & Milne (2004)	9-month postgraduate training course	90 Included waiting list control (WLC)	Self-report measure of reactions to training knowledge, skill, and generalization to work environment at four time points	Significant differences on all measures compared to WLC
Barnfield et al. (2007)	30-week postgraduate training course	13 Varying experience	CTS-R Self-report and supervisor measures of knowledge and skill at two time points	Significant improvement on all measures (CTS-R; initial 38.94, final 44.54)
Bennett-Levy & Beedie	1-year postgraduate training course	24	Self-reported competence at six time points during training	Significant increase in self-reported competence over time

Sholomskas et al. (2003), in a study with important implications, evaluated CBT training for substance abuse and compared Web-directed, manual-based, and live training. They found positive changes in competence with all three, but competence did not reach criterion level with a brief twenty-hour training in any of these modes without supervision. Morganstern, Morgan, McCrady, Keller, and Carroll (2001) assigned twenty-nine counselors to CBT training involving delivering CBT for substance abuse by manual or to a control group. Attitudes to CBT and adherence and skill were measured.

CBT trainees exhibited greater levels of satisfaction and confidence in their ability to use CBT interventions. They reported that 90 percent were judged to have reached at least adequate levels of CBT skillfulness. Table 10.2 summarizes these studies.

REVIEW OF TRAINING STUDIES

An important review article by Rakovshik and McManus (2010) located forty-one articles evaluating training up to 2009. Of these, only seven studies were not linked to a treatment outcome study in which CBT was being evaluated. It was found that nineteen studies showed clear competence enhancement, measured in acceptable fashion, thirteen studies showed positive effects but not necessarily meeting the criteria of competence, and five showed no significant effects of training.

Evaluative studies are hard to appraise because they use different outcome measures (Muse & McManus, 2013). Many studies used knowledge, satisfaction, or attitudes to CBT rather than skill measures (Freiheit & Overholser, 1997; Hamblen et al., 2010; Myles & Milne, 2004). A number of studies use self-rated skill (Ashworth et al., 1999; Bennett-Levy & Beedie, 2007) as an outcome measure that correlates poorly with observer-rated skill. Studies using observer rating of skill, CTS (McManus et al., 2010; Simmons et al., 2010), or CTS-R (Barnfield et al., 2001; James et al., 2001; Milne & Milne, 2004; Milne et al., 1999) are likely to be those that are the most reliable.

However, Keen and Freeston (2008) report less reliability with observer recordings ratings than with knowledge or other measures. Measures of patient outcome were used in several studies (Milne et al., 1999; Simons et al., 2010) in addition to other competency measures. Ideally (Fairburn & Cooper, 2011), there should be a measure of therapist skill in real-life settings, but that can be expensive and time consuming (Muse & McManus, 2013). Few of these studies had control groups of any sort, the exceptions being Milne et al. (1999) and Morganstern et al. (2001).

The literature is somewhat sparse regarding which components of training are most effective, and few dismantling studies exist. The role of supervision in training has been evaluated in some studies but has rarely been compared to training alone. All intensive training and many other studies included in this

Table 10.2 Training Evaluation Studies: Specific CBT Training

Study	Training	Trainees	Outcome Measures	Results
Beidas et al. (2012)	1-day workshop on CBT for anxious youth delivered by routine training, computer training, and augmented (active learning) training with three months of ongoing consultation	115 community therapists	Adherence and skill checklist rating of role play Knowledge test, Satisfaction rating	All modalities showed limited gains in three measures, no difference other than less satisfied with computer Consultation hours after training a significant predictor of adherence and skill at three-month assessment
Manassis et al. (2009)	20-session weekly training in CBT for children	22 community therapists	Knowledge, self-reported confidence in doing CBT, and desire to do further CBT	All measures showed increase after training and at six-month follow-up
Simons et al. (2010)	2-day workshop plus 1-year phone case consultation on CBT for depression	12 community therapists	CTS before, after, and at six and twelve weeks compared to treatment as usual (TAU)	Significant change in CTS scores, maintained at follow-up CBT > TAU
Hamblen et al. (2010)	2-day training on CBT for PTSD plus ongoing consultation	104 community therapists	Questionnaire assessing knowledge and utilization of skills plus client report	90 percent showed excellent retention of CBT Self- and client-report showed high utilization of skills
Sholomskas et al. (2003)	3-day training, manual, Web-based or live with monthly supervision for CBT of substance abuse	24	Therapist competence on Yale Adherence Competence Scale	Therapist competence reached criterion for skill only after supervision
Morganstern et al. (2001)	CBT training using manuals for substance abuse	29 counselors	Adherence and skill (rated from recordings) training satisfaction and intention to use CBT assessed pre- and post-training	Compared to control group high levels of satisfaction and confidence in ability; 90 percent were reported at having attained adequate level of competence in adherence and skill

review evaluate training programs containing various amounts of supervision (group or individual) or case consultation.

Several indicate the effects of supervision over and above didactic training (Beidas et al., 2012; Sholomskas et al., 2003). Video conferencing and computer-assisted trainings (Beidas et al., 2012; Rees, Krabbe, & Monaghan, 2009) and the use of manuals (Sholomskas et al., 2003) and self-help materials (Williams et al., 2011) have all been researched and shown to be effective in dissemination. Bennett-Levy and Padesky (2014) and Bennett-Levy, Turner, Beaty, Smith, Patterson, and Farmer (2001) have reported on the effectiveness of a self-practice/self-reflection component (see Bennett-Levy, Thwaites, Haarhoff, & Perry, 2015, for a description) in creating positive training outcomes.

Rakovshik and McManus (2010), following a comprehensive review, conclude that

- More extensive training variably leads to increased therapist competence, which is positively related to better patient outcome.
- More traditional approaches (workshops and manuals) seem insufficient to produce significant change in therapist skills or patient outcomes.
- Some mode of theoretical instruction (workshops, reading, Web-based) is integral in initial training but needs to be followed by experiential or interactive training through practice cases, co-therapy, or supervision.
- Treatment adherence through monitoring and feedback may be a productive and necessary focus in training.
- Sustained supervision over a prolonged period of time may be necessary to maintain competency gains.

DESIGNING TRAINING

Fennell (2010) demonstrates how to design training carefully to best meet the needs of trainees. She draws on Kolb's (1984) learning circle that describes a four-stage process of experiential learning, namely experience, observation, reflection, and planning. Different methods may be more useful in each stage of training. For example, watching videos or role playing may give trainees experience, but to facilitate observation, reflection and planning prompts in the form of questions and direction may need to be added. Relatedly, we should consider whether the principle goal of a specific training is to increase knowledge, to develop skill, or both. Methods employed vary accordingly. Knowledge involves information stored in memory and relates to knowing about theory, methods, research evidence, and applications of methods. In addition to *knowing what* it is, it also involves *knowing how*, without which skill development cannot take place. Knowledge and information can be imparted through didactics (live or online lectures), reading, observation of live sessions, or videos. Short training courses

Table 10.3 Framework for Designing Training

Level	Fostered by (teaching methods)	Assessed by (competency measures)
1. Knows (has knowledge)	Didactic instruction (live, computer based, DVD/audio) Guided reading	Essays Multiple-choice questions
2. Knows how (knows how to apply knowledge)	Observation Case discussion Self-reflection	Case reports Response to clinical vignettes Essay or tests
3. Shows how (demonstrates skill)	Role plays or behavioral rehearsal Experiential methods Self-reflection Self-practice Monitoring Feedback	Evaluation of role play or behavioral rehearsal Assessment of skill in simulated or standardized case presentations
4. Does (uses skill independently in practice)	Case work Self- & observer monitoring Supervision Feedback	Supervisor or observer rating (CTS, CTS-R) of actual therapy sessions

usually focus on knowledge acquisition alone in contrast to skill development. Skill involves the ability to apply knowledge in practice. Skill development ideally builds on *knowing how* by allowing *practice in doing*. Skills are usually acquired over time: initially performance may be conscious and effortful, but with practice it becomes more automatic. Although theoretical knowledge and skill acquisition may be poorly correlated, improvements in skill can easily be facilitated by active learning methods, including participant observation, modeling, practice (self, with trainees and others, with clients), behavioral rehearsal, role plays, feedback, and supervision. More intensive training focuses on both knowledge and skill acquisition with many practice, feedback, and supervisory components. Chapter 2 reviews different models of learning and the empirical support for each model.

Bennett-Levy, McManus, Westling, and Fennell (2009) surveyed former trainees to assess what they considered the most useful aspects of training. For declarative knowledge trainees rated reading, lectures, modeling, and demonstration as most helpful. In contrast, trainees indicated that role plays, self-experiential exercises, self-reflection, and practice facilitated the acquisition of procedural skills.

Fennell (2010) suggests that training quality may be evaluated at four levels, comprising (1) participant satisfaction, (2) acquisition of knowledge and skills, (3) behavior changes in the real world (work) context, and (4) the outcome of these

changes clinically. In both designing and evaluating training, these four indices of quality need to be kept in mind.

Another very useful schematic for the consideration of how training design might be tailored to learning objectives, based on Miller's (1990) clinical skills hierarchy, is described by Muse and McManus (2013). They describe methods of assessing competency for the following hierarchical skill levels: (1) knows, (2) knows how, (3) shows, and (4) does.

In Table 10.3 both the training methods and assessment of competency relevant to each level are described. Chapter 3 describes empirically supported educational methods that can be incorporated into CBT training.

Training Methods

CBT training should optimally include a blend of the following methods, each based on the goals of training (knowledge, skill acquisition).

Didactic Methods All training courses will include a didactic component, critical for declarative knowledge acquisition. Live lecture presentations, computer-based, or online programs including webcasts and podcasts, instructional audio or video recordings, or guided reading are methods of providing such learning, but an active or interactive component should be part of any training. Quizzes, trainee–trainer interactions, role-play exercises, discussion, feedback, and reflective components involve the participant. Chapter 6 demonstrates how CBT teaching tailored to specific diagnostic groups can be optimized. *Appendix I, Recommended Readings and A/V Resources* (www.wiley.com/go/sudak) provides recommended readings for a wide range of CBT applications. Lecture content and examples should be made specific to the trainee's population. Participants need to understand how the didactic content relates to their practice. Another important consideration is the length of didactic sessions. Case material and demonstrations may be blended with more purely didactic content to ensure continued attention and foster learning. Stewart and Chambless (2010) have shown that case illustrations when tied to scientific presentations of therapy techniques tend to invoke more interest in training in practitioners than research reviews. Feedback from trainees verifies this; often it cites case examples and demonstrations as the most helpful facets of CBT training. Because many practitioners undergoing continuing education training may have some familiarity with the concepts of CBT from previous reading or training exposure, it is important that theoretical constructs are balanced with examples of applications in real-life situations similar to their own clinical practice.

- If training is more advanced, there should be a greater emphasis on more detailed research or theoretical constructs, but trainees must have a grounding in the basic cognitive behavioral model, the structural and

more generic components of cognitive behavioral therapy, and conceptualization before teaching specific techniques. Without this, CBT may be seen as a collection of techniques applied in a nonsystematic way rather than being conceptualization driven and applied within a good collaborative relationship.

Demonstrations and Modeling

- Skill development is significantly improved when a concrete behavioral description of a particular skill is followed by a video or live demonstration. Ideally, trainees should self-reflect concerning this skill, set learning goals concerning the skill, and then practice during training with other trainees, on their own, using self-CBT, or with designated clients during or after training with consultation opportunities. One recommended approach in developing CBT skills is to use a competency measure such as the CTS or CTS-R (as detailed in chapter 4), train participants to use the measure and then demonstrate therapy skill with a recorded CBT session with a client (simulated or actual or a live demonstration or role play). Demonstrations should closely resemble the trainee's client populations as well as the appropriate level of skill for the training in question (beginner, intermediate, advanced). Trainers should create a library of video demonstrations from different sources. See *Appendix I, Recommended Readings and A/V Resources* (www.wiley.com/go/sudak) for more information on Audio/Visual Resources for CBT Training and Supervision. You'll also find there many helpful appendixes, including *Appendix VII, Video Library* and *Appendix VIII, Podcasts*, that contain video and audio materials that are useful teaching aids. To facilitate active learning, trainers may pause video demonstrations asking trainees to rate therapy skills in evidence or to suggest alternative therapeutic responses to material presented. Also, utilizing more active learning may occur when a complete or partial session presented by video or a detailed case example is used to have trainees practice writing a CBT case conceptualization following didactic instruction. Recruit participation from trainees by posing questions to increase trainee attention and learning.

Practice

- Practicing the skills being trained is essential for trainee learning. Behavioral rehearsal or role-play practice provides opportunities for skill practice and for immediate feedback from the trainer and/or other trainees. At a minimum, training events should include some basic practice with key competencies. Even in brief trainings it is possible to build in simple practice opportunities. Role plays ideally include examples that come from the trainees' work with clients. If trainees have limited access to client

material, “real plays” can be utilized, in which the trainees use personal material that is not too revealing for the purpose of practicing skills. Methods to facilitate role plays or behavioral practice are described in chapter 4. Beidas et al. (2014) describe in some detail the use of behavioral rehearsal as both a training tool and a tool to assess competency and provide empirical backing for the importance of this method in CBT skill acquisition.

Supervision and Clinical Consultation

- The role of supervision and consultation in developing competency is widely supported. Formal supervision, either individual or group, provided as part of intensive CBT training, is a key element in high-quality training. Research highlights the effectiveness of maintaining supervision after training ends.
- Optimal practices for supervision are discussed in chapter 12. If formal supervision sessions either during or after training are not feasible, at a minimum CBT training for therapists in practice should involve discussion of case material supplied by trainees with a focus on case conceptualization and treatment planning. This may be accomplished with the group as a whole or with subgroups of trainees once foundational knowledge has been imparted. As a result of this discussion trainees should self-reflect on their use of CBT and set goals for future therapy sessions with both the clients discussed as part of the case consultation and with other clients who have not been discussed but where these strategies and skills are applicable. This process will sharpen skills and facilitate self-reflection and self-practice in the same way that feedback and goal setting function in supervision.

Personal Application of CBT Self-Practice and Self-Reflection

- To facilitate active learning, trainees should be encouraged to apply various cognitive and behavioral strategies on themselves. Trainees, for example, may record automatic thoughts and identify the connection between them and their emotional responding in different stressful situations.
- Trainees may be encouraged, as mentioned previously, to engage in self-reflection along with self-practice, which have been found to be an invaluable aspect of training (Bennett-Levy et al., 2001; Bennett-Levy et al., 2015). This can work in two ways: (1) trainees can review their own reactions using a CBT framework and practice self-intervention, and (2) trainees can closely monitor their use of CBT skills with clients (possibly using competency measures or checklists to rate themselves) and use this information to set related behavioral goals, execute them, and review the

outcome. Trainees might, for example, review how well they are applying skills like structuring, collaborating, and assigning homework based on the behavioral descriptors and exemplars found in the CTS and make notes about goals for improving intervention planning and delivery. Empirical evidence indicates that adding this component even to brief training creates superior outcomes to didactics alone (Bennett-Levy & Padesky, 2014).

Handouts and Manuals

- When skills development is the focus, simple and practical handouts containing step-by-step instructions about key skills taught and utilizing examples grounded in the trainees' clinical context facilitate trainees' continued study prompting key learning points after the training event. Similarly, and particularly when specific CBT skills are being taught, the use of a manual or protocol, which has established empirical support, can guide training and provide a coherent structure around which teaching can be organized.

Knowledge and Skill Measurement

- Measuring the impact of training is essential. Many different methods of assessing competency exist (Muse & McManus, 2013), but the most frequently used assessment method is a post-training exam of acquired knowledge. Case study presentations and written case conceptualizations are also useful and widely used, especially in post-graduate training programs. The optimal way to measure behavioral skill is through the assessment of work samples. This may be most usefully accomplished through CBT supervision. If supervision is not a part of training, role plays of key competencies can be used to assess skill. The training literature is dominated by self-report evaluations of skill which does not correlate well with actual behavior. Some sample of therapist behavior is optimal for assessing actual skill. Chapter 4 describes and reviews assessment methods to measure therapist competency.

SUMMARY

This chapter has outlined the issues in training CBT therapists who are already in practice. Options available for practicing therapists to receive training and the pros and cons of each were considered. Guidelines were offered to evaluate the quality of training. The research literature concerning the effectiveness of training was reviewed, with particular attention given to the implications for designing

training. Conceptualizing and planning training to optimize the benefits was addressed. Different modes of training and practical methods to utilize these were considered.

LEARNING EXERCISES

- Following a didactic presentation on case conceptualization, have the trainees break into small groups and have one of the trainees in each group present a case with which he is familiar. This individual, with the help of questions from other trainees in the group, should write out a case conceptualization following the format here (Beck, 2005).

Relevant childhood data



Core beliefs developed



Triggers and life events



Automatic thoughts



Emotions



Physiologic responses



Behaviors

- After a discussion of the key therapeutic elements in CBT, ask trainees to self-reflect by considering how they would rate themselves on the following list (based on the CTS) and encourage them to set goals for their future practice. Alternatively, they can self-reflect and set goals related to a specific patient with whom they are working.

CBT Skills	Self-Rating (N = needs improvement, A = Adequate, G = Good)	Goal (specify what will be done to create improvement)
1. Agenda setting		
2. Case formulation understanding		
3. Feedback		
4. Interpersonal effectiveness		
5. Collaboration		
6. Pacing and time management		
7. Guided discovery		
8. Focus on key cognitions		
9. Strategy for change		
10. Application of CBT interventions		
11. Homework		

- Following a didactic presentation with a demonstration of key CBT interventions (live or recorded), present the following scenarios to trainees and ask them, either in group discussion or as an individual written assignment, to indicate which CBT intervention they would consider using in each case.
 - Patient reports in session and also on thought records a characteristic automatic thought, “I am a failure.”
 - Patient is easily overwhelmed and cannot get started or complete any of the major tasks he wants to accomplish.
 - Patient predicts that if he is asked a question in a college class he will panic, freeze up, and everyone will think badly of him.
 - Patient reports that because her child is doing badly in school, she is a bad parent.

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Chapter 11

TRAINING AND SUPERVISING NONTRADITIONAL CARE PROVIDERS

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This chapter discusses the adaptation of CBT training and supervision methods to meet the needs of nontraditional trainees. Nontraditional trainees are a heterogeneous group that vary by type and by practice setting. One unifying definitional feature of this group is that their jobs require them to provide some level of direct care rather than simply social support. Some examples include paraprofessionals, clergy, camp counselors, and community mental health workers. These care providers work in diverse settings such as in-home, wilderness, and school settings. Training such individuals presents certain challenges that can only be addressed with modification of traditional training and supervision procedures; these methods are outlined here. Methods must be “user-friendly,” effective, tailored to varied educational and other training backgrounds, and must maximize participant engagement in training. These methods are discussed in detail with particular attention to the “nuts and bolts” of maximally effective implementation and evaluation of CBT training in such settings. Guidelines regarding training content areas as well as common pitfalls and potential solutions are described.

The demand for CBT training and clinical supervision for nontraditional care providers has increased substantially in recent years. Examples of this increasing demand exist internationally and include:

- In the United States several state-level initiatives, including some in Michigan, North Carolina, and Texas, have been enacted to introduce evidence-based therapy training criteria in mental health centers (Lopez & Basco, 2011). Training in CBT is commonly required, or at least a prominent training option, to satisfy these evidence-based criteria. Typically these requirements specify a certain number of training and/or supervision hours that must be completed. Some states, in contrast, require care providers to achieve a certain level of competence in CBT. In the latter circumstances it is left to the care provider to determine the amount of training required to achieve the competence criterion. The Texas Department of State Health Services, for example, currently requires clinicians to achieve a score of 40 or higher on the Cognitive Therapy Rating Scale (CTS; Texas Department of State Health Services, 2013; see chapter 4 for a description of this scale and other methods of trainee evaluation).

Additional sources of increased CBT training demand include state and federal funding bodies. Agencies reliant upon these funds are often mandated by these bodies to provide or acquire such training for their staff. Many of these agencies are multidisciplinary in nature and are often made up of nontraditional care providers.

- In the United Kingdom the development of the Low Intensity CBT movement (Bennett-Levy, Richards, & Farrand, 2010) was stimulated by the publication of the National Institute of Health and Clinical Excellence (NICE) guidelines on creating access to evidence-based psychological interventions in 2004. Subsequently there were major funding provisions by the British government in 2007 for this initiative that led to a major CBT training focus and the creation of Psychological Wellbeing Practitioners in CBT. A large number of mental health workers, often from nontraditional groups, were and are being trained to deliver low-intensity CBT to depressed and anxious patients in the community. Individuals trained within this movement have included case managers (Ekers, 2010), general practitioners (Bilsker & Goldner, 2010), and peer supporters with experience of mental illness (Lawn et al., 2010).
- In countries such as Canada and Australia, because there is a dearth of mental health services, especially in rural areas, dissemination efforts have been offered to general practitioners and social workers, among others. Often these dissemination efforts occurred via nontraditional methods such as video conferencing and computer-assisted training (Manassis et al., 2009; Rees, Karabbe, & Monaghan, 2009). See chapter 7 in this volume on the use of technology in training.

We assume there will be increasing demand for CBT training and supervision among nontraditional groups of care providers to facilitate delivery of empirically supported psychotherapies to a wider segment of patients.

NONTRADITIONAL GROUPS

Nontraditional care providers and groups are providers other than licensed psychotherapists who practice in traditional in- and outpatient settings. Nontraditional providers constitute a heterogeneous group that varies by discipline and by practice setting.

The provider types may include general medical practitioners, nurses, non-license-eligible counselors (for example, those with bachelor's-level training or less), mental health technicians, clergy members, and camp counselors. Notably, educational levels and areas of experience vary considerably.

Practice settings of nontraditional providers also vary. Nontraditional providers may practice in the wilderness, in medical practices, religious settings, community mental health, and in-home settings. Such settings provide the clinician with unique challenges. For example, many community health workers frequently see patients in locations where there are real safety concerns. Further, these settings often are a challenge to provide confidential treatment because patient housing often provides no private area to use for therapy. Many settings put various pressures on providers to maintain high levels of billing and paperwork productivity. These pressures compete with their time and interest in participating in training efforts and treatment.

Training needs in this group vary. Training and experience with CBT exists on a continuum from no knowledge to sophisticated knowledge. Our experience is that most nontraditional trainees have minimal proficiencies at the start of training. The trainer must be prepared to educate the neophyte as well as the more experienced practitioner, possibly during the same training event. It is often more cost effective for an agency to have all staff, regardless of background, participate in the same training event.

Motivation to participate in CBT training varies among this group; therapists may have an allegiance to another model. Existing training materials provide examples of interventions delivered in traditional settings (for example, private practice psychotherapy settings), so many nontraditional providers have difficulty generalizing from the modeled settings to their own. Motivation is often affected by a perception that trainers do not fully understand their practice settings, their type of clientele, and their specific constraints regarding providing therapy. Good training should take these obstacles into account. For example, many community mental health patients, in addition to dealing with various mental health diagnoses, are often also dealing with many life stressors such as extreme poverty and homelessness. If these realities are not addressed in training events, therapy cannot be modified to help the patient, and trainees are more likely to see CBT as irrelevant. Finally, many trainees may hold a number of misconceptions about CBT, such as "CBT only addresses surface-level symptoms," "CBT is only for bright and motivated patients," and "CBT won't work for patients who don't have distorted cognitions—many of our patients have upsetting beliefs, but their beliefs

are true! Their circumstances are horrible!” These and related issues along with suggested responses to them are discussed later in this chapter.

WATCH: Go to www.wiley.com/go/sudak: *Appendix VII, Video Library* to View Videos:

- Problematic Trainee: CBT Seems Superficial
- Problematic Trainee: Trainee Afraid CBT will Damage Therapeutic Alliance
- Problematic Trainee: Trainee Does Not Believe in Psychotherapy

DESIGNING TRAINING FOR NONTRADITIONAL GROUPS

A key principle in the design of effective training is that training is optimized when it is highly individualized. This is best accomplished through interviews with clinical directors and other relevant administrative staff in advance of training delivery (see Form 1 Interview Template for Administrators of Nontraditional Trainees at www.wiley.com/go/sudak: *Appendix II, Forms and Tools*).

We recommend the following topics of discussion:

- Trainee academic background and training level
- Trainee motivation in relation to CBT training and service delivery
- The heterogeneity of the trainee group on the day of the event(s)
- The clinical population(s) they serve
- Difficulties frequently encountered in serving their target populations
- Work culture issues that may affect training, and so on

Next, a baseline assessment of clinical skill should be conducted, when feasible, to identify participant needs. When possible, solicit information from trainees in advance of a training event (see Form 2 Survey for Nontraditional Trainees during Training Design Phase at www.wiley.com/go/sudak: *Appendix II, Forms and Tools*).

Following an assessment of the trainee group, the following specific components should be considered in training design. (See chapter 10 for a discussion pertaining to trainees at the postgraduate level.)

- *Length and duration of training.* What is the optimal length of training? Should the training be delivered in small, widely spaced doses? Or small, narrowly spaced doses? Should it be delivered in intensive doses? If so, widely or narrowly spaced? Over what time horizon will training delivery occur (for example, six months, one year)? Effectiveness is an obvious, but not the only, consideration when making this determination. Many providers are not earning income when they are not engaging in clinical activity. Thus, when they are participating in training events their livelihood

is negatively affected. Trainee morale can be harmed in these circumstances, so one must consider whether delivering training over a weekend is more palatable (if clinical activity does not typically occur then). Financial pressures may be mitigated by a larger number of one-day events spaced over time rather than a week-long intensive event (the loss of one billing day each week may be more tolerable). It is not uncommon in practice settings with high billing and paperwork demands for trainees to initiate work following the completion of the day's training event and to stay into the late evening hours. This results in a fatigued and resentful trainee the next day, a problem only compounded when multiple training days are scheduled in succession.

- *Ensuring training includes practice, case supervision, and follow-up.* The strategy known as “train and hope” is generally considered an ineffective method of producing generalization of learning (Stokes & Baer, 1977). An example occurs when the trainer provides a training event without subsequent clinical supervision or booster training following the initial event or set of didactic events. Supervision and booster training are crucial to generalization. It can indeed be difficult to convince an agency that supervision and further training contact is important. Trainers should critically emphasize this need and help agencies identify and overcome barriers to adding these components. Trainers should maintain a list of common barriers (many have been noted in this chapter), useful responses to these barriers, and practice responding to these objections through role-play practice with colleagues. For example, cost is a commonly expressed barrier. Some possible responses include suggesting weekend training (if billing does not occur then), training or consultation delivered remotely (so the agency can save on travel and travel-related costs because the trainer will not need to travel to them), offering payment plans, and so on.
- *Ensuring active learning during training.* The practice of CBT involves therapist behavior. Therefore, it is essential that the behavior involved in CBT delivery be practiced for learning to occur—not just lectures or reading. Trainees must have adequate opportunity to practice CBT skills and to do so in contexts in which immediate feedback can be given. (See chapter 5 for a detailed discussion of feedback in training.) Practice should occur in every training event and continue in the context of supervision post-training sessions.
- *Training methods.* What methods will be used? Didactic? Modeling? Experiential? What percentage of the event will be dedicated to each method? (See chapter 3 for a full treatment of educational interventions.)
- *Training setting.* Where will the event take place? At the agency? Another site? Important considerations include the availability of equipment (computer, projector, or other technology) and technical support for such equipment. Training away from the agency may avoid the disadvantages

of trainees being interrupted or prompted to engage in tasks that compete with the training. It is not uncommon at sites where billing and paperwork requirements are high for trainees to attempt to work while participating in the training (this is distracting to themselves and to those surrounding them). Trainees may also attempt such multitasking off-site, but the risk is reduced with the removal of related cues.

The physical space is important. Will trainees be uncomfortable because it's too small and too hot? Will there be enough room for trainees to break off into dyads for role play or other purposes? How noisy or otherwise distracting is the site? If distractions are unavoidable, trainers should discuss ways these might be mitigated with the agency's representative. It is important to set the stage for a productive training environment and to minimize difficulties on the day of the event.

- *Composition of training group.* Are the trainees all licensed professionals? Or are they a mix of licensed professionals and paraprofessionals? Diverse audiences are more typically the case with nontraditional group training. Do they work in teams? Some agencies have teams made up of members who have varying amounts of training. Trainers should know this in advance—it may be important to separate trainees by team and to design training with the team organization in mind. Does the group have allegiances to other training models? Such information will help trainers design a training program so everyone benefits and skillfully circumvents any resistance.
- *Organizational support.* Is the organization just “checking off a box” to fulfill a training requirement or is it genuinely invested in its trainees acquiring competence in CBT? How can you enlist the organization's commitment in supporting the training event and implementation following training delivery? Can the organization reduce any billing or paperwork demands on training days? It would be ideal if the administration delivered reinforcement for participation in the event. For example, if there is typically a billing quota of thirty-five hours per week, perhaps they can modify that to thirty hours for any employee who participates in the training event. This can be a powerful negative reinforcement contingency in these settings. Help the administrator build something like this into the cost of the training and understand how that benefits the agency (better service delivery, increased motivation for subsequent training events, increase in the administrator's reinforcing properties, and so on).

TRAINING DESIGN PROCESS

Fennell (2010) described a useful training design process, although with the more typical trainee in mind. Nonetheless this process is also helpful in designing

training for nontraditional trainees. The key components of the described process are

- *Context of training.* What are the goals of the organization or group pursuing training? Are their goals specific and attainable?
- *Performance gap.* What are the knowledge and skill deficits of the trainees? What competency is desired? Can this be measured? If so, how?
- *What are the reasons for the gap?* Is training the best way to narrow the gap? Is this a “can’t do” or “won’t do” problem? If it’s a “won’t do” problem then training is unlikely to be helpful. Rather, the solution is likely to reside at the systemic level.
- *Training needs.* What, in general terms, do trainees need to close the performance gap?
- *Learning objectives.* What specific knowledge, skills, and attitudes will participants gain? It is important that once these are identified, they must be operationalized in behaviors.
- *Training design.* What training interventions are required to achieve these objectives?
- *Training delivery.* What specific components will the training event contain?
- *Training evaluation.* How can the impact of training be measured immediately after the event and over time?

Refer to the Training Design Sample in *Appendix IV, Sample Syllabi, Course Modules, and Training Design Sample* at www.wiley.com/go/sudak for an example of this process.

TRAINING METHODS

A number of training methods are available, each with unique strengths and weaknesses in this trainee group (see chapter 3 for a full discussion of instructional methods). Ideally training events include several, if not all, of the following methods, adapted as indicated:

1. *Didactic methods.* Didactic methods are the backbone of many training events. Didactic success with nontraditional populations is increased when lecture content and examples are specific to the trainees’ population and setting. Relatedly, trainees must understand how the didactic content is relevant to them. Another important consideration is the length of didactic sessions. Many master’s- and doctoral-level trainees are accustomed to, and prefer, lectures. Consequently, they can remain attentive and engaged in lengthy lecture sessions. This is not typically the case for those without such degrees, who find lengthy lectures tedious. The trainer and training context then become aversive. Further, for those with limited academic

preparation, lengthy lecture sessions can be overwhelming, especially when they contain substantial new content. Briefer didactic sessions interwoven with other training methods are more likely to retain the attention of the trainee, give time for behavioral practice, and allow for reasonable amounts of information to be imparted.

2. *Modeling.* This can be accomplished through recorded or live demonstrations. In addition to being effective, modeling is a commonly requested training method. As with didactics, it's crucial that demonstrations closely resemble the trainees' client populations and the real-world constraints they experience when delivering interventions. Most existing video demonstrations of CBT occur in traditional settings with licensed psychotherapists. The trainer may need to create a library of video demonstrations that more adequately meet the needs of these trainees. See *Appendix VII, Video Library*, at www.wiley.com/go/sudak for video demonstrations and instructional use of chapter-related videos for guidance pertaining to the instructional use of these videos.

WATCH: Go to www.wiley.com/go/sudak: *Appendix VII, Video Library* to View Videos (all shown in an in-home setting):

- Difficulty Identifying Automatic Thoughts, Parts I and II
- Dealing with Homework Noncompliance, Parts I and II
- Working with In-Home Setting Distractions, Part I
- Working with In-Home Setting Distractions, Part II
- Dealing with Realistic Automatic Thoughts, Part I
- Dealing with Realistic Automatic Thoughts, Part II

Role-play demonstrations must mirror the context of the care delivery of the group. Recruit participation from a large group by posing questions and reviewing concepts. For example, ask what previously taught concepts and skills did they observe in the role play. Another technique is to have the group observe two or more demonstrations and then ask which better represents the competencies they are learning. Role-play demonstrations can be paused at various points and participants asked what to do next and why. This provides an opportunity to shape trainee behavior and increases trainee attention and learning.

3. *Behavioral practice.* Practicing the skills being trained is essential for trainee learning. There are a number of ways to construct behavioral practice opportunities, including:
 - a. *Role-play practice.* Ultimately, to learn a skill one must perform it. The only way to learn to swim is to get in the water and swim. Role-play

practice provides a context for skill practice and for immediate feedback from the trainer. At a minimum, training events must include some basic practice with key competencies. If at all possible, vary the practice parameters including the complexity, client type, and intervention setting.

There are many ways to creatively construct effective role-play practice exercises. One concept is to utilize “real plays” wherein the trainees use their own personal (not client) material. This makes the exercise more realistic to both the “therapist” and the “client.” If “real plays” are used it’s important that trainers define parameters for the content trainees use. For example, it’s safer to use stress reactions and behavior change goals linked to diet and exercise with coworkers than to discuss childhood sexual trauma histories. Relatedly, trainers should make sure that a supervisor is not paired with a supervisee during “real plays.”

Role-play practice can be constructed with dyads or triads. The dyadic method is fairly straightforward and involves each member providing the other member with feedback at the completion of each role play. We prefer triads, when possible, because both members of a dyad are actively involved in the activity and important observations may be missed. Triadic arrangements in which one person is the client, another the therapist, and the third an observer can help overcome this difficulty. At the completion of each role play the observer can provide feedback. Rotate through the triad so that each member has played each role before discontinuing the exercise. Socialize trainees to stop the role play when you call time and to stay focused on the activity until you call time. Otherwise, their practice may devolve into conversation unrelated to the purpose of the training.

The value of feedback can be increased by providing very specific items on which trainees provide feedback rather than simply eliciting open-ended feedback. For example,

Please tell your partner (a) how the pacing of the intervention felt to you. Did it feel rushed? (b) how effective their questions were in eliciting automatic thoughts. Are there alternate questions you’d suggest? If so, please provide your partner with examples. Or, did you find your partner to be on target with her questioning? (c) How was your partner’s empathy? Did you feel heard and truly understood? Why or why not?

This type of specificity is important and differs from the all-too-commonly utilized open-ended prompt, “Please give your partner some feedback on the role play.” Most important, the specific feedback prompted by the trainer must be tightly related to the event’s training

objectives. (The different ways in which feedback can be used to optimize training and supervision are described in chapter 5.)

Role-play practice can be anxiety provoking for trainees, which sets the stage for additional learning opportunities. Trainees can be instructed to apply cognitive and behavioral methods on themselves to manage such anxiety.

Another useful strategy is for the trainer to first play the role of therapist and then reverse roles with a trainee. Alternatively, the trainer can use the training group as tag-team therapists with the therapist playing a client grounded in their clinical context.

The reader is referred to Beidas, Cross, and Dorsey (2014) for a comprehensive description of effective behavioral rehearsal exercise construction.

- b. *Clinical consultation around patient material.* Once foundational knowledge has been imparted, discussion of a patient with a focus on case conceptualization and treatment planning enhances learning. The group as a whole in subgroups may be given the same or different patients to discuss. Trainees' knowledge will generalize further with repeated practice.
- c. *Personal application of CBT.* Trainees should be encouraged to apply various cognitive and behavioral strategies on themselves. This may occur during the training session, during the lunch hour, and/or in between training sessions. Examples of such self-practice include self-monitoring automatic thoughts and the connection between thoughts and emotions; self-monitoring CBT intervention applications with clients, measuring the outcome of the application, noting goals for improving intervention delivery (Riggs, Wiltsey-Stirman, & Beck, 2012). Some empirical evidence indicates this to be superior to didactics alone for skill acquisition (Bennett-Levy & Padesky, 2014; readers are directed to Bennett-Levy, Thwaites, Haarhoff, and Perry [2015] for an excellent handling of incorporating self-reflection and self-practice in CBT training).
4. *Handouts.* Simple and practical handouts containing step-by-step instructions around key skills taught, using examples grounded in the trainee's clinical context, will facilitate continued study and will prompt key learning points after the training event.
5. *Guided reading or viewing.* Professional books, manuals, and self-help materials (firmly based on the CBT model and well validated) should be assigned. With nontraditional groups motivation and appropriate preparation may be obstacles to trainee compliance with readings. Select reading that is highly applied in nature, versus theoretical and research heavy. Keep the volume of reading realistic (which will vary by group). Consider the cost of these materials.

6. *Knowledge and skill measurement.* Measuring the impact of training is essential. Many different methods of assessing competency exist (see Muse and McManus [2013], and chapter 4 in this volume), but the most frequently used assessment method is a post-training exam of acquired knowledge. This is a useful assessment method, but not as important as assessment of behavioral skill.

The optimal way to measure behavioral skill is through the assessment of work samples. This may be most usefully accomplished through CBT supervision and rating of recorded materials. If supervision of patient sessions is not a possibility, role plays of key competencies can be used to assess skill. The training literature is dominated by self-report evaluations of skill. Self-report does not correlate well with actual behavior, however, so evaluate samples of actual behavior when possible.

EVIDENCE BASE FOR TRAINING NONTRADITIONAL GROUPS IN CBT

A number of recent studies of varying types examine CBT training with non-traditional groups. The following is a review of these, organized by trainee group.

Nurses and Related Disciplines

Several studies have described CBT training for nurses, health visitors, and case managers. Haffner, Cargo, Christensen, Lia, and Scarborough (1996) examined a twenty-six-week in-service program (five hours per week) that taught CBT skills for nurse case managers along with supervisors. The training package had positive effects on patient outcome. Reilly (1999) described a distance education CBT course for nurses who worked with substance abuse patients and reported that trainees found the information helpful in their practice. Reilly and McDanel (2005) described a program for advanced practice nurses working in community-based health centers in underserved areas; however, they did not report any outcome data on their program. Saarmann, Daugherty, and Reigel (2002) described a pilot project in which a brief cognitive behavioral program was developed and taught to nurses to improve patient education strategies geared toward changing health behaviors and lifestyle modification. They reported significant symptom improvement in patients treated by these individuals. Cort et al. (2009) reported on a randomized trial in which clinical care nurse specialists in a palliative home care team were randomly assigned to CBT training or to practice as usual. No details of the training were given. On interview, nurse specialists receiving CBT training reported a positive change in their approach to patients, felt more skilled, and reported being empowered to help assess and support cancer patients experiencing anxiety and depression. Clark et al. (2012)

described a CBT training program for front-line cancer care professionals with a three-day training workshop including role plays, didactics, small-group sessions, and subsequent post-course support and follow-up evaluation. No outcome data were reported. In a well-designed study, Mannix et al. (2006) trained inexperienced palliative care practitioners with the equivalent of nine days of didactic teaching and four hours of group supervision per week for three months. Significant gains were found in CBT skill levels, but, notably, skill acquisition deteriorated for those who did not continue supervision. Morrell et al. (2011) trained health visitors in CBT for use with postnatal depression as part of a randomized controlled trial comparing CBT and person-centered approaches. They found a reduction in depressive symptoms at six months and some evidence of benefit for some of the secondary outcomes at an eighteen-month follow-up. No details were provided on length or type of training.

Primary Care Staff

There is a growing literature on CBT training in the primary care setting. This literature examines a number of different disciplines involved in primary care services (for example, physicians, nurses). For example, Rose et al. (2011) reported on CBT training for fifteen primary care staff who were trained to deliver computer-assisted CBT to anxious clients. Training involved didactics, video demonstrations, role plays, computer-assisted practice, and group supervision. High levels of proficiency and satisfaction were reported. Maunder, Milne, and Cameron (2008) described a brief CBT training for twenty-five primary care practitioners (PCPs) that involved a three- to four-hour workshop, followed by group case discussion for six hours and the provision of a manual. At post-test CBT knowledge (measured by a quiz) increased. In addition, the PCPs had positive reactions to CBT and reported transfer of CBT to their practice. King et al. (2002) described a training program for general practitioners (GPs) that equated to two full days of training. No discernible differences in patient outcome compared to a control group were found. The researchers concluded that greater duration of training and continued support may be required to achieve positive findings. Pierce and Pearce (2003) surveyed GPs who had participated in previous CBT workshops. Most stated that they regularly or occasionally used CBT, recognized its usefulness, but saw several barriers (such as time constraints) to implementation in their practices. Taylor, Davidson, and King (1997) described CBT training designed to assist GPs in managing depression. No outcome data were reported.

Community Mental Health Staff

In this section, brief CBT training for a variety of professional groups is described. This is not intended to describe more extensive post-graduate CBT training as detailed and reviewed in chapter 10. Westbrook, Sedgwick-Taylor, Bennett-Levy,

Butler, and McManus (2008) reported on the training of inexperienced mental health workers, including occupational therapists, nurses, and day care officers. These trainees received ten days of didactic training and fifteen hours of group supervision. The Cognitive Therapy Scale (CTS) and patient outcome were compared from baseline to the end of treatment, and significant changes were found on both measures. Simons et al. (2010) described the training of twelve community mental health therapists with a two-day workshop that was followed by one year of phone consultation. Trainees were specifically prepared to provide CBT to depressed patients. Comparing the Cognitive Therapy Scale (CTS) before and after training, and at six and twelve months post-training, significant changes in scores were found in the short term and were maintained at follow-up. Patient outcome was also shown to be affected by treatment following training versus treatment as usual. Lopez and Basco (2011) described the feasibility of disseminating CBT in public health settings in Texas. Training and supervision over five months, of a small number of clinicians, resulted in competency levels equivalent to those used as the criterion for competency in outcome studies. Treated clients also had positive outcomes. Hamblen et al. (2010) trained 104 community therapists to deal with post-Hurricane Katrina trauma through a two-day training in CBT for post-traumatic stress disorder with ongoing consultation. Trainee knowledge and self-perception of skill was assessed through self-report questionnaires. Training was further evaluated through client reports. They reported that 90 percent showed excellent retention of CBT knowledge, and both client and self-report questionnaires suggested utilization of skills. Williams, Martinez, Dafters, Ronald, and Garland (2011) trained community and inpatient mental health staff in CBT self-help-based services with 38.5 hours of didactic training and 5 hours of supervision. Both CBT knowledge and skills were evaluated, and both improved significantly and were maintained at three-month follow-up. Manassis et al. (2009) described an innovative child CBT training model for community mental health practitioners in Ontario. At the end of training, some of which was delivered via video conference, and at six-month follow-up, knowledge, self-reported confidence, and desire to do further child CBT improved. Beidas, Edmunds, Marcus, and Kendall (2012) compared three training modalities in CBT training for anxious youth. Three one-day workshops were provided to each group, who received standard training, an augmented/active learning training, or a computer-based training. All 115 community therapists in the study participated in three months of ongoing follow-up consultation. Role-play ratings, a test of knowledge and satisfaction measures, overall, showed limited gains in knowledge and skill with no difference between groups. Number of consultation hours after training did predict better outcome. There was more satisfaction in the other two groups compared to a computer-based training group. Rees and Gillam (2001) and Rees et al. (2009) described the use of video conferencing for training mental health professionals in rural and remote areas of western Australia. They found significant improvements in knowledge

after training, and high levels of satisfaction and self-reported use of CBT in their practice. Armstrong et al. (2010) reported on social workers given brief face-to-face CBT training (fifteen hours) and who were subsequently evaluated using the Cognitive Therapy Scale in simulated consultations with depressed patients. They found significant CTS changes from pre- to post-training and also increases in confidence and self-reported competency. Kerfoot, Harrington, Harrington, Rogers, and Verduyn (2004) compared brief CBT training for mental health providers working with depressed adolescents with a control group who later received training. Perceptions of knowledge and skills improved after training, but the outcome for clients did not differ between the groups.

Several studies evaluated CBT training for substance abuse treatment providers. Morganstem et al. (2001) described training twenty-nine substance abuse counselors in CBT for substance abuse, using a treatment manual, one hundred hours of training and two hours of supervision per week. They found knowledge, attitudes, and ratings of competency improved from pre- to post-training. The training was well received as evidenced by high levels of reported satisfaction and positive attitudes, and 90 percent of trainees achieved adequate levels of competence. Sholomskas et al. (2005) compared the utility of CBT training for inexperienced therapists using a manual versus using a manual plus supervision. The training involved three days of didactic training on the manual, role plays, and three phone supervision sessions. Competence was similar to that achieved in randomized controlled trials. One notable finding is that skill improved only when there was a supervision component. Weingardt et al. (2009) described training 147 substance abuse counselors using Web conferencing and supervision. There were two conditions with variations in adherence to the CBT protocol (high and low fidelity) and control over the curriculum sequence and emphasis. They found similar improvements in CBT knowledge and self-efficacy ratings. Larson et al. (2009) also used a Web-based CBT course and found high levels of satisfaction and learning of new information.

CONCLUSIONS FROM THE EVIDENCE BASE

Conclusions are difficult to draw regarding the efficacy of CBT training for nontraditional groups because of the methodological issues pervasive in this literature. Measures of competency vary widely. Such measurement variation is also a problem in the broader CBT training literature (Muse & McManus, 2013). Very few of the studies reviewed used both observer competency rating (CTS) and patient outcome measures, with Westbrook et al. (2008) being one notable exception. Most researchers used measures of knowledge, or self-report of skill, or both. Neither method bears a strong relationship to actual behavior change. In some cases patient outcome was used as a measure of training effectiveness, although the use of patient outcome as a measure is also problematic (Muse & McManus, 2013).

Despite the methodological concerns, several important conclusions can be drawn from the literature:

- One-time training events do not lead to sustained change in clinician practice at an acceptable level of competence and with acceptable levels of fidelity (Miller & Mount, 2004; Sholomskas et al., 2005).
- Increases in knowledge may not lead to change in behavior, and self-perception of skill is not correlated with actual behavior (Brosnan, Reynolds, & Moore, 2008). This suggests the importance of engaging trainees in actual practice through case work, behavioral rehearsal, self-reflection, and self-practice.
- Training may require a more systematic approach than the “train and hope” approach (Stokes & Baer, 1977). Some of the reports previously described used more than traditional didactic instruction and an experiential component (Rose et al., 2011; Westbrook et al., 2008). Consultation/supervision components were used in several studies (Hamblen et al., 2010; Simons et al., 2010; Westbrook et al., 2008; Williams et al., 2011) and in studies in which a comparison was possible pointed clearly to the advantage conferred by continued supervision (Mannix et al., 2006; Sholomskas et al., 2005).

Other methods of effective training delivery have been identified and include:

- Computer-assisted training (Rose et al., 2011; Weingardt et al., 2009)
- Video conferencing (Rees & Gillam, 2001; Rees et al., 2009), and
- Distance learning (Bennett-Levy & Perry, 2009; Reilly & McDanel, 2005)

These are good options for trainees in remote areas, and when cost is an issue for an agency (which is very often the case) because no costs are associated with travel and housing for the trainer (see chapter 7 for a thorough discussion of the use of technology in training).

- Work sample ratings using the CTS added to supervision/consultation follow-up may extend learning (Simons et al., 2010). Beyond ongoing assessment of skill and competency, this method allows learning through feedback and shaping (see chapters 4 and 5 for more information regarding this aspect of training).
- Treatment manuals (Morgenstern et al., 2001; Sholomskas et al., 2005) and self-help materials (Williams et al., 2011) may augment learning with good results.

Research indicates that providers from nontraditional backgrounds, such as nurses, occupational therapists, case managers, palliative care workers, and relatively inexperienced counselors and therapists (CBT “novices”) can be successfully trained, especially when the training is of adequate length and includes a supervision component.

BEST PRACTICES FOR TRAINING

A number of best practices can be identified that are related to training nontraditional groups. These practices include:

- Tailor training to the specific needs of those being trained.
- Utilize different training modalities with a heavy emphasis on active methods.
- Utilize online delivery methods to increase training contact and overall dissemination.
- Include follow-up components whenever possible, such as continued skills practice, and ongoing supervision and consultation.
- Measure core competencies and skills, not just knowledge (see chapter 2).
- Utilize scientifically supported instructional methods.

Common Pitfalls and Solutions

There are several common pitfalls in training nontraditional groups.

Pitfall 1: Trainees Believe CBT Is Not Applicable to Their Client Populations and/or Work Settings *Possible solutions.* Stirman et al. (2013) surveyed clinician perspectives on CBT in community mental health settings and found most believed CBT could be effective for at least some of their clients and that a minority did not perceive it to be a good fit for all of their clients' needs.

- Demonstrate the relevance of CBT for the trainee population and work setting. Many clinicians remain skeptical regarding the generalizability of research findings to their clients and their practice setting.
- Training events must emphasize the empirical evidence for CBT with clients who are not bright, not psychologically sophisticated, and who have multiple diagnoses. Common myths regarding CBT should be actively dispelled. Such myths include the beliefs that a high IQ, good vocabulary, and psychological mindedness are necessary for good outcomes. Training should clearly describe, demonstrate, and instruct trainees in the modifications of standard CBT when working with such populations. Training must deal with the kinds of issues that surface in trainee daily practice rather than those encountered by the trainer.
- Video demonstrations or role plays of CBT delivery with the type of client, setting, or type of problems they encounter are valuable means of aiding the “buy-in” of these trainees. A number of videos that model CBT delivery with these kinds of parameters are available at www.wiley.com/go/sudak in *Appendix VII, Video Library*.

WATCH: Go to www.wiley.com/go/sudak: *Appendix VII, Video Library* and View Videos:

- Dealing with Distractions in the Home Setting, Part I
- Dealing with Distractions in the Home Setting, Part II
- Difficulty Identifying Automatic Thoughts, Part I
- Difficulty Identifying Automatic Thoughts, Part II
- Dealing with Realistic Automatic Thoughts, Part I
- Dealing with Realistic Automatic Thoughts, Part II
- Dealing with Homework Non-Compliance, Part I
- Dealing with Homework Non-Compliance, Part II

Pitfall 2: Trainees See CBT as Being Beyond Their Competency *Possible solutions.* This issue, related to Pitfall 1, occurs when trainees view CBT as an “ivory tower psychotherapy” only traditional therapists can do. Stirman et al. (2013) found that a number of surveyed clinicians considered CBT implementation a challenge.

- Convey outcome evidence about the effectiveness of CBT delivery by nontraditional professional groups (for example, nurses, case managers, paraprofessionals, and peer specialists) reported in the literature. (*Note:* Bennett-Levy et al., 2010 is an excellent resource in this regard.)
- Challenge the underlying self-perception of these trainees (that they are incapable of doing CBT) and facilitate a sense of self-efficacy by means of graded assignments and a gradual acquisition of knowledge and skills. Remember that many trainees, especially those with bachelor’s-level education, possess minimal knowledge of basic counseling skills and theory. Peer specialists may not possess more than a high school education. A useful perspective to adopt is that individuals undergoing training can learn the model and skills characteristic of CBT easily just as clients do.

Pitfall 3: Trainees Are Resistant to the Model Because of Prior Therapy Allegiances or for Other Reasons *Possible solutions.* Individuals have been practicing for some years and were trained in a different model (for example, family systems, client-centered therapy, and so on). So may be uncomfortable with learning and delivering CBT because they see it as inconsistent with their previous practice or training. The trainer who is aware of this issue (possibly because of comments made or questions raised during training, but preferably identified during a pre-training assessment) can consider a number of different strategies.

WATCH: Go to www.wiley.com/go/sudak: *Appendix VII, Video Library* and View Videos:

- Problematic Trainee: CBT Seems Superficial
 - Problematic Trainee: Trainee Afraid CBT Will Therapeutic Alliance
-
- At the onset of training, questions can be asked such as “How familiar are you with CBT? Are there other models you have a lot of experience with? If so, how do you think they can be integrated?” This encourages an inclusive rather than an “either/or” view. Often this leads easily to a discussion of myths regarding CBT when they can be elicited (it is too rational and doesn’t deal with emotions, it never looks at developmental history which is important, and so on) and dispelled.
 - Throughout training the trainer can point to ways in which CBT and other approaches have been successfully integrated (for example, the incorporation of systems approaches into couple and family CBT by Dattilio, 2013; the use of Rogerian methods in motivational interviewing as described by Miller and Rollnick, 2012).
 - Have the training group brainstorm what they know or have heard about CBT. They should be asked to include any negative impressions or perceived weaknesses. This can lead to a discussion that may provide some corrective information and also models the openness, nondefensiveness, and collaborative approach inherent in CBT practice.
 - Finally, trainers can speak to the issue of skepticism being inherent in the CBT approach. Trainees and clients, in line with the model, are encouraged to review evidence and test assumptions rather than accept them at face value. This would mean that the skeptical trainee is encouraged to see whether CBT might make sense to them or work for their clients after they have acquired knowledge and skills or tried it in practice.

Pitfall 4: Trainees Superficially Implement CBT or Use It in a Purely Technical Manner *Possible solutions.* Stirman et al. (2013) reported that a minority of clinicians surveyed regarding CBT in community mental health setting thought of CBT as one of many interventions they would use with clients. Reasons provided included preferences for other modalities (see previous) or a belief that CBT would be most useful when integrated with other practices. The danger here is that clients do not receive best-practice CBT, which is conceptualization driven.

- Stress the formulation of cases from a cognitive-behavioral perspective leading to a systematic and planned use of interventions (which could include techniques derived from other models). This approach prevents the

more unsystematic shotgun approach of using techniques somewhat arbitrarily.

- Because CBT has many effective techniques, it is important that trainers introduce these only in the context of a good understanding of the CBT model in general, the CBT model of specific disorders, CBT conceptualization, and the more general skills of CBT practice (structure, collaboration, guided discovery, and so on).
- Prevent trainees from adopting a PACMAN version of CBT (every negative automatic thought elicited is immediately challenged using a CBT technique).
- Integrating CBT and other approaches should be addressed and the idea promoted that this is not necessarily inappropriate provided there is a coherent conceptualization which provides a framework for interventions. Steps should be taken to ensure the client is not confused if this approach is elected and both therapist and client must have a good understanding of the direction of therapy. That is, technical eclecticism versus theoretical eclecticism should be discussed with an emphasis on the acceptability of the former relative to the latter.
- Stress that following a protocol in its entirety (for example, ERP [Exposure and Response Prevention] for obsessive-compulsive disorder) is much more likely to result in a positive outcome than picking and choosing elements that the trainee arbitrarily decides will be successful.

Pitfall 5: Trainees Have Been Mandated to Training Possible solutions.

Frequently trainees are required to attend training whether they are interested or motivated to acquire skills. This issue is often related to the degree of organizational support for training. Mandated training often creates a good deal of resistance both for the individual and the organization. Training mandated by the state or other agencies is often hastily cobbled together and thus less optimally designed and delivered. Training mandated for weekends or other unsuitable times is likely to create animosity. Agencies often do not wish to schedule trainings at times when they will lose billable hours. Explore training-day options with this in mind and, if possible, train at locations that are separate from the work place to facilitate the optimal “learning set.”

- Address mandated training from the start with trainees: “How do you feel about undergoing the training?” This may be an excellent opportunity to explain the cognitive model of situation-thoughts-feelings and explore how thoughts could be reframed with a better outcome.
- Explore with the group how they could make the best use of time in training and what they might wish to know (Fennell, 2010). This openness and collaboration, highly consistent with CBT itself, may be disarming and conquering of a potential impasse. Highlight the commonsense appeal of

CBT and discuss how this feature may facilitate client “buy-in” relative to other approaches. Because most people have a general notion that thoughts are related to emotions, they are able to readily see how CBT may be of benefit to them. However, one must communicate that, although intuitive, CBT is more than “folk psychology.”

- Programming instruction that enhances trainee motivation is essential and should be a routine part of training delivery. Specific methods for accomplishing this are detailed in chapter 3 of this volume.

Pitfall 6: Lack of Organizational Support Inhibits the Training Experience, Transfer, and Generalization *Possible solutions:*

- Release trainees from work obligations during training.
- Provide a pleasant off-site venue for training to engender more positive attitudes toward training.
- Stress the value to the individual and not just to the agency of quality training (the benefits of professional development) and providing opportunities for follow up by the trainees. We refer the reader to Stirman et al. (2013) for an outline of barriers and boosts derived from their survey data.

A good example of managing these pitfalls occurred in North Carolina, where agencies have been mandated to provide twenty-four hours of evidence-based training to all staff who provide billable services reimbursed by Medicaid. One agency required individuals to attend training on a Friday, Saturday, and Sunday with eight-hour training days. The staff were not pleased with losing their weekend, losing billable time on the Friday, nor with the extremely long training days. In contrast, another agency requested three weekday training dates, each separated by a month. The time between training dates allowed for trainee practice as well as consultation experiences with more experienced CBT staff. Following training, group consultation/supervision was set up monthly for one year with the original CBT trainers. The messages given to trainees in these two instances were quite different. One communicated a stronger value attached to training and this had a positive impact on the trainees. Trainers should engage in early discussions with organizations regarding how they can maximize the learning opportunities for individuals. Stirman et al. (2013) found that clinicians frequently identify high workloads and productivity demands as barriers to adequate supervision and training time. These organizational-level concerns should be addressed to optimize training impact.

Pitfall 7: Training Is a One-off Experience with No Follow-up *Possible solutions.* The literature is clear: Workshops alone rarely lead to behavior change. Consistently, the literature points to the superior training outcomes achieved with supervision or practice added to didactic instructions. Unfortunately, training

delivered to nontraditional groups is often organized in a stand-alone fashion. Here are some solutions to this problem.

- Emphasize the importance of follow up. This could take a number of forms: follow-up training sessions focused on concept and skill review, discussions about the application of previously learned methods, group case consultation/supervision (in person or by video conferencing or telephone), and/or goal setting around self-reflection and self-practice with opportunities for review and feedback. These follow-up sessions may be conducted by the original trainer or by the original trainer taking a train-the-trainer approach.
- More highly skilled practitioners within the organization may be identified and instructed in these methods of follow-up. This approach may also reduce cost for the agency which may help remove a barrier to continued training. Again, the primary goal is to abandon the “train and hope” philosophy, which is ineffective (Stokes & Baer, 1977), by carefully designing training to ensure more robust behavior change over time by providing follow-up and supervision. As previously noted, an immediate increase in trainee knowledge and self-reported skill do not correlate well with actual behavior change in clinical work (Brosnan et al., 2008).

For an example of the general process described here, a brief description of the results of a pre-training assessment and the resulting syllabus can be found at www.wiley.com/go/sudak: See *Appendix IV, Sample Syllabi, Course Modules, and Training Design Sample* for Sample Syllabus: Training Nontraditional Trainees. Also refer to *Appendix II, Forms and Tools* for the Interview Template for Administrators of Nontraditional Trainees (for interviewing administrators’ pre-training) and the Nontraditional Trainee Survey (for surveying trainees pre-training when possible; this may be done inexpensively through online survey platforms, too).

SUMMARY

The demand for training delivery to nontraditional groups is increasing substantially. In this chapter, the key characteristics and training needs of this highly diverse group were described and a general instructional design process proposed. Further, several barriers to effective instructional design and delivery to this population were depicted and solutions offered.

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EVIDENCE-BASED SUPERVISORY PRACTICES IN CBT

Derek L. Milne and Robert Reiser

What is cognitive behavior therapy (CBT) supervision? CBT supervision meets the general definition of clinical supervision (Milne, 2007), adding some distinctive features that reflect CBT as a therapy. According to authoritative procedural accounts (Beck, Samat, & Barenstein, 2008; Liese & Beck, 1997; Padesky, 1996), these elements include a high degree of session structure and direction (for example, detailed agenda setting), but within a fundamentally collaborative relationship. A helpful description of the overlaps between CBT and CBT supervision can be found in chapter 13 by Sokol and Fox, which also includes a discussion of session structure. Within CBT supervision there is a primary emphasis on cognitive case conceptualization, mainly through the use of case discussion to develop diagrammatic CBT formulations, but discussion should be combined with other CBT techniques including Socratic questioning, guided discovery, educational role play, behavioral rehearsal, and corrective feedback (see chapter 13 by Sokol and Fox for more on the advantages of using multiple methods). Another distinctive aspect is a focus on evidence-based principles and methods, including the use of reliable instruments for feedback and evaluation, in

We thank Valentina Short and Rob Dudley for permission to use the recording of their CBT supervision session within the learning exercises. SAGE grew out of other tools, involving collaboration with Ian James, Ivy-Marie Blackburn, Mark Freeston, Peter Armstrong, Mike Dudley, Dominique Keegan, Polly Ashworth, and Alison Chalk. We thank them all for their input.

relation to both therapy and supervision (Reiser, 2014). Perhaps the single most defining characteristic is thought to be the active and routine commitment to research methods and findings: where other approaches turn to theory and clinical/supervisory experience for guidance, CBT supervision ultimately appeals to “the data”. Ironically, to date the data indicate that we have some way to go in actually conducting CBT supervision according to this theoretical blueprint (Milne, 2008). Therefore, the aim of this chapter is to assist in improving fidelity to the model, through providing detailed guidance on the supervision competencies, by encouraging and by offering enabling resources (guidelines and a tool to facilitate corrective feedback). (See www.wiley.com/go/sudak. Here you’ll find Evidence-Based Clinical Supervision Guidelines and the SAGE Rating Manual in *Appendix III, Manuals* and the SAGE Record Sheet in *Appendix II, Forms and Tools*.) Chapter 7 by Trent Codd III notes some technological advances that could also prove enabling.

In common with other approaches, CBT supervision recognizes the importance of a vigorous collaboration between supervisor and supervisee, an alliance in which both play necessary and complementary roles. This contrasts somewhat with the traditional view of the supervisor as the sole influence or primary consideration, and this modern partnership is suitably reflected in the account that follows. A clear illustration of effective collaboration can be found in studies of the supervisory alliance (Beinart, 2014), whereas the damaging consequences of problematic co-working underline the vital necessity of a strong alliance (for example, unethical supervision: Ladany, 2002).

WHAT ARE THE EVIDENCE-BASED SUPERVISORY PRACTICES IN CBT?

They are the subset of the CBT supervision competencies (Roth & Pilling, 2008), for which there is adequate empirical support (for example, Milne et al., 2010), which are specified with sufficient procedural detail to apply directly within supervision (“micro-competencies”). What exactly does the existing literature tell us about the evidence for CBT supervision? There are four broad types of literature about CBT supervision: narrative and systematic reviews; expert consensus statements; and original research. These CBT literatures have been reviewed conjointly by Milne (2009) and most recently by Reiser (2014). Relevant recent contributions include:

- *Narrative reviews*, in which authors set out the theoretical aspects, guiding principles, and practice recommendations, as they perceive them (Gordon, 2012; Reiser & Milne, 2012; Reiser, 2014)
- *Systematic reviews*, in which a carefully selected body of research is analyzed in a replicable, objective manner (Milne et al., 2010; Reiser, 2014)

- *Expert consensus statements*, in which a systematic approach is taken to capturing what experts regard as the key theoretical and empirical aspects (for example, Milne & Dunkerley, 2010; Roth & Pilling, 2008)
- *Research studies*, in which hypotheses about supervision are examined, measurement instruments are presented, surveys of supervisors are conducted, and so on (Breese, Boon, & Milne, 2012; Milne, Reiser, Cliffe, & Raine, 2011; Townend, Iannetta, & Freeston, 2002)

Such supporting evidence should be sifted by experts and summarized within detailed specifications of supervision (for example, research protocols, training manuals, practice guidelines, measurement instruments), preferably following some established procedure, and subjected to peer review (for example, Milne & Dunkerley, 2010). We believe that combining these sources together provides the best-available evidence for CBT supervision (Milne & Reiser, 2012), and will next specify some of the practice implications that follow from this knowledge base.

EVIDENCE-BASED CBT SUPERVISION PRACTICES

What are the most effective, evidence-based competencies within CBT supervision? In this section we summarize SAGE, one of the few available instruments for measuring competence in CBT supervision by direct observation (SAGE: *Supervision: Adherence and Guidance Evaluation*; Milne et al., 2011). This instrument specifies seventeen micro-competencies for which there is sound evidence, linked to their impact on the supervisees' learning during supervision, specified in terms of five modes of experiential learning (experiencing, reflecting, conceptualizing, experimenting, and planning). Some of these competencies require leadership from the supervisor (for example, managing), some are shared responsibilities (for example, collaborating), while some focus on the supervisees' response (for example, reflecting). In this sense, we regard SAGE and this summary as potentially empowering for supervisors and supervisees alike. For space reasons we summarize these twenty-two SAGE items here: a more detailed account can be found in the full SAGE manual (see *Appendix III, Manuals* on www.wiley.com/go/sudak). Each such item is rated on a seven-point competence rating scale, ranging from "incompetent" to "expert." SAGE operationalizes the CBT supervision competencies concerned with facilitating supervisees' learning (Roth & Pilling, 2008) and is consistent with international, consensus-based guidelines (Olds & Hawkins, 2014).

SETTING THE STAGE FOR COMPETENCY-BASED SUPERVISION

Before detailing the SAGE competencies, we mention something about procedure. We would encourage supervisors and supervisees to place competencies on

the initial supervision agenda, as part of the process of agreeing to the learning/supervision contract. Within this discussion we believe that SAGE can provide guidance on relevant educational needs (for example, preferred learning styles; valued supervisory methods), and clarity about the goals (for example, frequency of using identified competencies—such as demonstrating—to facilitate experiential learning). Thus, SAGE can provide an initial framework for discussing the supervisor's orientation and approach to supervision and clarifying expected roles, behaviors and expectations with the supervisee. For example, we are likely to introduce our supervision model quite explicitly. An illustration follows in a written supervision contract that we review directly with the trainee in initial sessions to set the stage for what is to come.

Supervision Model

My theoretical orientation is based on a behavioral and cognitive behavioral approach to treatment with a focus on interpersonal dynamics and emotional processing. I am committed to providing evidence-based supervision. Supervision sessions are typically structured and agenda driven with a focus on identifying and developing a clear learning objective in each session. This requires a higher level of preparation for supervision sessions than may be necessary for other types of supervision. You will want to prepare for your sessions with me by taking an active role in identifying what you hope to learn, specific problems you are having, and cueing up your recordings to the proper place for us to watch together. Some students prepare by jotting down notes or bullets to help organize their thoughts before the session. It is possible that your supervision sessions will be audio- or videotaped so that I can get feedback from a consultant on my supervision.

My supervision is designed to enhance didactic information with experiential approaches including reflection and emotional experiencing in the session, modeling of desirable interventions and behaviors, direct video observation, and rehearsal of interventions with specific feedback. It is likely that you will be anxious at times in supervision, and I want to make sure we discuss this as it occurs. Discussion of your feelings and personal experience in supervision and as a therapist in training is an important part of the process of your professional development. I strongly encourage you to consult empirically based resources such as treatment manuals, journal articles, and other texts and to conceptualize cases and develop action plans based upon these resources. I routinely review videos of your sessions with you in addition to discussing your cases with a focus on case conceptualization. You are likely to be asked to complete assignments outside of supervision some of which may involve using SR/SP (self-reflection/self-practice) exercises designed to help you understand more about your thoughts, feelings, and reactions as a therapist and supervisee. My

supervision utilizes a developmental model that attempts to take into account your competence level and your ability to practice independently and allows graduated degrees of freedom for you to rehearse and practice interventions. My goal as a supervisor is to focus on your professional development, and to provide learning, teaching, and mentoring that will be of benefit in terms of your personal development.

Nature of Supervisory Relationship

In order for supervision to be effective, I hope that our relationship includes open communication and two-way feedback. I value openness to learning as a continuous, developmental, lifelong process, and I will do my best to promote openness and receptivity to your feedback. I will ask you for feedback in every session, and I may ask you for written feedback about me regularly. Your honest feedback will help me navigate supervision with you and be as effective as I can. Also, it is important to me that supervisees be willing to openly explore their values, beliefs, interpersonal biases, and conflicts considered to be sources of counter-transference in the context of case material. I expect that supervisees will express disagreements and differences in opinion with me, their supervisor. I expect that supervisees will attempt to address conflicts in the supervisory relationship. Supervision will take into consideration personal factors such as values, belief systems, biases, conflicts, and predispositions. I believe in the importance of respecting and addressing cultural and diversity differences in the supervisor–supervisee–client(s) triad. Attention will be addressed to assessment of your individual learning needs at the onset of and throughout the training sequence. The supervisory relationship is a two-way process through which growth is enhanced and mentoring is accomplished. We will jointly develop goals for your professional development.

SAGE can also contribute to clarifying how things are going during ongoing supervision sessions, and, finally, in reviewing/evaluating supervision at its close. The learning exercises provided at the end of this chapter offer some illustrations of how SAGE might be used to evaluate and provide feedback on specific competencies and how deficiencies or problematic supervisory behaviors might be addressed by a trainee. Please note that this book also provides a detailed account of feedback, including ways to use it most effectively (chapter 5, by Sudak), and chapter 13 (Sokol & Fox) discusses the importance of relating feedback to explicit criteria (like the SAGE items).

The first theme within SAGE concerns the way that a competent CBT supervisor should structure and generally manage supervision sessions, which we label the “common factors,” as we believe them to be shared across the various supervision approaches.

1. *Relating* The supervisor ensures that the “core conditions” (warmth, genuineness, concreteness, empathy, and understanding) are present within supervision. Also, a nurturing mode of relating fosters the learning relationship, including nonspecific reassuring, agreeing and encouraging, and a responsive rapport (including nonverbal gestures—for example, nodding of the head), together with motivating messages and positive reinforcement. At times, competent supervision will entail conceptualizing how and why difficulties arise and collaboratively problem solving these with their supervisee. To acknowledge and normalize difficulties, supervision could begin with a “check-in,” initiated by simple questions, such as “How are you today?” or “How are you finding the work?” Through this kind of check, supervisors can detect significant problematic feelings (for example, anger or lethargy), and can collaboratively decide how to address these issues with the supervisee.

2. *Collaborating* The supervisor should encourage the supervisee to be an active partner in the supervisory experience (for example, having shared goals and a mutual engagement in the work). There should be productive teamwork, with the supervisor encouraging the supervisee to participate fully. The collaboration ensures that the needs of the supervisee and the requirements of the training course/workplace/supervision are met. It also ensures that supervisees take the appropriate level of responsibility and control, with respect to their learning experience. The manner in which supervisors conduct the session is crucial to this competence, as they must neither be too passive nor too domineering. The supervisor must also give the supervisee sufficient time to think (for example, to reflect on recent experience). Common examples include attempting to make decisions collaboratively; explaining why an action is important; grading tasks (for example, prioritizing the learning objectives on the agenda); activity scheduling; coordinating and liaising; encouraging supervisee input regarding topics and learning processes; and inviting the supervisee’s feedback on clinical demonstrations (modeling).

3. *Managing* Competent supervisors provide structural statements (“signposts”) or offer similarly appropriate verbal and nonverbal “scaffolding” (for example, reminding supervisees about time limits or other boundaries). Pacing should be appropriate to the needs of the supervisee, ensuring that the session flows smoothly yet addresses the agenda fully. Although digressions may be indicated if important (for example, unexpected issues arise), unproductive digressions should be dealt with swiftly. The structuring involves establishing order (for example, agenda setting; introducing a topic or creating a task); setting up learning situations (for example, creating or arranging teaching materials); and other leadership acts (being “in charge”). Other examples include creating a bridge from the previous session, by asking questions (for example, “What did you learn last time?” or “What did we discuss last time that was most important or useful to you?”). Other

common examples of “managing” are prioritizing tasks; actively scheduling; coordinating; and liaising.

4. *Facilitating* The supervisor fosters the supervisee’s development through a gentle, quizzical style of questioning, or through setting challenging behavioral tasks. The aim is to help supervisees to reconceptualize and change their approach, as necessary. This type of questioning (which parallels Socratic questioning in cognitive therapy) or activity should ultimately promote appropriate consolidation, or change, in terms of the supervisee’s actions, feelings (for example, attitudes), or conceptual understanding. The supervisee may enter a stage of cognitive dissonance (perplexity) or behavioral deskilling as a result of the questioning (or due to struggling with a behavioral task, like a role play). This should be acknowledged as a necessary preliminary to significant development, that is, normalized and praised. Prior to the end of the session, efforts should be made to stabilize any new learning (assimilation or accommodation). An example is a supervisor facilitating a supervisee’s reconceptualization of a case by asking open-ended questions (such as, “How do you understand the client’s behavior toward you in the therapy session, in relationship to their unassertiveness?” and, “What options do you have at this point?”).

The next thirteen competencies relate to behaviors that are more specific to CBT supervision, all belonging to a factor that we term the “supervision cycle” (borrowing from the training cycle). These behaviors represent a problem-solving cycle, so they work best when combined and when reviewed in the light of emergent progress or problems (as per the “experiential learning cycle” specified in SAGE items 18–22).

5. *Agenda Setting* The supervisor ensures that agenda topics are agreed to in an appropriate way and are carefully defined. This helps to focus the session on specific goals, facilitating management, pacing and review. The topics should be “needs led,” taking into account the supervisee’s current concerns, what stakeholders deem relevant (for example, a training program’s need for evaluation), and the current needs of the clinical service (for example, patients’ needs). The supervisor is a major stakeholder, and may choose to place an item on the agenda because the supervisee’s therapy tape indicated a poorly focused session. Within the supervision session, the supervisor might decide to review the structuring of cognitive therapy sessions, and the direction that therapy should take. Once agreed, the agenda should be followed, although flexibility in collaboratively redirecting the agenda when pressing clinical issues arise in the moment is an indicator of expertise. But any change of plan should usually be made explicit (for example, agreed or renegotiated). It is also desirable that the supervisee is socialized into collaborative agenda setting. The supervisor may therefore use questions like “What are you hoping to learn today?,” and “What specific skills

should we reflect on today?” From the perspective of the supervisee, we have found it empowering to provide them with a helpful list of experiential learning “milestones”. These can readily be rephrased as agenda items (for example, “I want to learn to better recall and summarize recent events”: Milne, 2009, pp. 151–152).

WATCH: Go to www.wiley.com/go/sudak: *Appendix VII, Video Library*, and View Video:

- CBT Supervision: Agenda Setting

6. *Demonstrating* The supervisor actively attempts to develop the supervisees’ competence by modeling the correct performance of a skill (or ways of thinking, or of responding to affective material). The supervisor helps supervisees to learn by engaging them in an appropriate experiential activity, such as leading practical learning activities. Examples include modelling (demonstrating), drawing on video materials, simulation, rehearsal, and educational role play. These activities can also help supervisees to identify potential obstacles and to think through their therapy work (for example, the change mechanisms that are considered important to facilitate their patients’ progress). These types of activities are strongly linked to acquisition of procedural skills, preparing the supervisee to actually enact the skill in the upcoming therapy session.

7. *Discussing* Like a good tutorial, this supervisory competence is intended to skillfully and constructively challenge supervisees’ understanding or grasp of key concepts (for example, “I wonder why you think that?” or, “I am very interested in how you might explain that”). It has an educational (exploratory) emphasis and should serve to energize and “prime” curiosity or reflection, at times even destabilizing them (introducing perplexity, confusion or doubt), so as to create the basis for an enhanced understanding or a cognitive shift. For example, supervisors might question, disagree or gently dissent from a supervisee’s clinical formulation. Discussing often entails the use of Socratic questioning, designed to be open-ended (divergent or exploratory) and to raise the supervisee’s awareness of key issues or concerns, without imposing answers or understanding authoritatively (unlike “teaching” or “training”).

8. *Evaluating* This can occur in minor, informal ways, such as noting the supervisee’s changing understanding during a discussion. More conspicuously, evaluation entails explicitly monitoring, checking, or evaluating the supervisees’ competence (for example, eliciting their knowledge of mental health presentations, judging their clinical proficiency, or assessing their cultural competence). It also includes encouraging supervisees to self-evaluate, as a vital part of their work

(for example, applying clinical outcome measures). Linking these different applications of evaluation is the idea that the supervisees' learning and clinical activity should be judged against relevant objectives, with the recurring question being: "Are we making progress?"

9. Giving Feedback Feedback often notes the positives and negatives in the supervisee's performance (for example, key strengths and weaknesses). It is intended to support and guide the supervisee through the use of praise, which should for maximum effect be specific, contingent and constructive (for example, "I really liked the questions you raised about the homework in the last session, particularly where you tried to heighten the patient's awareness"). At the very least, feedback should be provided through a general summary at the end of a session. Effective feedback helps the supervisee to gain insight (for example, perspective), to define improvement goals, to learn new things (for example, through a "shaping" process), to consolidate good practice, and to weaken faulty practice. Good feedback also allows supervisees to see that the supervisor has a good appreciation of their situation (empathy and understanding), contributing to the power of the feedback and to collaboration. The feedback style should be both supportive and constructive, and not given in a critical or belittling manner. Feedback can be either verbal or written. Examples include "I like what you have done here. You are being very clear and direct with the client about your formulation—nice work." Or, "I don't think you have really been collaborative enough in this part of the interview, I would like to see you ask more open-ended questions."

10. Receiving Feedback This is commonly done by asking supervisees about any helpful aspects of a session, such as things that can be transferred to the supervisees' clinical work. The supervisor can also ask the supervisee to summarize aspects of the supervision session, thus permitting the supervisor to determine whether the material being discussed has been understood and integrated. The manner in which the information is elicited should be open, encouraging supervisees to be honest and candid about their opinions and impressions of supervision. This feedback helps the supervisee and supervisor to develop a shared focus, and helps to ensure that both are collaborating fully. Examples include the supervisor actively eliciting feedback about any difficulties or discomforts that may have been experienced. Specific questions might include "What did you think of our session today?," "What did you think was helpful?," "Do you feel that it's been a bit difficult today?"). In such ways (and through self-disclosure), the supervisor demonstrates a willingness to receive feedback, which should be processed in an authentic, reflective, and genuine manner.

11. Formulating When formulating, the supervisor describes, analyzes, synthesizes, and explains aspects of their work, most typically patients' presentations. For

instance, the supervisor might use a whiteboard or flipchart to sketch out a diagrammatic formulation of a patient's depression or panic, based on questioning the supervisee in considerable detail (for example, "In what way do you see this client's behaviors in the session reflecting problems that they have discussed previously?"; "How might you best respond, based on your conceptualization of the case?"). In addition to modeling, supervisors may make considerable use of explanations, systematic questioning (as in raising a series of model-generated queries), or educational role plays (for example, playing the therapist, raising fresh perspectives with the supervisee, playing the patient). This blend of methods is intended to help supervisees to develop their own formulation skills. The process heightens the supervisees' grasp and awareness of issues, allowing them to develop clinical understanding.

12. *Listening* Supervisors should listen actively, paying close attention to what their supervisees' say and any other vocalizations. This is usually evident from their behavior, and it enables the supervisor to summarize, paraphrase, raise related issues, and in other respects to respond appropriately. For example, a supervisor might attend to an audio recording of the supervisee's therapy, using this to seek clarification or to offer feedback. Responsive listening is demonstrated by empathy, or by other suitably attuned reactions (for example, subtle changes in tone or direction, depending on what has been heard).

13. *Observing* Supervisors should observe their supervisees directly (for example, by sitting in or by conducting co-therapy, or through video or audio recordings). This is vital, because novice supervisees may fail to recognize important phenomena and may overestimate their competence, while experts may underestimate their ability. Supervisors should ideally review entire recorded therapy sessions prior to conducting supervision. Alternative options are to encourage the supervisee to play selected sections during supervision (for example, using the "interpersonal process recall" method), or to role-play significant interactions (for example, how to explain a formulation to a patient). Such observational practices enable supervisors to assess directly their supervisee's strengths and weaknesses, helping to prioritize topics to be discussed or rehearsed in supervision. When supervisees are reluctant to record their sessions, supervisors facilitate their doing so by exploring and addressing their objections in a professional and reflexive way (for example, by clarifying their automatic thoughts, such as "Recording will cramp my style").

14. *Prompting* The supervisor can help remind the supervisee about relevant material by prompting them to recognize a pattern or a link through verbal prompts (for example, "That sounds like your earlier point"). This can include repeating information, in order to encourage a fresh direction or deeper questioning (for example, "So, it seems that you are highlighting various ways in which

the patient may be unresponsive. How else might that be understood?”). Prompting may also include rephrasing or paraphrasing what the supervisee has said, both sharing an emphasis on adopting a fresh angle or action (for example, “To put it succinctly, all the patient’s concerns involve a fear of being embarrassed by their social incompetence”). Prompting can also be used to encourage reflection or the recall of key information, such as deliberating on implied feelings. These examples feature verbal prompting, but a supervisor may also use physical or visual prompting.

15. Questioning We have already noted how questioning can contribute significantly to such tasks as formulating or evaluating. The supervisor can also use questioning to help the supervisee to develop hypotheses regarding their current work problems, and to generate potential solutions, alongside other goals (James & Morse, 2007). This is partly because questioning helps the supervisee to develop a range of perspectives regarding the therapeutic process, and to better appraise the usefulness of different therapeutic techniques. A gentle, quizzical style of questioning, combined with appropriate nonverbal forms of communication, can be used to help supervisees to review, reconceptualize and possibly change their approach. Questions effectively fact-find, probe an issue, requesting a clarification, or exploration of a situation, action, or feeling (for example, “What will you do next?”). The supervisee may often enter a stage of cognitive dissonance as a result of questioning. Such a state of transient perplexity should be acknowledged and then resolved prior to the end of the session, in order to increase the likelihood of learning. Awareness-raising questions are particularly likely to trigger difficulty, as in a supervisor asking about the emotional accompaniments of the supervisee’s work. Questions have also been classified as Socratic, generic, critical engagement, task specific, transformational, and imaginative (for example, the “miracle” question: “If a miracle occurred, how would things be different?”). These are associated with characteristic functions, as in Socratic questioning guiding the supervisee’s discovery learning (Milne, 2009, pp. 124–125).

16. Teaching This refers to the supervisor providing public domain information to guide the supervisee (for example, theories, facts, ideas, methods, research findings). It is intended to achieve “information transmission,” and its style is suitably didactic, prescriptive, and directive (“traditional” teaching, conveying accepted knowledge). This process should inform supervisees, indicating what they might best do to achieve their goals (for example, reconsidering a treatment plan, based on learning about a recently published case study). Supervisors can also teach by referring to their own private domain information in order to reveal something relevant and appropriate about themselves (for example, personal experiences of evaluation). Techniques include summarizing relevant theories, guided reading, seminar-style presentations, detailing recent research findings,

recounting personal applications of techniques (“Here’s how I do it”), highlighting clinical guidelines, correcting misunderstandings. Expert teaching takes due account of the supervisee’s current concepts (is developmentally appropriate), the problems being discussed (is needs led), and the stage of therapy (is contextualized).

17. Training Teaching may be wide ranging, largely as it should be in response to the supervisee’s material (needs led). By contrast, training is a more circumscribed activity, being dictated (in the form of competencies or service standards, and so on), by accrediting bodies, the purchasers of clinical services, professional groups, and other stakeholders. Another key difference is that the reliance on talk within teaching (the “symbolic” mode) is supplemented by an onus on action and observation within training (the “enactive” and “iconic” modes). As a result of this experiential emphasis on action, supervisors should utilize a blend of methods to help their supervisees to learn by doing, through trial and error experimentation (classically by engaging them in an educational role play). Complementary methods include modeling, demonstrating, co-therapy, studying videos, simulation, and behavioral rehearsal. These training methods need to be appropriate to the learning needs of the supervisees, to their stage of development, and should also build on their strengths. The supervisor needs to be sensitive to the anxiety that is often encountered when conducting experiential activities, and thus should conduct the activity in a considerate/thoughtful manner.

FACILITATING EXPERIENTIAL LEARNING: THE INITIAL EFFECTS OF SUPERVISION

The effectiveness of these competencies can be judged initially by reference to the supervisees’ reactions. According to experiential learning theory (Kolb, 1984), the optimal response to supervision is when all learning modes are activated fairly equally within a session. For example, a supervisor who listens and asks questions may well encourage the supervisee to reflect. These are the five learning modes that make up the remaining SAGE items.

18. Experiencing The function of experiencing is to aid the supervisee in grasping (understanding) their sensory or affective experiences, in supervision and in relation to the material provided in supervision (for example, recounting incidents in therapy). Examples include the supervisees’ indicating awareness of current sensations; recognizing or identifying their own feelings; expressing an emotion or an awareness of a situation (for example, laughter, insight); regulating or managing emotions (positive or negative ones).

19. Reflecting The function of reflection is for supervisees to draw on personal understanding to make sense of recent experience. Examples include integrating material and assimilating things into a reasoned understanding. Reflection involves the free expression of the supervisees' own information and ideas (for example, storytelling, recalling), forming their own meaning.

20. Conceptualizing The function of conceptualizing is to enable public domain ideas to be better grasped or more deeply understood (for example, supervisee assimilating information, or reasoning something through). It may occur through drawing on the knowledge base (for example, theories, case studies); via analysis and synthesis; or through reformulation (and other ways of drawing on the supervisor's understanding).

21. Planning The functions of planning are problem solving and decision making. Supervisees draw on their own understanding to plan relevant action, possibly jointly with supervisor. Planning may occur in relation to making predictions; considering next steps; making action statements; goal setting; homework assignments; deciding or summarizing what to do next; drawing out the implied actions.

22. Experimenting The function of experimenting is to engage in action to test-out an understanding; it classically involves problem-solving efforts to develop knowledge through "trial-and-error" activities. Experimenting is most likely to lead to "accommodative" learning, where supervisees substitute old skills or understanding with newer, improved schemas or competencies. Examples include supervisees rehearsing a new skill (for example, in order to see what happens, gain competence, or to get feedback) and may occur in relation to educational role plays, learning exercises, or assigned tasks (like an experiment).

SUMMARY

CBT is distinctive in its commitment to research methods and findings, and we have summarized a blueprint for CBT supervision that reflects this empirical tradition. But surveys and direct observation indicate repeatedly that adherence to this model has been poor, so the aim of this chapter was to improve fidelity through providing detailed guidance on the supervision "micro-competencies,"

by recognizing and empowering the supervisee, and by providing enabling resources (guidelines and a tool to facilitate corrective feedback). Having detailed seventeen supervisory micro-competencies (together with the supervisees' experiential learning), we now use the following learning exercises to present these guidelines and an observational tool, developed alongside the competencies guidance.

There are four guidelines—Evidence-Based Clinical Supervision Guidelines—in *Appendix III, Manuals* on www.wiley.com/go/sudak. They provide a more general summary of these seventeen micro-competencies, in terms of the following macro-competencies: supervisory alliance, goal setting, facilitating learning, and evaluation (Milne & Dunkerley, 2010). Each guideline was prepared systematically, following an established procedure for building expert consensus on what constituted best practice. We next suggest a learning exercise that draws on these guidelines.

Research on the implementation of evidence-based practice indicates low adherence to such competence statements and guidelines, unless they are combined with supervision and active learning, including corrective feedback (for example, Beidas & Kendall, 2010). To help the implementation of evidence-based practice in CBT supervision, the second learning exercise uses our direct observation tool, SAGE, as the basis for such feedback. Corrective feedback is a particularly well-supported example of an empirically validated method in training and supervision (see, for example, Reese et al., 2009). SAGE operationalizes the competencies summarized earlier in the chapter, some of which we focus on in the following exercises. You may also wish to refer to www.wiley.com/go/sudak: *Appendix I, Recommended Readings and A/V Resources* for Audio-Visual Resources for CBT Training and Supervision.

LEARNING EXERCISES

- *Supervision guidelines.* From the four guidelines—Evidence-Based Clinical Supervision Guidelines—available in *Appendix III, Manuals* at www.wiley.com/go/sudak, choose the one that is most relevant to your current development. Study the guideline for points of agreement with your current approach (“hits”), but be especially alert for new ideas that might strengthen your supervision (for example, conducting an educational needs assessment). List these hits, drafting an action plan to develop your supervision accordingly. This could link to the use of SAGE (the SAGE Record Sheet is available in *Appendix II, Forms and Tools* at www.wiley.com/go/sudak) as a way to evaluate your progress.
- *Using SAGE to measure adherence to guidelines.* In this learning exercise we invite you to practice using SAGE to evaluate a brief segment of a supervision session, with the goal of applying your knowledge and obtaining feedback.

- You will find a completed SAGE record sheet (*Appendix II, Forms and Tools: Completed SAGE Record Sheet*) and the video CBT Supervision: Agenda Setting (*Appendix VII, Video Library*) in the Web resources at www.wiley.com/go/sudak.

For the purposes of this exercise, please review the brief clip aiming to identify as many as possible of the twenty-two SAGE competencies summarized earlier. You may view this clip repeatedly, until you feel that you have observed it thoroughly.

WATCH: Go to www.wiley.com/go/sudak, *Appendix VII, Video Library* and View Video:

- CBT Supervision: Agenda Setting

Once you have identified all competencies within this clip, the second task is to rate the supervisor's competence. Refer to the rating scale on the SAGE Record Sheet (1–6), making the rating for all your observed SAGE competencies.

The third part of this exercise is to make some written notes and suggestions, to explain your ratings and to capture the strengths and weaknesses of this brief sample of supervision.

Finally, compare your identified competencies, ratings, and feedback with our completed SAGE record sheet (www.wiley.com/go/sudak, *Appendix II, Forms and Tools*). Reflect on any rating discrepancies (two or greater): Why might these have arisen? The guidelines may shed some light, or you could study the full SAGE Rating Manual (www.wiley.com/go/sudak: *Appendix III, Manuals*).

- *Using SAGE as a self-study tool to rate your own supervision sessions.* SAGE can also be used as a fidelity check on your own supervision sessions. The supervisor can listen to their recorded supervision session or rate their supervision session ideally directly after supervision is completed. After completing the SAGE Record Sheet and reviewing your profile, we suggest that you then select two to three items with low scores that you wish to improve on, make a plan about how you might incorporate specific strategies to improve your performance, and monitor those areas specifically in your next supervision sessions. For example, “demonstrating” may have been largely absent from your reviewed supervision session and you might want to experiment with limiting teaching, discussing, and formulating in favor of adding a role play or video demonstration of the skill being addressed. It could then be useful to get verbal or written feedback from your supervisee to see what effect this had on learning in the session.

- *Using SAGE to evaluate supervision from the supervisees' perspective.* Falender and Shafranske (2012) have noted the great difficulties that trainees and supervisees experience when they identify problems or shortcomings in supervision, and how tempting it is to “stay the course” and hope for an adequate final evaluation without addressing the problems. They recommend trying to address these problems directly with your supervisor rather than avoiding a difficult or challenging discussion: “We have found that most supervisors strive to meet supervisees’ training needs; however, they need honest, respectful feedback to correct any shortcomings. Also, if not addressed, these shortcomings may pose difficulties in the relationship, strain the supervisory alliance, and limit the effectiveness of supervision” (p. 192). In summary, there are compelling reasons to attempt to directly address problems in supervision. This exercise is designed to help you to address concerns.

Specifically, in this learning exercise we focus on helping supervisees to evaluate their current supervision (or consultation) in terms of adherence to our evidence-based guidelines. As noted earlier, even experienced CBT supervisors may experience “drift” and have problems staying adherent to the most effective supervision practices over time. SAGE can be used as a barometer of fidelity, helping supervisor and supervisee stay on track. Especially for therapists who are evaluating consultants/trainers for additional training, SAGE could be used to objectively evaluate supervision experiences and provide grounds for identifying areas for feedback and discussion.

Getting feedback as a supervisor can be challenging, difficult and distressing, but the capacity to self-reflect and collaborate with supervisees or trainees to improve supervision are key supervisory competencies. In order to approach the problem diplomatically, the supervisee might suggest independently completing SAGE on a typical supervision session. This can lead to a review discussion, including comparing ratings and notes, which should progress to jointly identified improvements that might be made to some competencies (SAGE items). Even discrepant scores on specific items might lead to a really productive conversation about how supervision or consultation is going.

To provide some context, we now highlight five common problematic issues that are likely to come up:

1. Supervision lacks appropriate structure, agendas are not set or adhered to, or excessive time is spent on irrelevant details: supervision is missing the “big picture,” and time management is a problem. The relevant SAGE items are managing and agenda setting, which are likely to be scored in the lower competence range.

2. Supervision is not sufficiently collaborative and there is a sense that the supervisor is being overly directive and discounting the supervisee's opinions or approaches. Relevant SAGE items: Collaborating, listening, observing, and prompting are likely to be scored in the lower range.
3. There is a poor alliance and low levels of empathy, warmth, and support (core conditions are weak). The supervisee feels criticized or overly anxious. Little attention is paid to the process of supervision itself, including little or no processing of negative affect with the supervisee (anxiety, worry, fear). SAGE items: Relating and facilitating are likely to be in the lower range.
4. Supervision is "too intellectual." Discussion of cases and teaching take up a great majority of the time, with little attention to modelling, behavioral rehearsal, and feedback. Experiential learning suffers when an overly didactic approach dominates supervision. Typically, there is a low level of emphasis on recognizing and processing affect, both in the audio or video recordings of client interactions and in the supervision itself. SAGE items: Demonstrating, observing, training/experimenting are likely to be scored in the lower range.
5. There is insufficient specific, direct, and constructive feedback in supervision (for example, "What should I do now? How did I do with this CBT intervention? How should I deal with this specific issue? How can I improve in this area?"). SAGE item: Feedback-giving likely to be scored in the lower range. The supervisor may skirt around important issues for fear of being perceived as being overly critical or harsh. Unfortunately, the outcome is often lack of concrete "how to" guidance where the trainee feels lost—that they are not getting concrete, specific, and useable feedback as to problems and methods to improve.

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Chapter 13

TRAINING CBT SUPERVISORS

Leslie Sokol and Marci G. Fox

The training of clinical supervisors is the focus of this chapter; a critical focus of cognitive behavioral therapy (CBT) education. CBT workshops, lectures, and seminars are useful in providing clinical knowledge but often fail to produce clinically skilled therapists. Clinical supervision is the most important method of training skills in new cognitive behavioral therapists as well as furthering and maintaining skills. More and more professional accrediting bodies require that supervisors have systematic instruction about supervision (American Psychological Association and Commission on Accreditation, 2009; British Psychological Society, 2003). Internationally, the European Federation of Psychologists' Associations has established required guidelines for trainers and supervisors. The European Association for Behavioral and Cognitive Therapies (EABCT), after the initiation of the working groups on training standards (WGTS) in 2002, established official formats for training and supervision. The Academy of Cognitive Therapy (ACT), an organization that credentials CBT therapists and CBT trainer/consultants, also has established formal guidelines for certifying CBT trainers. Details of both of these organizations' guidelines are presented.

THE SUPERVISORY EXPERIENCE

The supervisory experience can be broken down into three major stages. Establishing expectations and goals for supervision is the first step; followed by the implementation of specific supervisory experiences to fulfill those established goals and concurrently a formal process of evaluation of the therapist's work, and finally summative feedback and plans for sustained and continued skill development.

Stage 1: Establishing Supervision's Expectations and Goals

Cognitive behavioral therapy is founded on the principles of learning theory; therefore collaboratively identifying specific concrete therapy goals is useful in maximizing treatment outcome. The same principle is true for CBT supervision. Supervision goals should be collaboratively set by first identifying the problem areas, deficiencies, or weaknesses in the supervisee with a needs assessment. Ask the supervisee directly to identify goals and problem areas along with specifying strengths in CBT therapy skills to increase engagement. The Cognitive Therapy Scale (CTS; Young & Beck, 1980) or The Assessment of Core CBT Skill (ACCS) (Muse, McManus, Rakovshik, & Kennerley, 2013) may be used, as detailed in chapter 4.

New therapists with limited experience may lack basic skills while more experienced therapists often struggle with more sophisticated problems. Beginning therapists frequently have problems with limitations in all the key areas of implementation of the treatment. In more experienced CBT therapists, the deficits may be less global and more disorder or tool specific, or they may have more challenging clinical situations to manage.

Supervision goals are intended to directly link to the supervisee's problem areas but all CBT supervision has the overarching goal of developing CBT competency. CBT competency includes the capacity to form a clear conceptualization of the patient and his or her problem and the ability to deliver the efficient and targeted treatment. Supervision is challenging when the expectations of the therapist and supervisee are misaligned. Thus, it is critical to clearly establish at the onset both the supervisee's and the supervisor's expectations. The framework of supervision — establishing cancellation and lateness policies, emergency contact numbers, duration, time, and fee structure — is a good starting point. Typically supervision should involve the evaluation of the supervisee's work with regular submission of work samples expected. This should be clearly specified. Supervisees with expectations of learning mechanisms to “blend” treatments or modify CBT to meet their own personal values and style are likely to be a problem for a supervisor unless this is identified and addressed at the onset of the relationship.

Stage 2: The Supervisory Experience

The Supervisory Relationship According to Newman (2013) attention to the supervisory relationship is of paramount importance and reflects similarities to the therapeutic relationship. He states that both relationships benefit from tactful words of encouragement, instilling hope, teaching skills, incorporating warmth and caring in the context of respectful boundaries, providing instructive feedback that aims to improve skills, and from an objective measurement of progress. Openness is essential since without safety and trust, supervisees may neglect to

disclose vital data (Ladany, Hill, Corbett, & Nutt, 1996). Openness may be facilitated when the supervisor is willing to share his or her own struggles. A safe environment encourages openness and thus clear rules of confidentiality must be established. Supervisees must know exactly how objective scores obtained in supervision will be used and by which methods they are being evaluated. Openness and cooperation on the part of the supervisee may be enhanced at the start of supervision if work samples are rated solely for the purpose of instruction prior to using in any evaluative capacity.

Structure The structure of supervision frequently parallels that of therapy. As previously discussed, supervision is goal oriented and focuses on psychoeducation. Structure in supervision facilitates skill training and goal attainment. Structure in therapy has been associated with improved outcomes (Shaw et al., 1999) and in supervision likely also enhances efficiency and trainee preparedness. Typically supervision structure parallels therapy and includes check-in, agenda setting, homework review, working on each agenda item, periodic summaries, homework assignment, final summary, and feedback.

Developing and Evaluating Competency The most commonly used scale of CBT competency in adults is the CTS. Because it is used in clinical trials, it correlates with a level of CBT competency that is associated with improved outcome for clients. The Assessment of Core CBT Skills (Muse et al., 2013), a new CBT competence scale, aims to further develop and build upon currently available measures such as the CTS. It provides a framework that assessors can use to deliver formative and summative feedback about a therapist's performance within an observed session of CBT. Both the CTS and the ACCS can be used as tools for self-reflection (See chapter 4 for a complete discussion of such uses of these instruments.) According to Newman (2013), by learning to observe, instruct, facilitate, and rate supervisees on a measure of CBT competency such as the CTS, supervisors-in-training also are made aware of their own adherence to the model, and may improve areas of personal clinical weaknesses. Newman (2013) also states that the CTS may be used as a checklist of reminders for the supervision session such as setting an agenda for the supervision session, collaborating with the supervisee, using guided discovery, focusing on key cognitions and behaviors of the supervisees' clients and the supervisee, having strategies for change for each of the supervisees' clients, and homework. Supervisee scores on individual CTS items can be helpful guides in establishing goals and agenda setting in supervision.

Measures for evaluating children and youth work samples are still in the development phase. One such instrument is the Children and Adolescent (CTRS-CA) scale by Robert Friedberg (Friedberg & McClure, 2009). The CTS scale, although developed and normed on adults, is currently commonly used by child CBT experts in the evaluation of competency in work samples.

Selecting a Work Sample In selecting a work sample to evaluate during supervision, the following considerations are important: patient level of hopelessness, problem severity, phase of treatment, frequency of treatment sessions, and group versus individual therapy sessions.

1. *Level of hopelessness.* Hopelessness is not easily penetrated and can inhibit a novice's learning CBT in supervision. Patients without significant hopelessness are encouraged for the beginning therapist because the focus of supervision can be on developing basic skills and structuring of the session. Advanced clinicians may elect to focus specifically on more challenging cases.
2. *Problem severity.* Patients with acute problems tend to be more amenable to intervention and are typically encouraged for beginning trainees. The more significant the impact of treatment the more reinforcing it is to the trainee. Supervision should start with less challenging cases, if possible, so interventions may be practiced in a more straightforward way. Once a clear understanding of the model and skills for the application of core strategies is acquired, it becomes easier to apply the principles more creatively with difficult patients. Patients with more chronic and less acute problems should be the focus later in supervision or in supervision with more advanced trainees. The more challenging a patient is, the more creative the therapist and supervisor must be to modify therapy and remain effective.
3. *Phase of treatment.* Ideally when supervising a beginning therapist one should supervise a new patient from the start of treatment. This allows for continuity and the supervisee has the capacity to put the skills and knowledge acquired in supervision immediately into practice and sees them work. Another reason to supervise one patient longer term is when that patient has been a particular challenge and warrants the focus of supervision. Ideally, focus attention on one patient until learning goals have been achieved. It is also reasonable to discuss a few patients intermittently to reduce the risk of not having a work sample if the primary patient cancels. Limit the number of cases supervised as it may limit substantial learning from taking place—depth rather than breadth is the goal.

Additionally, patients must be informed and consent to the therapist receiving supervision particularly if the patient has been receiving non-CBT treatment and will now be changing treatment models. It is important to assess supervisee comfort with implementing CBT. Anticipate potential patient concerns on supervision and script out and role play how to discuss them.

4. *Frequency of treatment.* A major disadvantage to working with a patient who is seen infrequently is the inability to put into practice what is learned in supervision. Typically supervision should occur several days prior to the next therapy session so that the work sample is current and new skills can be

applied and practiced more immediately. In this way the next work sample can actively demonstrate what is learned in supervision. Additionally, supervision is less efficient when it becomes “catching up” on basic information rather than learning new skills.

5. *Group versus individual therapy sessions.* Although there are similarities in the delivery of group and individual CBT towards the goal of competency, evaluating individual therapy sessions is standard in CBT supervision. Competency measures such as the CTS were designed to evaluate individual sessions and only are psychometrically valid in that framework of service delivery. It is recommended that individual session review precede reviewing group therapy work samples. This assures basic skills and an understanding of the CBT model is established before creatively modifying those skills in a group format.

NUTS AND BOLTS OF SUPERVISION

A number of considerations are important for a supervisor in selecting priorities with a supervisee including: balance between reviewing a work sample, case conceptualization and formulation; supervising case material; providing objective scores, and clinical feedback. Duration of supervision, methods of instruction, delivery of learning, and group versus individual supervision are also important areas to consider.

1. *Balance between reviewing a work sample, case conceptualization and case formulation.* Milne et al. (2011) note that giving feedback is one of the most important features of evidence-based supervision. Regularly reviewing supervisees' work products is essential to that aim. Work products can include recordings of actual work samples, transcripts of actual therapy sessions, therapy notes, case conceptualizations, problem lists, goals, treatment update plans, and termination summaries. To attain CBT competency it is essential that work products of actual sessions as well as case conceptualizations be reviewed (Ladany et al., 1996). Make sure the supervisee has a solid conceptualization of every case being supervised, derived from a discussion of recorded patient sessions with the supervisee. Again, the focus of supervision is guided by the collaborative goals established. When the goal of supervision is clinical competency, direct evaluation of work samples should constitute the main focus of supervision.
2. *Supervising patient material.* A case conceptualization consists of the patient's diagnosis, current problems, including how they developed and how they are maintained, associated dysfunctional thoughts, and the beliefs that trigger emotional, physiological, and behavioral reactions (Beck, 2011). Case conceptualization also includes a focus on events and

automatic thoughts as well as early experiences and core and intermediate beliefs related to the automatic thoughts (Wenzel, Brown, & Beck, 2009). A solid case formulation emphasizes a patient's typical behavioral and coping strategies. Asking supervisees to format a case conceptualization with a case conceptualization diagram is helpful because it organizes information and teaches supervisees how to understand patients via the cognitive model. In this format, data are collected about specific situations that trigger strong reactions including problematic thoughts, feelings, and behaviors. Themes and underlying beliefs are organized and linked to conditional assumptions and behavioral strategies. Additionally, supervisees are encouraged to develop a problem list for each patient, followed by a goal for each item.

3. *Duration of supervision.* Ideally, supervision timelines would parallel accomplishment of the supervisee's goals. For example, if the goal is clinical competency, determined by a consistent (three out of four work samples) passing score of 40 on the CTS, then the supervision would continue until that goal is reached. Self-study, continued practice, and further education should be inculcated in the supervisee to accomplish any unfulfilled goals and prevent drift. Without expert formal evaluation of actual work samples, the goal of competency is hard to reach. Many variables contribute to the length of training required to reach competency including therapist experience, previous CBT training, motivation, and patient difficulty. As with any educational venture, the more intensive the dose of supervision (for example, once a week rather than once a month) the greater the gain. Typically, in postgraduate training, weekly supervision for one year is required to establish competency, with a minimum of six months necessary to establish basic skills.
4. *Balancing objective scores and clinical feedback.* Discussion of the work sample should precede a dialogue about the scores on an objective measure like the CTS to enhance learning. Supervisees can better learn by discussing the specifics of the session and the supervisor can then tie them directly back to the specific items on the CTS. Discuss the identified problem, its cognitive conceptualization and appropriate treatment strategy first, and then examine the work sample from a micro-level. This process helps the supervisee learn ways to improve their work and modify their mistakes. When a supervisor points out the specific words used in a session, it allows for concrete and explicit directed learning regarding how to modify the work and increases adherence to the CBT model. Supervisors must take detailed notes about the work sample discussed so that the specific details of the session can be reviewed. Supervisors should specify how a particular section of the sample matches to a criterion on the CTS. Wait to provide specific scores until the work sample has been discussed in its entirety.

The following is an example of such a discussion:

SUPERVISOR: When you ignored the upset your patient was experiencing over the text she just received and instead told her, “Let’s start with what you have written down on this paper,” there was no collaboration. By offering your patient the option of talking about the text, you would have had an opportunity to collect her automatic thoughts and perhaps more underlying beliefs that may have been associated with those tears. At this point in the session we don’t know if what you have chosen to work on is reflective of what is driving the patient’s distress or even related to the patient’s goals. Failing to clarify and understand the problem, work collaboratively, or identify key cognitions and behaviors will impact your scores on the agenda setting, understanding, collaboration, key cognition, and strategy for change items of the CTS.

Once the entire work sample has been reviewed and discussed in detail, scores on each of the independent items on the CTS can be presented. Supervisees over time should learn how to rate their own work with a scale and calibrate their scores with the supervisor. This helps with growth of therapeutic skill and improves trainee development as future supervisors. Supervisors should discuss the specific strengths of the session overall and exactly what weaknesses need more work, as the following example indicates:

SUPERVISOR: Clearly in this session you did a nice job relating to this patient, as demonstrated by her willingness to talk openly and tell you her deepest fears. However, your biggest weakness was your inability to define a problem to work on. Although you spent a lot of time listening, there was no evidence that any work took place. When you appropriately asked the patient what she learned from the session, she responded that it is always good to talk. This again reinforces the success of your relationship, but demonstrates a failure to focus on an agenda and work on specific problems. Next time ask the patient what problems have been causing her distress, see if she wants to talk about them, and establish a goal for the session that will help reduce her distress.

5. *Methods of instruction.* Supervisors are more effective as clinical teachers when they use multiple methods of instruction in their interactions with their supervisees (Milne et al., 2008). Supervisees differ in the clinical knowledge obtained prior to supervision and sometimes basic skill training is required in the context of supervision. Comprehensive supervision may involve education in many forms: formal didactic information, recommended readings, or viewing or listening to audiovisual or audio samples. Homework is critical as it allows supervisees to implement learning, practice skills, and identify personal shortcomings. Supervisors should

attend to developing supervisees' skills as future supervisors. It is easy to tell a supervisee how you might have handled a clinical situation differently and provide them with alternative language or treatment strategies. Modeling can be an effective teaching tool but must be balanced with active learning for best results. One way to do this is by role play and guided discovery. The trainer can play the role of the therapist to start and then let the supervisee do so or ask the supervisee to start first as therapist and intervene with suggestions when the supervisee gets stuck. Utilize the principles of guided discovery and ask the supervisee what they were trying to accomplish and use guided questioning to determine a new understanding about how to intervene, as the following example illustrates:

SUPERVISOR: When your patient said she was afraid of being prescribed pain medication, you appropriately asked her what she was thinking. However, when she said, "I was angry" and when you pressed she then responded, "I was confused," you moved on rather than obtaining the key cognitions that were driving her anger or confusion. What could you have said to help the patient identify her thoughts?

SUPERVISEE: I don't know, maybe I could have just kept asking what she was thinking, but that wasn't working.

SUPERVISOR: It might have been helpful to point out that anger and confusion are emotions, not thoughts, and then specifically ask the patient, "When you noticed you were feeling angry what thought was in your head? Or, what about being prescribed pain meds felt confusing?" Since anger is often associated with expectations or demands that typically are expressed as "should" statements, you might have asked if she was having any "should" thoughts, such as, "I shouldn't take these," or "He shouldn't have prescribed them." Why don't we try role playing it again and this time I will play the part of the patient?

SUPERVISOR (*playing the part of the patient*): I feel angry and confused that the doctor gave me pain medication.

SUPERVISEE: When you noticed that anger, was there a "should" thought running through your head?

SUPERVISOR: Yes, exactly, I was thinking he shouldn't be giving me these with my history.

6. *Delivery of learning.* Meeting in person has been the traditional delivery system for supervision; long distance learning also is an option. Phone and computer technology allows for audio and audiovisual contact long distance. (Please see chapter 7 for specifics regarding the ethics and legal issues involving such training.) Although the supervision process is not substantially affected by virtual contact, more effort is required in obtaining patient consent signatures and sharing and protecting patient information for confidentiality and privacy.

There are a variety of ways to provide feedback on work samples. When supervisees' work samples are in the form of audio or audio/visual recording, feedback can be provided verbally or in writing. An example of written feedback provided on an audio work sample is shown here, in "Written Feedback to Supervisee."

WRITTEN FEEDBACK TO SUPERVISEE

"When you were establishing an agenda, the patient wanted to talk about what happened with mom this weekend and how very upset she was over the fight, but you suggested the topic of problem solving. Additionally, the patient also wanted to talk about her grades and your response was, 'If we have time.' It would have been more collaborative to ask the patient what her priorities were, then prioritize the agenda item of problem solving and her agenda items of anger and mom and her grades. By ignoring her agenda items it is likely the patient will not engage and leave the session in the same distress that she arrived.

"When the patient then told you she was having a lot of negative thoughts all weekend, instead of asking her if she wanted to talk about that, you simply told her you would talk about them next week. This was another lack of collaboration and a missed opportunity to socialize her to the cognitive model and do some real work on cognitive restructuring. Telling the patient to think about the topics she wanted to talk about and then failing to address them is not helpful.

"Without clear direction homework is not likely to be assigned or be helpful, which will discourage homework cooperation in the future. You appropriately asked the patient to review what she gained in the session, but the patient was only able to say what she talked about and not what she learned or gained. It is important that you summarize when the patient cannot and if you cannot provide any content of learning then it is a sign that adequate work did not take place."

When work samples are provided in the form of translated transcripts, written feedback can be given directly on the transcript as well as independently.

Here is an example of such feedback:

CLIENT: In short, I cannot solve the problem. Therefore, I cannot do the homework.

THERAPIST: So you cannot do the homework.

CLIENT: Yes, I cannot concentrate on it. I have a headache.

THERAPIST: I understand you cannot concentrate on your work. I also understand that you did not want not to do the homework, but your concentration and motivation are affected by your unpleasant feeling and physical condition.

CLIENT: Um . . .

THERAPIST: What do you think when you do not do the homework?"(*Supervisor feedback*: Instead of asking further questions it would be better to put her difficulties with homework as an item on the agenda, but before you proceed it is best to establish all the topics she may wish to address.)

CLIENT: I am guilty because I do not complete the task. I take it out for several times but still cannot finish it. I do not know what to do.

THERAPIST: Um . . . (*Supervisor feedback*: I would suggest validating that she tried to do the homework and help her look at it from a non-all-or-nothing perspective. Instead she can give herself credit for the work she tried to do as even just thinking about it means she did something. Plus taking it out and looking at it was a start.)

7. *Group versus individual supervision.* CBT supervision is effective both provided individually and in groups. There are advantages and disadvantages to each type of approach. In individual supervision, there is an opportunity to work on developing specific skills and correcting particular weaknesses on a one-to-one basis, which allows for tailoring the discussion specifically to the supervisee's needs. One-to-one supervision also presents opportunities to work closely over a period of time and focus solely on the goals of an individual supervisee. It is less anxiety provoking for the supervisee and allows for more mentorship about personal development.

Group supervision allows for the presentation of more diverse work samples and provides illustrations of CBT applied in different disorders. Individuals are able to build skills via listening and modeling when that supervisor actively shares feedback with other trainees. Informally and formally evaluating the work of others promotes development of individual skills and future supervisory skills. Additionally role play in dyads and triads can occur and broaden learning. A disadvantage of group supervision is when the goals of supervisees in a group format are discrepant; thus, goals for the group supervision should be collaboratively developed at the beginning and prioritized, and clear group norms should be set regarding how presentation of case material should occur. Individual tapes must still be reviewed in their entirety, even if supervision is held in a group.

Many organizations begin with group supervision so that larger numbers of individuals gain skill, in a pre-determined period of time, then one or two members of the group are selected based on interest and skill to sharpen their skills further with individual supervision to become supervisors for the organization. This is an effective way to examine the skills of all the

members first and to then choose specific members to sharpen their supervisory skills.

WATCH: Go to www.wiley.com/go/sudak: *Appendix VII, Video Library* to View Video:

- Goal Setting for Supervisors

Stage 3: Feedback and Plans for Sustained and Continued Skill Development

Milne et al. (2011) note that giving feedback is one of the most important features of evidence-based supervision. Chapter 5 highlights this vital part of CBT education. Providing data on objective measures of performance is one way of indicating progress to the trainee. Positive feedback about effort, adherence, and enthusiasm are other ways to boost the self-esteem and confidence of the beginning or struggling therapist. Corrective feedback may be necessary about other issues than competency scores on work samples. An open and honest supervision experience in the spirit of education and collaboration will maximize learning and satisfaction. Eliciting feedback from the supervisee is also crucial in the supervisory process as it is in therapy. Supervisees are empowered in this interchange, which furthers collaboration and provides data for corrective action in the supervision process ensuring that supervision goals are being obtained. Continual progress monitoring regarding supervision goals makes accomplishment of these goals more likely.

Supervisors should train students to have a plan in place to prevent straying from the model and continue to develop CBT skills. Supervising others in CBT is a practical way to stay true to the model and structure of CBT. Supervisees may be simultaneously trained in their own skill development and in skills to supervise others. Processes facilitating this include learning how to evaluate therapy sessions—both their own and others with the CTS, or other validated instruments. Peer supervision discussing work samples naturally develops skills and fosters adherence to the model. Continuing education in CBT should be emphasized as a helpful way to stay current and practice skills.

PROBLEMS THAT AFFECT SUPERVISION

Variables that interfere with the supervision process can impede learning and necessitate a longer duration of supervision. One frequent challenge is obtaining work samples from supervisees. Other factors such as supervisees' interfering beliefs, self-confidence, language barriers, HIPPA rules, and lack of compliance

may also impede the supervision process. The following are some solutions to common barriers in supervision:

- *Difficulty obtaining work samples.* Supervisees often fail to provide audio, audio/video, or written work samples. Fear of negative evaluation may play a role, particularly early in the supervision relationship. Remind supervisees that anxiety is normal, but their role is to provide the material for learning so you can help them develop skills. The less expert the work samples from the start, the better for all because improvement is likely. Objective measures of competency may be helpful at the start of supervision but should be clearly defined as learning tools rather than grades to reduce trainee fear of negative evaluation. Supervisees also may want to find the “ideal work sample” rather than one that does not represent their best work. Guidelines should encourage supervisees to present any and all recorded material because every work sample is a unique opportunity for specialized learning. In fact, supervisees learn the most from less “perfect” sessions. When a supervisee does not regularly record sessions, it may be helpful to role-play asking for the patient’s permission to do so. Review the advantages of recording sessions with the supervisee so they believe it is in the best interest of their patients and their learning. When actual patient sessions are not available, simulated role plays may be used as an option, but cannot take the place of actual patient sessions in evaluating competency.
- *Supervisees’ interfering beliefs.* The supervision process is more challenging when supervisees do not embrace the cognitive model and endorse an alternative view of the therapeutic process or only want to add “pieces” of the model to their existing repertoire. Share factual information about the efficacy of CBT to help motivate the supervisee; the best way to elicit the “buy-in” is to have the supervisee experiment with CBT tools in practice and evaluate the effectiveness firsthand. Seeing a patient improve is the surest way to make a believer out of a reluctant therapist.
- *Lack of supervisee confidence.* When supervisees let insecurity impede learning, the result may appear as resistance to trying new things or self-criticism when the delivery is not perfect. Use CBT techniques to ask supervisees about the data that exist about their career so far to help them to recognize they are equipped to meet the challenge of learning a new treatment. Remind them that you are there as a resource.
- *Language barriers.* When the primary language of the supervisee and his or her patients is different from that of the supervisor, reviewing work samples becomes more challenging. This challenge can be overcome by obtaining translated transcripts of the actual therapy sessions for review. Because this task is arduous, supervisees may prefer to provide short segments of the session along with descriptive summaries. Such shortened work samples can be used for learning purposes but it is essential that full-length sessions are intermittently reviewed to ensure competency.

- *HIPPA*. The Health Insurance Portability and Accountability Act of 1996 (HIPPA) has led to the standards for Privacy of Individually Identifiable Health Information (“Privacy Rule”) (www.hhs.gov/ocr/privacy/hipaa/understanding/index.html). This has made access to work samples from mental health organizations and government agencies more challenging. Use HIPPA-compliant data encryption and file transfer services to eliminate this problem. See chapter 7 for such services. However, digital recording devices capable of uploading content to a computer drive are necessary.
- *Supervisee noncompliance*. Supervisees’ noncompliance manifests as cancellations, no shows, lateness, an unwillingness to do supervision homework, and resistance to putting new theory and skills into practice. One key to overcoming noncompliance is to obtain “buy-in” to the model. Instead of demanding supervisees cooperate, the principles of guided discovery and empirical data collection may be more effective. Develop hypotheses with the supervisees and create experiments to test them out. Make sure they specify their predictions and then discuss the factual outcomes, compare them, and help them draw new conclusions in support of CBT. Non-compliance may be manifestations of genuine practical problems; the supervisor can help the supervisee problem-solve potential solutions.

WATCH: Go to www.wiley.com/go/sudak: Appendix VII, Video Library to View Video:

- Frustration

Guidelines for CBT Clinical Competency: Clinicians and Trainers

Guidelines for Competency Use established criteria for clinical competency to guide supervision. Two organizations that have established clear guidelines for clinical competency and consultant/trainer competency are the Academy of Cognitive Therapy (ACT) and the European Association for Behavioral and Cognitive Therapies (EABCT). In establishing clinical competency as a CBT provider, both the ACT and the EABCT require core professional training, professional accountability, specific years of practice and CBT cases, and CBT specific education. ACT also requires proof of clinical competency in the form of a work sample of both an actual session and a case write up including case history, formulation, and treatment plan. Both of these work samples are scored and a minimum cut-off score is required for credentialed status.

Specific guidelines have been established in credentialing CBT trainers/consultants (ACT) and CBT supervisors (EABCT). Both ACT and the EABCT require specialized training in CBT supervision, established competency of their own work as accredited by the ACT or for EABCT an EABCT member

Association, and at least five years' experience as CBT therapists and member of the prospective organizations. EABCT has elaborated the criteria for training, accreditation and re-accreditation of CBT supervisors and those details can be found on their website (www.eabct.eu). The ACT website (www.academyofct.org) also has details of specific criteria for trainer/consultant certification. The ACT also has mechanisms in place to evaluate the work samples of CBT trainers (supervisors). Additionally, ACT requires the submission of a personal supervisory model based on CBT principles, appropriate to the area of practice and setting in which the applicant works.

SUMMARY

The process of learning to supervise in CBT involves deploying many similar skills to those used in therapy. Supervisors can fine-tune the process of supervision by using Socratic questions, goal setting, and giving and receiving feedback. Direct observation of supervisee work is vital to the process.

LEARNING EXERCISES

Exercise 1: Case Conceptualization, Problem List, and Goals

Option 1: Exercise 1: When supervising a number of individuals at once Ask one person to play the role of supervisor. Using a whiteboard, ask another supervisee to discuss a patient. The supervisee at the board and the other participants must ask the appropriate questions to elicit the necessary information to formulate a case conceptualization. The supervisee at the board should transcribe the data onto a case conceptualization diagram. Then ask another supervisee to take his or her place at the board. Discuss the same patient but now the goal is to elicit a problem list. Once the problem list is established, change supervisees and have the group ask the appropriate questions to help formulate therapy goals.

Option 2: Exercise 1: When supervising one individual Have the supervisee discuss a patient with the goal of formulating a case conceptualization, problem list, and goals. Ask the supervisee to record the information from the discussion in writing and accurately transcribe the information onto a case conceptualization diagram, and specify the problems and goals correctly.

Exercise 2: Addressing a Problem and Working toward a Goal

Option 1: Exercise 2: When supervising a number of individuals at once Select one member of the group to be the leader and have that person go to the board. Another supervisee should present an active patient and whose

problem they have been having difficulty addressing. The leader and other participants should work toward defining the problem and establishing a clearly defined goal about the problem. Once the goal is established, the group should brainstorm strategic options to address it. Then the group should break into dyads and role-play one of the strategies. The designated leader then leads a discussion on the strategy selected and the tools used to operationalize it.

Option 2: Exercise 2: When supervising one individual Discuss a patient with the supervisee, and define one problem that causes the patient significant distress. Help the supervisee define the problem and guide them towards an appropriate goal to address the problem. Have the supervisee brainstorm different strategies and the pluses and minuses of each. Have the supervisee choose a preferred strategy and role-play the implementation of the intervention with you.

Note: In all of these exercises, it is appropriate for the supervisor to interject appropriate questions, suggestions, and even short demonstrations when the supervisees get stuck or are off track. However, the goal is to elicit knowledge and work from the supervisee.

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Chapter 14

SELF-MANAGEMENT IN CBT TRAINING AND SUPERVISION

John Ludgate

This book has focused on the optimization of training and supervision to develop competency in cognitive behavioral (CB) therapists, reflecting the traditional focus on acquiring knowledge and developing skills with the ultimate aim being to provide high-quality, effective patient care. However, therapists may experience significant stressors in their work, including factors related to training and supervision itself, that may interfere with this aim. This chapter focuses on the issue of therapist self-care and the need to include this competency in therapist training and supervision. Tools, including a CBT model that helps conceptualize therapist distress, and the application of CBT interventions for therapists are provided. The chapter concludes by offering suggestions on how self-care and self-management strategies can be incorporated into CBT training and supervision.

EXTENT OF THE PROBLEM

Working in the helping professions, especially in mental health, can frequently lead to negative consequences for the professionals and for clients. Such consequences occur on a continuum from transient incidents of emotional upset or frustration to a more generalized set of characteristic feelings, attitudes, and behaviors often labeled as “burnout” (Maslach, 1982). Burnout describes a collection of incapacitating symptoms including *emotional exhaustion*, *depersonalization*, and *reduced personal accomplishment*. Burnout occurs among individuals who are professionally engaged in helping people.

Another significant form of therapist dysfunction is *compassion fatigue* (Figley, 2002), a term used to describe a collection of negative behaviors, emotions, and cognitions that can occur in those who work extensively with trauma victims. In therapists and mental health professionals, rates of depression and suicidality (ideation and attempts) are high; Epstein and Bower (1997) report that one in four therapists will have suicide ideation and one in sixteen attempt suicide over the course of their lives. Mental health specialists are at high risk for burnout (Onyett, Pillinger, & Muijen, 1977). Evans et al. (2006) found that mental health social workers show levels of stress and emotional exhaustion twice that of psychiatrists and three times that of the general population. Burnout levels of up to 40 percent have been reported in US psychologists (Fortener, 1990). Results from surveys in the United Kingdom found British clinical psychologists displayed even higher levels of emotional exhaustion, depersonalization, and reduced personal accomplishment—the three components of burnout—than their US colleagues. Less severe stress reactions are also reported frequently by psychotherapists. A survey by the American Psychological Association showed that 36 percent of psychologists felt stressed during their workday and 20 percent described high levels of distress (Clay, 2011). Similarly, Cushway and Tyler (1994) reported that 29.4 percent described themselves as “highly stressed.”

Although this literature points to the costs of working in the mental health field, there are also a number of studies that have found that practitioners receive many rewards from this work. For example, Norcross and Guy (2007) found that psychologists are consistently satisfied with their work, and, during many years researching this topic, they found the percentage of psychologists finding this work satisfying has never fallen below 88 percent. They also report data that are encouraging on the specific rewards received, such as the satisfaction of helping others, intellectual stimulation, and an increased capacity to enjoy life.

CONSEQUENCES OF THERAPIST DISTRESS AND BURNOUT

Distressed therapists (1) experience emotional, cognitive, and behavioral problems with a personal cost, (2) have diminished productivity in general, and (3) are potentially impaired in the provision of patient care, leading to negative clinical outcomes. This last consequence is particularly important in terms of the effectiveness and competency of therapists, which is a focus of training and supervision as detailed in chapter 3.

REASONS FOR INADEQUATE SELF-CARE

One theorized factor in the development of burnout and distress in therapists is inadequate self-care or failure to recognize early warning signs of problems (Figley, 2002). Often little attention is given to therapist self-care either by

agencies or by professionals themselves. Despite the high levels of stress experienced by professionals, interventions (self-directed, peer, organizational, or professional) are not implemented, and steps to improve self-care are not taken by many professionals. There is some irony in the fact that the same therapists who urge better self-care in their patients may neglect their own. Why this disparity? First, therapists may not recognize levels of distress because they do not take time to self-monitor or self-reflect. Second, distress may be manifested in nonpsychological ways (for example, headaches). Third, therapists may make false attributions about their stress and how to reduce it (for example, deciding they need a vacation rather than looking at the need for better self-care in general).

Additionally, practitioners may decide that improved self-care is simply not feasible given time constraints. Last, and perhaps most important, therapists may hold beliefs that result in not prioritizing or even downgrading self-care (for example, they feel they should spend time reading up on CBT rather than taking a yoga class). Therapists are frequently reluctant to seek help from colleagues or peers when burdened. This may be because of irrational or dysfunctional beliefs. Rates of depression and stress have been found to be high in professional caregivers; however, a large percentage of those who suffer do not reach out to peers or seek professional help. If trainees can be encouraged to explore dysfunctional beliefs in training and supervision, as is described in this chapter, therapists could learn to apply the same methods to themselves that they utilize with patients. This speaks to the reflexive nature of CBT described in chapter 1.

PREDICTORS OF DISTRESS REACTIONS

Research in this area (Bahrer-Kohler, 2013; Cushway & Tyler, 1994; Moore & Cooper, 1996; Shinn, Rosario, March, & Chesnut, 1984) shows the following factors to be predictors of therapist stress:

- Personal doubt
- Unrealistic expectations and over-responsibility for patients
- Feeling pressure to cure patients
- Dealing with problematic or high-risk clients
- Lack of recognition or positive reinforcement for good work
- Extremely high levels of empathy, resulting in “vicarious traumatization”

Moore and Cooper (1996) point out that beyond the demands made by clients or organizations, the demands or expectations that mental health professionals place on themselves are also an important predictor of burnout. This involves key cognitions that are, of course, amenable to CBT interventions. Ludgate (2012) offers a conceptual model related to therapist distress that posits that the following factors play a role in the development of therapist stress with the ensuing negative emotional and behavioral consequences.

- Situational triggers at work, including both patient related and other work stressors
- Personal characteristics of the therapist or mental health provider
- Expectations and beliefs of the therapist or mental health provider
- Personal coping style, skills, and resources
- Levels of nonwork stress
- The degree to which the professional training received has equipped the individual to deal with these stressors
- The presence or absence of staff support systems to reduce or alleviate these problems

There is little research on the preceding factors, although existing reviews (Moore & Cooper, 1996; Norcross & Guy, 2007) have indicated that working with certain high-acuity patients and certain personal characteristics of therapists (such as being overly demanding of themselves) raise the risk for burnout and distress. In addition, factors such as a trainee's level of stress and emotional state have been found to also correlate highly with self-perceived levels of competency during training (Bennett-Levy & Beedie, 2007). Thus, our ability to train skilled cognitive behavioral therapists may be influenced by trainees' personal functioning and level of distress and supervision, and training may need to focus on self-management issues, as is represented in some recent training initiatives (Bennett-Levy, Thwaites, Haarhoff, & Perry, 2015; Sheikh, Milne, & MacGregor, 2007), described later in this chapter.

The preceding conceptualization provided by Ludgate (2012), even in the absence of definitive research on each of these factors, may be a useful rubric for self-reflection regarding therapist distress. In addition, most of these factors are suitable targets for training and supervision or for self-directed intervention.

CBT AS A METHOD OF SELF-MANAGEMENT FOR THERAPISTS

Although there is general acknowledgment that working in mental health is stressful, there are few guidelines to help therapists deal with such stressors. The literature in this field initially emphasized psychodynamic theory and interventions (Grosch & Olsen, 1994; Sedgewick, 1994), but recently nonpsychodynamic approaches have been presented (Kottler, 1999; Norcross & Guy, 2007). In recent years the CBT literature has focused on therapist issues that can arise from working with challenging patients. The assumption is that working with challenging and complex patients is likely to arouse certain emotional, cognitive, and behavioral reactions. Historically, cognitive behavioral therapists have avoided terms like *transference* and *counter-transference*, because such terms are linked with the psychoanalytic tradition. However, it is recognized by cognitive behavioral therapists that when working with complex and challenging patients'

relationships, factors become increasingly important and are often a major therapeutic focus (Beck, Freeman, Davis, et al., 2006; Layden, Newman, Freeman, & Morse, 1993). A number of helpful suggestions exists in the literature to help manage negative reactions in therapists (Beck, 2005; Bennett-Levy et al., 2015; Leahy, 2001; Ludgate, 2012).

J. S. Beck (2005) describes a method of “emotional self-scanning” when working with personality-disordered and challenging patients. Using this strategy, therapists can develop skills to detect a change in their own thinking, emotions, behavior, or physiology before, during, or after a therapy session, which can cue them to the presence of a relational or other problem in therapy. Another way of monitoring negative reactions to patients is for the therapist to notice what thoughts and feelings emerge when reviewing the appointment list for the day. Feelings of discomfort in anticipation of a session or hoping that a particular patient may cancel is an index of negative feelings and associated distressing thoughts. Beck demonstrates how the therapist can modify these feelings and thoughts by questioning their validity, looking for distortions in thinking, and other cognitive techniques. Therapists working with very challenging patients are encouraged on an ongoing basis to identify their emotional reactions by asking questions such as:

- Am I feeling any negative reactions, such as anger, irritation, hopelessness, anxiety?
- What thoughts am I having related to my negative emotional state?
- What predictions am I making concerning how this patient will behave in today’s session?
- Am I engaging in any dysfunctional behaviors toward the patient, such as blaming, demeaning, or controlling?

If this self-monitoring reveals problems, then the therapist clearly needs to intervene to reduce distress and increase therapeutic effectiveness. Similarly, Leahy (2001) suggests that therapists pay close attention to their own distortions. For example, recognizing that the thought “Last week’s progress with this patient was just an illusion” is an example of a particular cognitive distortion (disqualifying the positive) may lead to more balanced, adaptive, and functional thinking concerning therapy with a patient whose progress is fluctuating. Layden et al. (1993) describe the steps that a therapist working with patients with borderline personality disorder may take to alleviate their own dysfunctional thoughts and feelings of distress—often elicited during the treatment of these individuals.

A self-therapy strategy they recommend is for the therapist to fill out a dysfunctional thought record (DTR) when they experience negative emotions. On this form therapists are encouraged to record situations, feelings, thoughts, and behavioral responses when an impasse or problem occurs with a patient. Additionally, Layden et al. (1993) advocate that the therapist engage in some cognitive rehearsal before any sessions that are predicted to be taxing or difficult. They and

other writers advocate examining the role played by the beliefs and schemas of both the patient and the therapist, which can have great potential for dealing with a therapeutic impasse. Therapists working from the CBT model often look for schemas and belief systems, acquired during childhood or in early experiences, that are activated by the current therapeutic relationship. Examining these beliefs may help explain many therapy-interfering behaviors and can prevent frustration with the patient from building up. Further, as Leahy (2001) suggests, therapists should also understand how their own schemas and belief systems may create a vulnerability to upset in certain situations. It can be instructive for therapists to ask themselves questions such as:

- Which kind of patients or patient situations tend to create strong feelings in me?
- Which kinds of problems in therapy lead to nontherapeutic behaviors (such as acting irritated, being controlling, or interrupting the patient) on my part?
- Which patients feel like friends and are hard to confront?

Having established what some of these “hot spots” are, the next step is to try to determine what the core beliefs or schemas are that are activated by these situations and their origins. Another way to identifying these beliefs, Leahy suggests, is for the therapist to ask himself or herself the following questions:

- What is my worst fear concerning a negative outcome in therapy (being sued, failing, being attacked)?
- If this did happen, what would it mean about me (“I am a failure” or “I am vulnerable”)?
- How do the patient’s problem and my beliefs and associated behaviors fit together? (If the patient acts out, I should not confront him, as he may leave therapy and I will then have failed.)

The literature has also stressed the importance of therapists establishing more functional belief systems (which foster a coping or problem-solving set) rather than a blaming attitude that involves “scapegoating” either themselves or the patient for the problems experienced in therapy. Last, it has been suggested that some limited self-disclosure of the therapist’s feelings of frustration or anxiety may be therapeutic for both the therapist and patient, provided this is done carefully and with consideration of the possible consequences.

Within the cognitive behavioral analytic system of psychotherapy (McCulluch, 1999), a cognitive behavioral approach used with chronic depression, it is suggested that when therapists strategically reveal personal feelings and reactions to patients, behaviors, described as disciplined personal involvement, can demonstrate to the patient the interpersonal effects of these behaviors in a manner that promotes empathy and motivation to change. For example, a patient might be informed that the therapist experiences frustration because every question or suggestion is being met with a discounting response. The patient may learn from

this that this interpersonal style is creating negative consequences that are not in his or her best interest.

Although these suggestions are embedded within classic CBT texts, the important work of James Bennett-Levy et al. in developing self-practice/self-reflection (SP/SR) as a component of training needs to be highlighted. A workbook for CBT therapists in training and those already trained entitled *Experiencing CBT from the Inside Out* (Bennett-Levy et al., 2015) details how to use CBT for personal and patient-related issues. This can be a very valuable aspect of CBT training because it targets both skills development (by practicing CBT on oneself) and also improved self-management in trainees and therapists.

The idea of therapists using the same techniques on themselves that are effective in reducing distress in clients is not new. More than twenty-five years ago, Ellis (1983) described some general principles for dealing with the emotional disturbance arising from therapeutic work. He encouraged therapists to:

- Identify irrational beliefs lying behind therapeutic upsets, especially those that contain absolutistic thinking (for example, “I should be able to help everyone I see”)
- Consider these as hypotheses to test and challenge
- Review disconfirming evidence
- Create alternative, rational, preferential statements (for example, “I would like to help all my patients”)
- Make self-acceptance nonconditional on therapeutic success or being liked by patients
- Refuse to “awfulize” about things that are challenging (for example, a patient not doing his homework is annoying or inconvenient rather than terrible)
- Persistently act against these irrational beliefs (for example, show oneself that, in fact, obnoxious behavior can be tolerated, despite the prediction that it cannot)

Ludgate (2012), in a guide to using CBT to reduce therapist distress and increase therapeutic effectiveness, describes a cognitive behavioral model of distress in therapists that is outlined in Figure 14.1.

Trigger Situations

The trigger situations that can precipitate emotional and behavioral reactions in the therapist may include (1) patient- or therapy-related events and/or (2) other work-related situations (organizational or administrative). Examples of triggers of the first type might be dealing with a demanding patient who makes frequent requests for extra emergency sessions or telephones regularly in crisis, working with a highly suicidal or hopeless client, attempting to do therapy with a “resistant” patient who challenges the therapist frequently, or working with emotionally

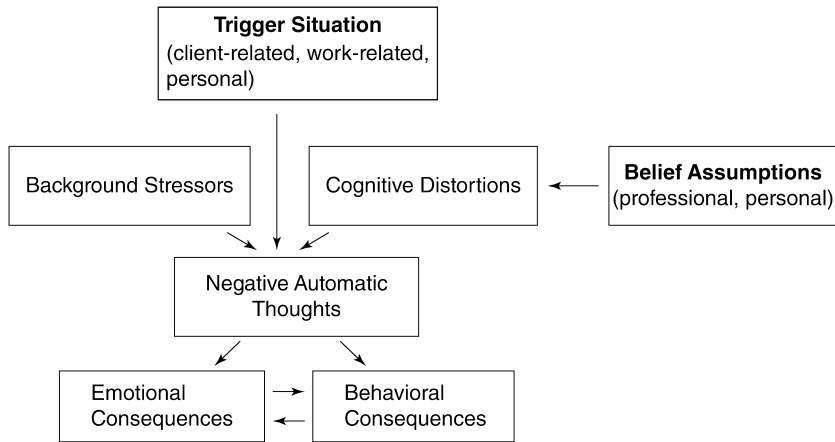


Figure 14.1 A Cognitive Behavioral Model of Therapist Distress

charged issues such as child sexual abuse, rape, or violence. Examples of other work-related stressors might include being overwhelmed by paperwork, being assigned too many cases or a large number of difficult cases, role conflict or role ambiguity, interpersonal conflict at work, or professional isolation.

Background Stressors

Background stressors, which might lower the threshold for emotional and cognitive reactions, would involve events inside or outside of work that create distress for therapists, such as a change of job responsibilities, increase in work hours, family problems, and financial difficulties.

Beliefs

Key dysfunctional beliefs relating to work as a therapist might include (Ellis, 1983; Leahy, 2001; Ludgate, 2012):

- I have to be successful with all my patients all the time.
- I must always have good sessions with my patients.
- I should not feel any negative emotions related to patients or therapy.
- I should not ask for advice or support from colleagues or get professional help myself.
- My patients should always respect and like me.
- People I try to help should not be difficult and resistant.
- If I extend myself to help patients, they ought to be motivated to change.

More general dysfunctional beliefs relating to work might include:

- I must always be totally competent and in control.
- It is terrible to experience criticism or disapproval.
- Life in the workplace should be fair and just.
- My worth as a person is dependent on my job performance.

Cognitive Distortions

In therapy practice the following distortions might be seen:

- *All or nothing thinking.* Seeing things as black or white. For example, the therapist thinks he is a total failure as a therapist based on the fact that some patients are not improving.
- *Overgeneralizing.* One negative event is seen as a general pattern. For example, an assumption is made by the therapist that if one of his patients is unhappy with his treatment, then none of his patients are satisfied with the therapy provided.
- *Mental filter.* Seeing only the negative aspects of a situation and filtering out the positives. For example, the therapist sees only the fact that a patient has had a setback and fails to recognize how stable the patient has been recently and how effectively the setback was handled.
- *Mind reading.* Assuming one knows what someone is thinking. For example, it is assumed that because a patient failed to keep an appointment this means he thinks the therapy or therapist is unhelpful.

Automatic Thoughts

Negative automatic thoughts related to a specific patient situation might include the following:

- There is no progress.
- I am not helping this patient at all.
- If the patient is angry or critical, I am not handling things properly.
- He is resisting me and doesn't want to change or improve.
- This person's situation is so realistically terrible that there is nothing I can do to help.
- I get all the difficult patients in my workplace.

Automatic thoughts experienced by therapists related to other situations unrelated to patients might include the following:

- My supervisor or colleagues are totally unsupportive of me.
- I will never get this paperwork done.
- Everybody is demanding too much of me.
- Why do I bother when I get so few rewards, financial or otherwise?

Emotional and Behavioral Reactions

Emotional reactions indicating some therapist distress include anger, frustration, anxiety, irritability, sadness, and dysphoria. Behavioral reactions may involve a range of unhealthy or maladaptive behaviors to deal with the distress encountered, such as working longer and longer hours; isolation from family, friends, and colleagues; or overeating, drinking, or using drugs. In addition there may be a tendency to behave toward patients in ways that are anti-therapeutic and involve a poor standard of care, such as withdrawing from patients in session, becoming much less active in therapy, providing support rather than problem-focused therapy, irritability toward the patient, or procrastination expressed in not returning phone calls and being chronically late for sessions.

ILLUSTRATIONS OF THE CBT MODEL

Example 1

Several years ago I had a “light bulb” moment related to my professional life, demonstrating clearly the critical role cognitions (core beliefs) played in an episode of distress I experienced in therapy. I was attending a CBT workshop and volunteered to do a role play/real play with the presenter. I was instructed to think of a recent experience involving a negative emotional shift. The previous day I had learned that a patient with whom I had worked in therapy for more than a year had relapsed and been hospitalized. I was still experiencing some distress concerning this development. When I described the situation (the patient’s relapse and subsequent hospitalization) in the real play, the following interchange took place:

PRESENTER: What feelings do you have about this situation?

ME: Guilt, anxiety.

PRESENTER: What thoughts are you having about this situation? What does it mean to you?

ME: That my therapy wasn’t successful.

PRESENTER: And if that was true, what would that mean?

ME: That I am not a good therapist.

PRESENTER: And if that were true, what would that mean?

ME: That I am inadequate.

THERAPIST: As a therapist?

ME: Yes, and as a person too.

The presenter then went back and summarized the chain of assumptions implicit in my moving from the factual knowledge that my patient had relapsed to my belief that I was inadequate as a person. These were

- If this patient has relapsed, then my therapy was not successful.

- If my therapy was not successful, then I am not a good therapist.
- If I am not a good therapist, then I am inadequate as a person.

I was startled to discover how irrational and dysfunctional my thinking was, especially because I was a practicing cognitive behavioral therapist who helped my clients daily with their negative and maladaptive thoughts. My work as a therapist did not automatically protect me from having irrational and dysfunctional thoughts myself. In addition, I had always seen myself as someone who was well adjusted, not likely to get overly involved emotionally with patients' issues, and who retained perspective and had realistic expectations regarding therapy. Since this "wake-up call" I have made it a point to closely monitor my own cognitions and feelings in therapy. I have also encouraged supervisees to examine the cognitive and emotional effects therapeutic impasses or other difficulties have on them. They are encouraged to use cognitive interventions on their own thinking that is linked to their negative emotional reactions, as the cognitive behavioral model would predict.

Example 2

In conducting CBT workshops I have often asked participants to imagine themselves being in the following hypothetical situation. They are asked to report what feelings might be experienced right before a first session with a patient referred by a colleague who notes that there may be some "borderline tendencies." Participants often report feelings of anxiety or irritation often linked to negative thoughts such as, "The patient will be very angry," or "The patient will be difficult to treat," or "The patient will be resistant and challenge me." As a result of the emotional and cognitive reactions just described, the therapist's behavior toward the patient might be different from usual; the therapist may be more distant, act defensively, or become overly vigilant. These behaviors may in turn trigger some anti-therapeutic behavior in the patient that appears "borderline" if he or she perceives the therapist to be uncaring, nontrustworthy, or disinterested. Following this cognitive behavioral analysis of therapist reactions, workshop participants can readily see how their own assumptions mediate feelings and behaviors in therapy. A subsequent discussion regarding how to challenge and reappraise these thoughts is then extremely helpful. Usually trainees can generate more adaptive thoughts such as, "I will have to wait and see what, if any, borderline features this patient has, and meanwhile I will concentrate on my two goals for this first session, to identify problems and targets and to develop initial rapport with the patient."

These modified cognitions are likely to both reduce the anxiety and irritation experienced and facilitate more effective therapy. This is a useful exercise in both training and supervision. Trainees and supervisees should be encouraged to focus

both on the overt interaction that occurs between the therapist and the patient and on the internal reactions of the therapist, including feelings and thoughts, that the therapist has to deal with while simultaneously responding appropriately and therapeutically. Ludgate (2012) points out that in some instances the therapist may be simultaneously conducting CBT with a patient and using CBT on himself or herself at the same time. Wilson, in his book *Mindfulness for Two* (2008), makes a very similar case for therapists using mindfulness and acceptance strategies with themselves as well as with their patients to facilitate maximum therapeutic benefit.

IMPROVED SELF-CARE FOR THERAPISTS

It seems obvious from the previous discussion that therapists need to learn to “take care of themselves,” emotionally developing skills to detect and deal with the challenges faced every day in addition to learning cognitive behavior therapy. Doing so should decrease their levels of emotional distress and facilitate their effectiveness as therapists because such reactions can interfere with the provision of effective treatment. Trainers and supervisors need to be mindful of the importance of including this component in training and supervision. CBT methods to identify and modify dysfunctional therapist thoughts are contained in the learning exercises at the end of this chapter and can be found in Bennett-Levy et al. (2015), Ludgate (2012), and Sanders and Bennett-Levy (2010).

Looking more generally at the interventions available to therapists experiencing stress, a list of activities that can reduce therapist distress and improve resiliency follows:

- Self-monitor and self-reflect to recognize early warning signals of distress, identify high-risk situations, and develop an action plan; see Learning Exercises at the end of the chapter.
- Use self-directed CBT for episodes of distress as described by Beck (2005), Bennett-Levy et al. (2015), Leahy (2001), Ludgate (2012); see Learning Exercises at the end of this chapter.
- Focus on issues of therapist distress in supervision and training.
- Develop support networks for peer interventions for colleagues who are struggling with these issues.
- Intervene at an organizational level (Teater & Ludgate, 2014).
- Use professional intervention when the previous are insufficient or the level of severity requires it.

TRAINING AND SUPERVISION IMPLICATIONS

Some therapists, including some reading this book, may have received professional training in which little attention was given to attending to their own reactions. For example, in more than eight years of professional training, I

received one three-hour workshop on this topic. Encouragingly, in current graduate training there is a great deal more focus on issues related to personal professional development. In the United Kingdom, training courses in clinical psychology are now required to address personal professional development (PPD) in order to be accredited. Sheikh et al. (2007) describe a model of PPD and detail how it is utilized within one training course. These developments are to be applauded. More and more CBT texts that deal with challenging cases (Beck, 2005; Beck et al., 2003; Layden et al., 1993; Leahy, 2001) devote time and attention to the topic of distressing reactions in therapists, and clinical and professional training should also focus on these important issues. At a postgraduate level, training for professionals working in the field has somewhat neglected the topic of psychotherapists dealing with emotions, thoughts, and behaviors triggered by therapy situations. Workshops and seminars on this topic, presented at national mental health conferences or as part of intensive CBT training for professionals, should be increased and made easily accessible. When there is a lack of attention given to this topic in the training arena or at conferences, a misattribution that therapist distress is really not a problem or is a low priority can occur. Consequently, any therapist experiencing some of these problems may experience secondary shame and embarrassment, which may in turn increase the reluctance to talk about these issues or ask for support, further isolating the therapist. Trainers and supervisors should prioritize this issue and provide opportunities to examine these issues to facilitate resilience and normalize and validate the experience. Trainers and supervisors should model and normalize these distress reactions by nonjudgmental and compassionate responses, followed by problem solving and, in some cases, appropriate self-disclosure.

Trainees should be encouraged and reinforced for monitoring their own reactions to patients and the experience of being a therapist. In this regard the inclusion of self-practice/self-reflection (Bennett-Levy et al., 2001; Bennett-Levy et al., 2015) in CBT training and supervision has been a welcome development and has received considerable empirical support. It has been found to both develop and enhance therapist skill (Bennett-Levy, Lee, Travers, Pohlman, & Hammernick, 2003) and also to produce personal and professional benefits (Bennett-Levy, Thwaites, Chaddock, & Davis, 2009; Laiter & Willutzki, 2003). An excellent resource, it demonstrates the use of SP/SR as part of self-directed CBT for therapists (Bennett-Levy et al., 2015) and this and other CBT-oriented materials on this topic (Kennerley, Mueller, & Fennell, 2010; Ludgate, 2012) should be utilized in CBT training and supervisory practice. A focus in training and supervision on therapist self-care, on compassionate approaches to both patients and to themselves, and an emphasis on mindful acceptance is important. This may have greater relevance when working with complex and challenging cases.

Supervision, especially on an individual basis, lends itself to a more personalized and customized experience with these issues than training. The supervisee's

development of skills and knowledge plus the issues of developing resiliency and improving self-care can be a dual focus. Skill development aimed at improving patient care may be compromised by a neglect of supervisees' emotional reactions to their work challenges. Therapists who have reached competency levels in delivery of CBT may be unable to implement therapy effectively if they are negatively affected by adverse reactions to patients. Trainers should address these issues in both training and supervision with the intertwined goals of (1) reducing or preventing significant therapist distress and (2) improving the level of patient care by ensuring that resilient therapists deliver evidence-based therapy with fidelity. These and related issues in effective, evidence-based CBT supervision are also discussed in chapter 12.

Supervisors need to focus on supervisees' emotional status with challenging patients as well as helping them develop better conceptualization and intervention skills. The following list (Ludgate, 2012) offers guidelines in this regard:

- Maintain a problem-solving attitude. Even when faced with obstacles, try to remain calm, collaboratively attempt to identify what is interfering with progress, generate alternative solutions, and adopt a plan.
- When an impasse occurs, do not attribute responsibility for this to either the client or to yourself but see it as a problem to be solved and attempt to generate possible solutions.
- Avoid labeling or stereotyping the patient. Instead try to use the patient case formulation (how you conceptualize the patient and his or her issues) to understand what is going on for this person in this present situation. For example, how does what seems like "resistance" fit in with the patient's beliefs and individual history? It may be that the patient values being in control.
- Identify and deal with any provider dysfunctional cognitions. Methods to facilitate this are described in the second Learning Exercise at the end of this chapter.
- Be realistic in your expectations. Avoid the trap of thinking that no one ever relapses, has setback, or doesn't show a good response to the application of techniques that usually prove helpful to other patients. In addition, do not expect linear progress. It is more likely to be in a somewhat jig-jag fashion, with stops and starts, even when the patient is improving.
- Try to remain guardedly optimistic. Hopelessness, cynicism, or pessimism in the therapy provider interferes with therapeutic progress, just as these attitudes in the patient can impair therapy. The provider should promote the idea that some change in some facets of the client's functioning is always possible and communicate this to the patient without creating false or irrational expectations.
- Maintain a high level of tolerance for frustration. Professionals working with challenging patients should expect and be prepared for roadblocks and

frustration. A comprehensive case formulation should allow a prediction of what difficulties are likely to come up in treatment itself or in the therapy relationship, based on the patient's beliefs and compensatory strategies, arising in part out of previous learning experiences. Being forewarned in this way, the provider may be able to plan in advance for these problems and adapt the delivery of therapy accordingly.

- Avoid buying into the patient's distortions. Even when an individual's situation is realistically "bad," it is important, although acknowledging this reality, also to examine the possible mediating influence of negative thinking or inadequate coping in "making a bad situation worse."
- Resist the urge to switch models or approaches inconsistently when the going gets tough. It is possible to creatively interweave therapeutic interventions from other models or approaches while still being guided by the original model. The unsystematic applications of many techniques or models is likely to be ineffective and possibly confusing and anti-therapeutic for the patient.
- Do not expect or believe that you will have all the answers to every problem. It sometimes "goes against the grain" for some providers who have unrealistic expectations for themselves to say to a patient, "I am not sure what the answer is but I will try and find out by consulting with colleagues or the literature," but this may model effective problem solving for the patient with the absence of a demand on oneself to be perfect or all-competent.

An important study of therapists in supervision during cognitive therapy training found that the trainees' ratings of their own competence was influenced strongly by their emotional state and stress levels (Bennett-Levy & Beedie, 2007). Supervision that focuses on both patient's issues and the therapist's reactions can greatly reduce personal work-related stress as well as fine-tune therapists' clinical skills. Many providers attest to the importance of good supervision in their personal and professional development. An invaluable benefit of supervision is that in this "safe" setting frustrations, anxieties, and other emotional issues can be addressed. Power differentials and evaluation anxiety can hinder supervisee honesty about more personal work-related struggles, so a spirit of openness is critical. There should be no fear of consequences on the supervisee's part, with the exception of ethical violations or professional malpractice issues. It is incumbent upon the supervisor to make it clear that supervision is "for the supervisee" and not geared only toward improving skill level, increasing productivity, or optimizing patient outcome. Effective "whole-person supervision" should focus on the supervisee's rewards, frustrations, stressors, and challenges with patients and in the workplace. Supervisors should focus on self-management and, by using guided discovery, generate plans to improve supervisee self-care. However, supervisors should be careful that supervision does not become personal therapy for the

supervisee. If the supervisee needs to use supervision to “recharge the batteries” and feel less demoralized in the workplace, this is a legitimate focus of supervision. Supervision should not be used, for example, to deal with partner or family concerns; personal therapy should be recommended and help with a referral offered. When formal supervision is not ongoing, practitioners can benefit from informal peer supervision or consultation. The benefits of having collegial support as well as having consultation on clinical issues are considerable, especially for individuals working in isolation. Regarding peer support, we should make every effort to facilitate the creation of a supportive environment for colleagues who wish to obtain support and consultation. The role of organizations in supporting this endeavor is critical.

Organizational factors have been found to be important in the development of stress and burnout in caregivers (Maslach & Leiter, 1997), and, conversely, agency and organizational initiatives can play a major part in improving staff morale and resilience and prevent distress and burnout. Organizational interventions are described in several texts (Figley, 2002; Teater & Ludgate, 2014). Chapter 11 in this volume stresses the importance of trainers working at the organizational level ensuring adequate support in developing and maintaining CBT training and supervision. Similarly, trainers and supervisors can help influence organizations to develop prevention and remediation strategies to reduce the risk of therapist distress and burnout and facilitate effective self-management. The role of organizations at state or national level in offering support and help to impaired or distressed individuals is also important, and recent initiatives taken by the British Association for Behavioural and Cognitive Psychotherapy (BABCP) are to be applauded.

Another important role for trainers and supervisors in assisting trainees or supervisees with some of the pitfalls and problems discussed here is to focus on issues relating to therapists’ reluctance to reach out to colleagues for help and the cognitions associated with this. Open discussions regarding when professional intervention may be indicated are helpful. The literature on this issue (see review by Geller & Norcross, 2005) and books by therapists who have shared their own experiences of mental health issues (Hinshaw, 2008; Rippere & Williams, 1985) can be used to facilitate this process.

SUMMARY

Working as a therapist can be rewarding and fulfilling but also has the potential to lead to distress. In this chapter the need for CBT training and supervision to focus on therapists’ personal reactions to therapy practice was emphasized. Practical guidelines for optimizing this were outlined in an effort to ensure that training is geared not only toward competency and skill development but also to professional development, including better self-care and resilience.

LEARNING EXERCISES

Exercise 1: Identifying Dysfunctional Beliefs Leading to Therapist Distress

A rating scale can help trainees reflect on some of their own beliefs regarding their patients, their work, and themselves as therapists.

Please rate your degree of belief in the following statements (3 = Strongly; 2 = Somewhat; 1 = Not at all).

Regarding Patients

- I have to be successful with all my patients all the time._____
- I must always have good sessions with my patients._____
- I should not dislike any of my patients._____
- I should not feel any negative emotions related to patients or to doing therapy with them._____
- My patients should always respect and like me._____
- People I am trying to help should not be difficult and resistant._____
- If I extend myself to help patients, they should be motivated to change._____

Regarding Your Work and Yourself

- I must always be totally competent and in control._____
- It is terrible to be criticized or disapproved of._____
- Life in the workplace should be fair and just._____
- My worth as a person is dependent on my job performance._____
- If I am not successful in alleviating patients' problems, I can't feel good about myself._____
- I must always have good judgment as a professional._____
- I should have all the answers._____
- I should not have any strong emotional reactions myself._____
- If I have emotional or other problems, I should control them and never show them to patients or colleagues._____
- I should not seek help from peers, supervisors, or professionally._____
- I will be seen as weak if I ask for help._____
- I must be perceived as totally competent._____

The functionality of these beliefs can then be discussed, and more adaptive alternatives can be rehearsed within training or supervision.

Exercise 2: Self-Directed CBT for Work-Related Distress

Trainees or supervisees can be encouraged to carry out the following analysis to deal with episodes of distress when they occur.

Ask trainees or supervisees to retrospectively focus on a recent time doing therapy with a patient when feelings of frustration, anxiety, or irritation occurred. Have them carefully note the following:

- What was the situation?
- What happened?
- What feelings did I have?
- What thoughts did I have?
- What was going through my mind when I began to feel upset in this situation?
- What meaning did it have for me?
- Why was it a problem?
- What is the effect of my thinking on my emotions and my behavior?
- What is the evidence for and against my thoughts?
- What are other ways I could look at this?
- What is the worst that could happen and how likely is this?
- What would I do in the event of the worst happening?
- What can I do or what ways can I think about this that will help me deal effectively with the current situation?

Encourage trainees or supervisees moving forward to carry out this same procedure when they experience difficulties either with their therapeutic practice or with the work situation in general.

Exercise 3: Recognizing and Dealing with Work-Related Stress

Encourage trainees or supervisees to improve detection and intervention strategies by reflecting and preparing as follows:

What Are My Warning Signals of Being Stressed or Distressed Relating to Work?

Behavioral: _____

Emotional: _____

Cognitive: _____

Interpersonal: _____

What Are High-Risk Situations for Me?

Patient related: _____

Not related to patients: _____

What Is My Action Plan for Self-Management When I Notice the Early Warning Signals or Encounter the Preceding High-Risk Situations?

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